The State of Population Health: Fourth Annual Numerof Survey Report

Conducted by Numerof & Associates in collaboration with David Nash, Dean of the Jefferson College of Population Health

March 2019

Copyright © 2019 Numerof & Associates, Inc.

These materials and the information contained in this report are provided for informational purposes only. If you have any questions about this material, please contact Numerof & Associates, Inc. No part of this document may be distributed, resold, copied, or adapted without written permission.

Share this report:

Executive Summary

For the fourth consecutive year, Numerof & Associates has partnered with Dr. David Nash, Dean of the Jefferson College of Population Health, to study the evolution of population health management in the United States. As U.S. government policy grows more focused on moving to a value-based model, population health management will be increasingly seen as a key part of the solution for realigning the healthcare industry to deliver better care at lower costs.

This report is based on an online survey of more than 500 C-suite healthcare executives, combined with open-ended interviews with selected executives that provide additional color around the numbers. Key study findings include:

Progress toward implementation of population health as a model for organizing healthcare delivery appears to have stalled in 2018. This is based on three subsets of survey data: 1) global perspectives of respondents; 2) reported progress on implementing supporting management processes; and 3) reported assumptions of risk-based contracts. This slow progress is predictable given the magnitude of the change the industry is experiencing.

Globally, respondents were lukewarm about their organization's ability to manage the cost and quality of care. Just over 60% said their organizations were at least moderately prepared to do so, unchanged from 2017. Respondents' median assessments of how well their organizations manage variation in cost were average (4 out of 7) and slightly above average (5 out of 7) for quality, both unchanged from 2017.

The survey asked about key management processes that support population health, and little change was observed there too. Less than half of respondents reported that their organizations routinely used a process to identify outliers in cost and quality at the physician level, or had a process to address such variation when it occurred. Further, less than 40% said that compensation was linked to cost and quality performance for at least some clinicians.

Given the lack of progress in underlying process development, it's not surprising that there was no reported change in the percentage of revenue at risk over the 2017 survey. The majority reported that 10% or less of revenue came through risk-based contracts. This measure not only remained flat relative to prior surveys, but also fell significantly short of the projections respondents previously made regarding how much revenue would be at risk in 2018. In addition, respondents' future projections of revenue at risk were lower than projections reported in prior surveys. This suggests that respondents –

Copyright © 2019 Numerof & Associates

Share this report

and the industry – anticipate slower implementation of population health going forward than they have expected in prior years.

Nevertheless, executives agree population health is the future. Consistent with past surveys, almost all respondents (94%) rated it moderately (12%), very (42%), or critically (40%) important. Nearly all respondents (99%) project their organization will have some revenue in models with upside gain and/or downside risk in two years.

Smaller healthcare delivery institutions lag. In our sample, 90% of large hospitals and/or health systems said they had at least one at-risk contract compared to 76% of mid-sized institutions and 71% of smaller institutions. Smaller organizations may have a limited ability to absorb the impact of outliers, but they can make up for it with nimble program design and implementation. For those organizations that have undertaken risk-based agreements, smaller hospitals tend to have more revenue at risk than medium and large hospitals.

Most organizations are still just experimenting with risk-based contracts. As in our last survey, over three-quarters of respondents reported some experience with an alternative payment contract, but for most (66%), less than 20% of revenue was involved. Among those who claimed experience with an alternative payment contract, a substantial portion (31%) didn't risk actual loss. Their risk was upside only – not receiving a "bonus" if targets were not achieved.

The potential for financial loss remains the single greatest barrier to the implementation of population health. Nearly a quarter of respondents cited the threat of financial loss as the primary barrier to moving to a risk-based model, followed by other concerns including difficulty in changing organizational culture (14%) issues with systems like IT, tracking, and management (14%), and uncertainty about when to make the transition from the current model (11%).

Finally, while respondents reported some progress in their ability to manage variation in cost and quality, there is still a long way to go. A majority of respondents (61%) rated their organization's ability to manage variation in cost as average or worse than average, an improvement of 8% over three years. More than one in three respondents (35%) view their organization's ability to manage variation in quality as average or worse than average.

Copyright © 2019 Numerof & Associates

Methodology

Although population health management has garnered significant attention, there has been little effort given to tracking the actual progress made toward value-based models of care. Recognizing the critical need for this research, Numerof & Associates partnered with Dr. David Nash, Dean of the Jefferson College of Population Health, on an annual study to define and track the evolution of population health management in the U.S.

In this fourth year of our study, we utilized the same approach as in prior years; an online survey which was designed to assess progress, challenges, and success factors in healthcare delivery organizations' transition to population health management, with particular interest in year-by-year trends. Approximately 10,340 individuals were invited to participate in the online survey, which was fielded from August to October 2018. The target audience was defined as physician group executives or vice presidents, as well as individuals working in U.S. provider organizations including healthcare systems, hospital and academic medical centers.

We received 528 surveys,[1] corresponding to a response rate of 5.1% of individuals and 16.7% of institutions. Respondents included C-suite executives across the entire U.S. in urban, suburban and rural areas. They represented stand-alone facilities, small systems, and IDNs; for-profit, not-for-profit, and government institutions; and academic and community facilities. Similar to 2017, survey respondents participating in accountable care organizations (65%) were overrepresented compared to recently published numbers (20%).[2]

In addition to aggregated data from the full set of survey participants, this white paper includes illustrations from open-ended responses and interviews with selected executives.

[1] 480 responses passed the inclusion criteria, which required that respondents work for a healthcare delivery organization or physician practice as well as have at least partial knowledge of their organization's current population health management efforts (i.e., a score of 3 or greater on a 7-point knowledgeability scale).

[2] Colla et al. Health Affairs, March 2016. Vol 35, no. 3, pgs 431-439.

Copyright © 2019 Numerof & Associates

Share this report

Introduction and Context

It is increasingly recognized that the current model of healthcare is broken. It is unaffordable, it is piecemeal, there is little accountability for outcomes, and it is not patient-centered. Moving forward, the model must focus on transparency and accountability for outcomes across the continuum. It must take into account both quality and cost to define relative value through the eyes of consumers, payers, and other stakeholders.

Population health has gained traction as an important solution in addressing the issues inherent in the current system. Although there are multiple definitions of population health, all articulate the general goal of achieving better health outcomes at lower costs. Regardless of the definition, new efforts toward effective implementation of population health management represent a paradigm shift.

The Evolution of Population Health

To understand this shift, it's helpful to take a historical perspective. Since the 1970s, Congress and successive administrations have tried to slow the growth of healthcare costs. Attempts have included the introduction of Medicare hospital payment formulas based on fixed payments for hospital services (payments for diagnostic related group services or DRGs), health maintenance organizations (HMOs), and preferred provider organizations (PPOs).

Costs have continued to rise despite these efforts. At the same time, concerns about fragmentation of care and diminished quality have increased significantly. **What has been missing from the discussion, and what lies at the heart of why healthcare hasn't changed, is the fact that costs have not been linked to outcomes.**

At the same time, employers have challenged increasing costs, seeking new ways to control them and shifting some of the burden to employees through higher deductibles, copays, and responsibility for premiums. Payers have also been challenged by plan sponsors to reduce costs, and both payers (commercial and government) and consumers are trying to get more value for the checks they write. Their mantra has become "moving from volume to value," with many adding in, "How do I achieve better outcomes for less?"

With the advent of "never events" in 2008, the Centers for Medicare and Medicaid Services (CMS) took a stand. For the first time, it attempted to connect payment to outcomes. No longer would CMS pay for mistakes that

Copyright © 2019 Numerof & Associates

should have been prevented (e.g., hospital-acquired infections, medication errors, wrong site surgery, etc.). In 2010, PPACA legislation picked up on this theme with a range of pilot programs designed to help delivery organizations get used to the idea that going forward, quality and outcomes would affect reimbursement. This has been reflected in approaches like bundled pricing and accountable care organizations, among others.

CMS continued on the path toward value-based care by announcing in 2015 that 50% of Medicare payments would be structured according to value-based models by 2018. To meet this goal, CMS introduced various programs, including bundled payment models. Commercial payers followed suit, publicly stating their own value-based payment goals and programs for achieving them.

Over the course of the past year, the policy uncertainty from Washington has left many healthcare administrators uncertain about what to do next. In particular, the cancellation of several mandatory bundled pricing programs in favor of voluntary versions has raised questions about the future of value-based care, just as many administrators were beginning to accept it as inevitable.

Some initiatives to change payment models to better reflect cost and quality have demonstrated promising results. While not all efforts have had the desired impact, more focus on connecting payment to outcomes is certainly warranted. This explains the broad political support for MACRA.

Signed into law in 2015 with data collection starting in 2017, MACRA is designed to encourage physicians to shift from fee-for-service to alternative payment models linked to cost and quality. As the replacement for less popular legislation intended to control federal healthcare spending, MACRA still enjoys bipartisan support. But MACRA's focus is on reshaping physician practice patterns – it is by no means a holistic solution.

Unconventional solutions with potential to cause major disruptions are on the horizon, like the announcement in January 2018 from Amazon, Berkshire Hathaway, and JPMorgan of their intent to find a better healthcare solution for their million-plus employees. Coming on the heels of the CVS-Aetna merger, the announcement created a palpable moment of shock and awe across the industry. The realization that the private sector might actually intervene and come up with a better model has knocked many provider organizations out of their complacency. This argues that the provider community should make a more focused and determined effort toward value-based care and risk-based models in the coming year.

Copyright © 2019 Numerof & Associates

The principal driver of healthcare cost growth is a payment model that rewards the provision of service, and not the clinical or financial outcomes achieved. Until that issue is addressed, we will not succeed in bending the cost curve. Providers still have the opportunity to rethink their business models and demonstrate the critical role they can and should play in keeping our population healthy and healthcare costs low. We strongly believe the push toward value will continue, but exactly how that will translate into future policy remains to be seen. Forward-thinking providers will continue to move in this direction – as long as they can maintain control over their trajectory.

Charting Progress Toward Population Health

If we are serious about better health and better health outcomes at lower costs, then we need to think about using nontraditional delivery options and consider how these tie into current efforts. Population health is not a new concept, but it has attracted renewed interest across the healthcare industry as a way to move toward a value-based model. Whether it's thought of in terms of the health of individuals in a given geographic area, or as a financial risk model relying on capitated funding for delivering health services, population health is likely coming into its own.

Despite a variety of definitions, at its core, population health is about managing the health of a defined population by providing the right intervention for a specific patient at the least costly point in the care continuum. Its goals include improving care coordination, enhancing health and wellness, eliminating disparities, and increasing transparency and accountability. When population health management works well, acute care utilization is reduced, total healthcare costs are lower, and "healthcare" finally becomes more than just "sick care."

Inherent in making the transition to population health management is the ability to assume financial risk. **This is newly charted territory for most healthcare providers. Many have questions about how to initiate the journey, and most importantly, how to ensure a successful transition.**

In the midst of this dramatic change, it is critical to define where organizations are in the transformation process, and to track those changes year by year. In response to this need, Numerof & Associates partnered with Dr. David Nash, Dean of the Jefferson College of Population Health, on a multi-year assessment of healthcare delivery organizations across the U.S. This whitepaper highlights key findings from the first four years of our study.

Copyright © 2019 Numerof & Associates

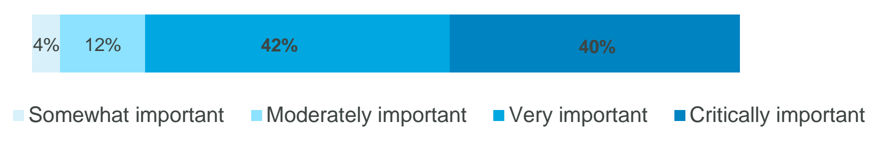
Key Research Findings

Building upon the firm's deep expertise in the realm of value-based care, Numerof's national surveys of healthcare executives across four successive years indicate that population health remains a dynamic area, as seen in the following key themes.

1. Executives agree population health is the future, but organizations have failed to keep pace with anticipated progress

In the survey, an overwhelming majority of respondents considered population health important for their future success. Similar to the previous year, almost all respondents (94%) rated it between "moderately" and "critically" important, with 40% rating it as "critically important" (see Figure 1).

Figure 1: How important is population health for future success?



No respondent selected "Not important at all," "Low importance," or "Slightly important"

The overwhelming agreement by executives that population health will be important to future success represents a clear contrast with their organization's progress in operationalizing it. In the 2016 survey, over half of respondents (61%) predicted they would be at least "very prepared" to take on risk in 2018. In the current survey, however, barely 25% felt they had achieved that mark (see Figure 2).

Copyright © 2019 Numerof & Associates

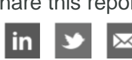
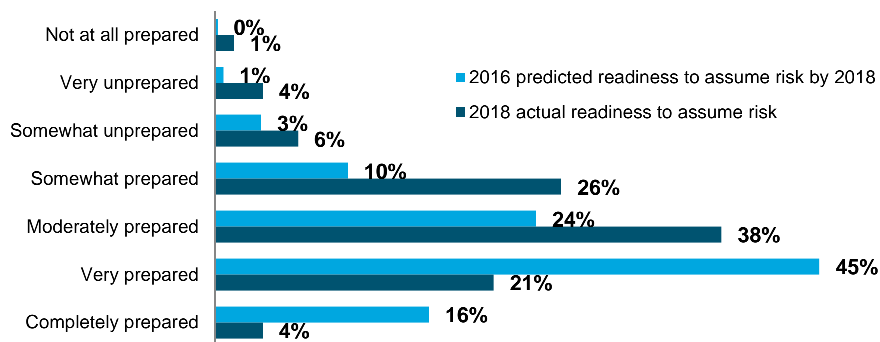


Figure 2: Respondents' readiness to assume risk falls extremely short of their prediction 2 years ago



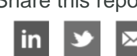
While there is widespread agreement that organizations need to move to population health, it doesn't make the task of getting there any easier. Last year, the Executive Director of Population Health at a mid-sized academic system shared that, "[P]laces where the academic environment runs counter to our population health goals have created institutional challenges. For example, our organizational structure and budgets aren't set up to support population health objectives. This has made us focus on small, proof-of-concept initiatives, but the results are encouraging even within the limited framework."

Similar to the last several years, the complexity of implementation and the demands of scaling were echoed by many executives. One C-suite executive of a large healthcare system shared last year that pilot projects have shown moving to population health "is not simply a matter of will. You have to anticipate where you want to be and construct the services necessary for success before you actually need them."

The importance of population health to the future success of healthcare organizations remains clear. However, implementing population health initiatives that effect change presents significant challenges. One COO at a leading hospital system pointed out that thus far their population health efforts "are all over the place and have grown organically without the benefit of a master plan. Our performance isn't where it needs to be given the amount of time we've invested, so we are beginning to redesign our strategy to put all the necessary pieces together across the continuum."

The challenge of building a central, organizational strategy while addressing market needs is a common theme for executives. An EVP at one health system shared that, "We must focus on what is common across our whole system while understanding what is market-specific. Our next step is to

Copyright © 2019 Numerof & Associates

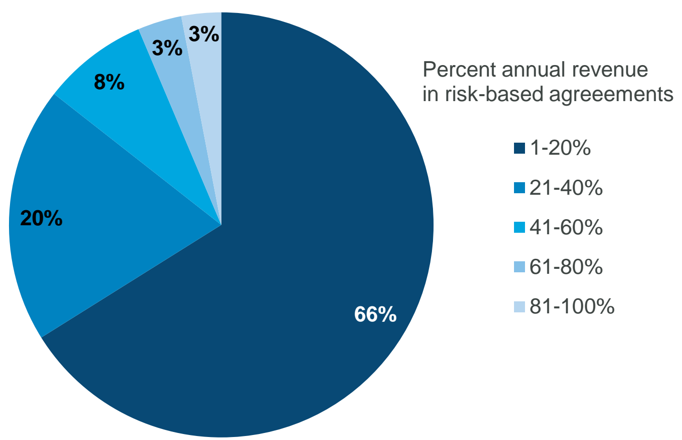


deploy a central strategy with elements that are specific to individual markets."

2. Most organizations are still just experimenting with risk-based agreements

Although most respondents reported some participation in alternative payment models, the extent of their progress – as measured by the percentage of revenues in risk-based agreements – still appears limited. Similar to 2017, more than three in four respondents reported their organization was in at least one agreement with a payer that includes upside gain and/or downside risk. However, organizations that are engaged in these agreements have limited exposure (see Figure 3). Two-thirds of the respondents in risk-based agreements said that less than 20% of their organization's revenue is at risk. In addition, nearly one-third of respondents (31%) in risk-based contracts in fact had no downside risk, only the possibility of a "bonus" if targets were exceeded.

Figure 3: Respondents engaged in risk-based agreements have limited annual revenue at risk

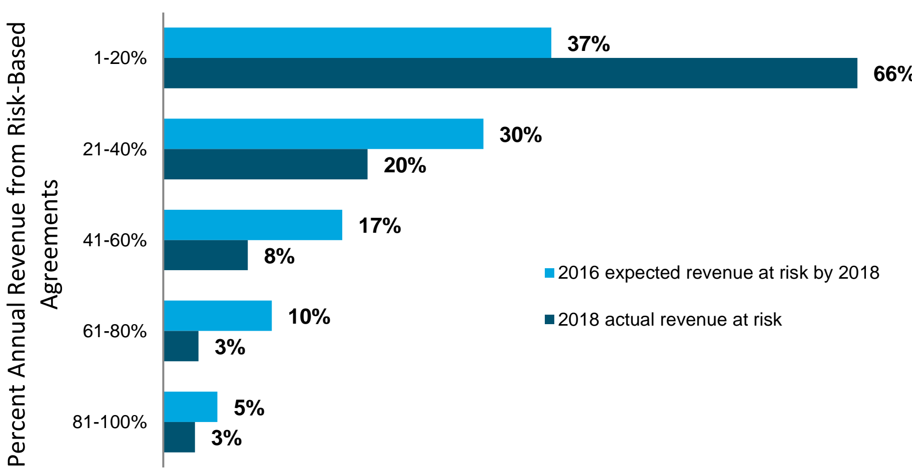


In each of the survey's prior administrations, respondents predicted a dramatic increase in the percentage of annual revenue that would be at risk in the next two years; however, actual progress has failed to keep pace with expectations. As shown in Figure 4, respondents consistently overestimated what their 2018 involvement in risk-based agreements would be when asked

Copyright © 2019 Numerof & Associates

in 2016. In our 2016 survey, nearly 1 in 3 respondents projected that by 2018 their organizations would have at least 40% of their revenue in risk-based agreements, but only 14% of respondents to the most recent survey met that threshold.

Figure 4: Respondents failed to meet predicted percentage of annual revenue in risk-based agreements



In some cases, respondents' initial experiences with at-risk contracting were not positive. In one such anecdote from last year, an organization wasn't fully prepared to take on risk because it hadn't aligned physician incentives. A C-suite executive at a small system commented that they "started with a large employer commercial contract with downside risk assumed by the organization but not the providers, making it hard to engage them – particularly the specialists. This first contract was unsuccessful and colored the organization's impression and progress."

In other cases, organizations were eager to move toward population health but, as shared last year by a senior executive at a specialty hospital, their expectations did not align with their progress in part because it "takes time to build out the capabilities, get continued buy-in, and scale programs from pilot to full risk."

Even those systems that are leaders in risk-based contracts experience challenges in changing the mindset and culture of their organization. One executive of a healthcare system with 50% of their beds under value-based or capitated contracts said that "value-based models are still an ethereal concept for hospitals" and that "CFOs still think in terms of heads in beds and fee-for-service." Many organizations like this one struggle to develop integrated

Copyright © 2019 Numerof & Associates

population health solutions and to communicate their overall value proposition to appropriate stakeholders.

Though many healthcare organizations have not met their projected targets for risk-based contracts, there are those who continue to focus their efforts on making progress in the future. As part of this process, providers are reevaluating how risk is shared with payers. A senior executive responsible for accountable care strategy at a healthcare organization experiencing significant savings from their risk-based model shared that, "We want to be in a position where there's more equitable sharing of benefit rather than having it go largely in the payer's pocket. We are optimizing our payer relationships based on where the world is going." Another executive echoed this sentiment in saying, "It's about costs, but it's also about the need for greater payer/provider alignment."

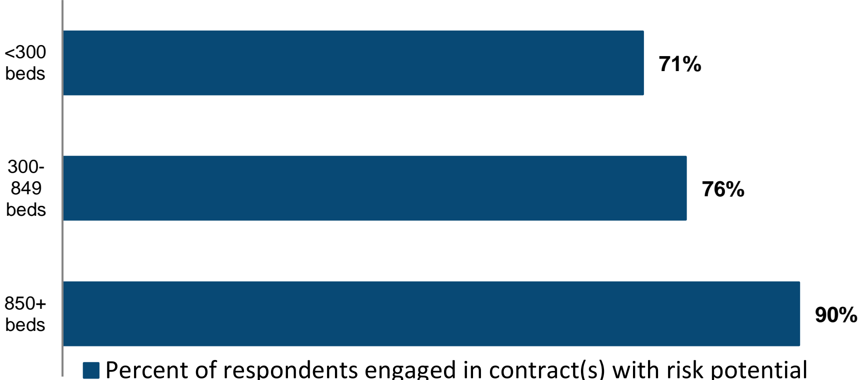
As was true in the last survey, there are those organizations that are comfortable with fee-for-service models and will not move until external events require them to do so. A senior executive of a multi-state system that publicly promotes its efforts in value-based care candidly shared last year that they are "fully capable and willing to advance in this area, due to programs in place or being developed, but we are awaiting a triggering event."

Copyright © 2019 Numerof & Associates

3. Smaller healthcare delivery institutions lag behind on engaging in risk-based agreements

Looking at participation in risk-sharing agreements by hospital size, we found that larger hospitals were more likely to take on such arrangements than smaller institutions. In our sample, 90% of large hospitals and health systems said they had at least one at-risk contract, versus 76% of mid-sized institutions and 71% of smaller institutions (see Figure 5).

Figure 5: Larger hospitals and systems are more likely to be engaged in risk-based agreements

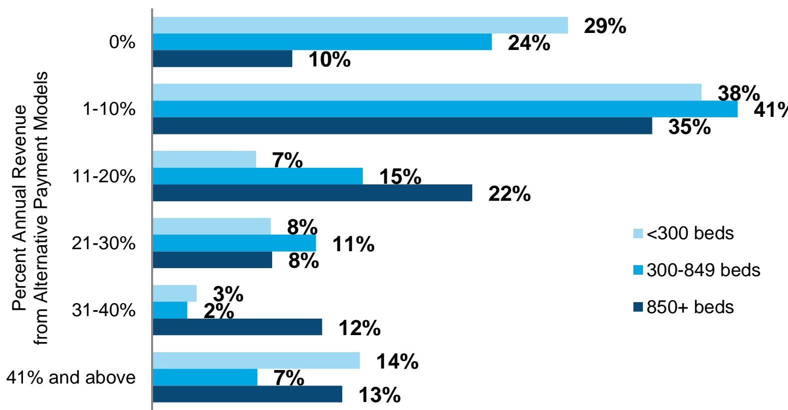


Risk is often more acutely felt at smaller institutions, which have more limited capital reserves and feel disadvantaged by the "tyranny of small numbers." That is, with a smaller population at risk, an outlier has a proportionally larger impact on overall results. At the same time, risk-based contracts are likely to represent a larger percentage of overall revenue in a smaller hospital than in a larger system.

This latter point is illustrated by the percentage of revenue at risk for hospitals participating in risk-based contracts. Only 13% of large hospitals and 7% of medium-sized hospitals had 40% or more of their revenue at risk, compared to 14% of smaller hospitals (see Figure 6).

Copyright © 2019 Numerof & Associates

Figure 6: Of those engaged in risk-based agreements, smaller hospitals and systems are putting more revenue at risk



Looking at hospital size as a factor, we find smaller hospitals less likely to enter into at-risk contracts, but for those that do, the decision is potentially more consequential when the at-risk revenue is seen as a percentage of total revenue. The latter point may simply reflect the reality of a smaller revenue base and reinforces the caution taken by smaller institutions regarding risk-based contracting.

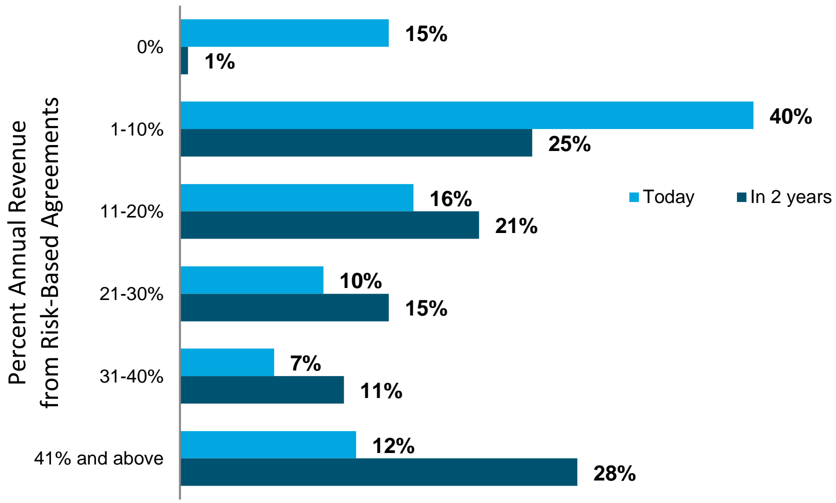
The corresponding advantage of smaller provider organizations is that their size can make timely monitoring and management of at-risk operations more efficient than these processes are for larger organizations. Through Numerof's work, we've seen smaller organizations make up for their limited ability to absorb the impact of outliers with nimble program design and implementation, along with early warning systems that enable more timely course corrections than larger organizations can typically execute.

Copyright © 2019 Numerof & Associates

4. Organizations have moderated their expectations about the pace of the market's transition to population health; many have a significant capability gap to close

Despite the limited amount of revenue currently at risk and the lack of progress over the last few years, respondents see the market moving to alternative payment models. Nearly all respondents (99%) project their organization will have some revenue in models with upside gain and/or downside risk in two years (see Figure 7).

Figure 7: Respondents expect to increase percent of annual revenue in risk-based agreements



Though their prediction to move toward risk-based contracts remains, the majority of respondents have failed to meet their 2016 forecast of having nearly one-third of revenues in risk-based contracts by 2018. In fact, respondents' median percentage of revenue in models with either upside gain or downside risk has flatlined at 10% for 3 years now. Furthermore, expectations for the future have also moderated as respondents' median projection for the percent of revenue in risk-based models has fallen slightly from 30% to 25% (see Figure 8). Even so, if organizations are going to meet this goal, they have a significant amount of work ahead of them.

Copyright © 2019 Numerof & Associates

Figure 8: Respondents have moderated their expectations for future revenues in risk-based contracts

	2016	2017	2018
Median % of revenue at risk today	10%	10%	10%
Median % of revenue at risk expected in 2 years	30%	30%	25%

Executives continue to highlight challenges that need to be addressed in order to meet this goal. One such challenge expressed last year is that "switching to the new models is interpreted differently by doctors than by administrators. We know it will take the participation of both to move toward the new models in an efficacious manner."

Many organizations face the challenge of scaling the payment models they have piloted across the organization. As one population health executive shared last year, "We are working to figure out how to grow population health beyond pilots in a responsible manner." This process requires translating experience into guidance that can be fully operationalized.

While executives of healthcare delivery organizations largely agree that population health is crucial to future success, many find difficulty in changing to new business models given their continued success in the old one. One executive at a healthcare system in the South with "huge margins" that is "flush with capital" for investment noted that, "Healthcare is local and value-based payment models are here to stay." Despite this recognition, this same executive shared that they are experiencing obstacles in moving to a population health model given "their challenge to keep up with heavy fee-for-service volume in a growing and largely commercial market where demand for their services exceeds supply." In this sense, a healthcare system's own growth and success can serve as an obstacle to the transition to population health, especially when resources to operate differently are not in place.

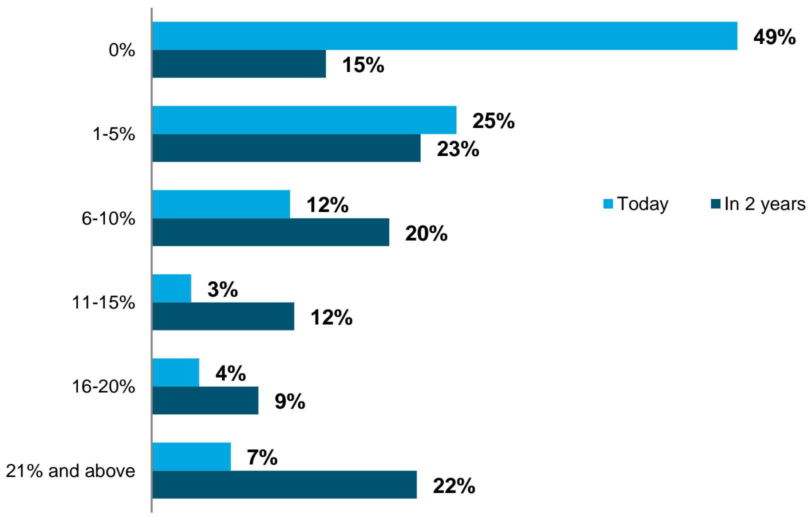
Copyright © 2019 Numerof & Associates

5. Executives expect revenue in capitated contracts to grow

To better understand the full-risk side of the spectrum, we surveyed participants on capitated contracts. While half of respondents (51%) are engaged in some capitated contracts today, we found them limited in their use and scope.

Executives do anticipate the use of capitated contracts to grow. Many respondents (85%) expect to have some revenue in them in two years (see Figure 9). However, organizations have fairly small amounts of revenue in capitated contracts. Only 14% of respondents have more than 10% of revenue in them (see Figure 9).

Figure 9: Respondents expect an increasing percentage of annual revenue in capitated contracts



Similar to their projections from 2017, respondents expect the proportion of their organization's revenue in capitated contracts to increase to 10% over the next 2 years (see Figure 10).

Copyright © 2019 Numerof & Associates

Figure 10: Respondents have moderated their expectations for future revenues in capitated contracts

	2016	2017	2018
Median % of capitated revenue	5%	0%	5%
Median % of capitated revenue expected in 2 years	15%	10%	10%

As was true in the 2017 survey, executives recognize that moving to capitation will be critical to maintain payers' perspective that their organizations are market leaders. Some organizations are actively "identifying where to provide services and how to address challenges to ensure success in a capitated environment."

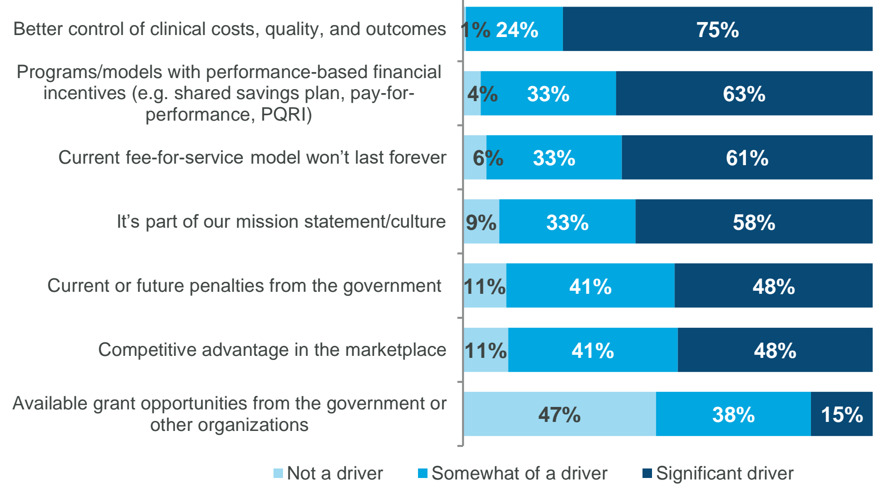
Organizations that have been able to take on a substantial amount of capitated contracts attribute success to their decades long experience changing their business model. These organizations have been "focused on managing lives, which means not just providing care but actually managing health." They've developed new capabilities and infrastructure to support this work, and the words of one executive continue to ring true, "Ultimately, we've built a system that rewards us for doing what's in the patient's best interest."

Copyright © 2019 Numerof & Associates

6. Organizations see population health as an opportunity to improve control of clinical costs, quality, and outcomes

In the survey, respondents indicated their organizations were pursuing population health for multiple reasons. There was clear consensus on two opportunities: 1) to better control clinical costs, quality and outcomes; and 2) to capture performance-based financial incentives in the process. Nearly all respondents (99% and 96%, respectively) rated each as a driver behind their move to population health (see Figure 11). This was closely followed by the recognition that the current fee-for-service model won't last forever (94%).

Figure 11: Multiple drivers recognized for pursuing population health



Population health programs "encourage" organizations to redesign their care models, creating a self-perpetuating skill mix with the right competencies. Those that do it well succeed in both shared-savings MSSP[3] as well as employee healthcare spending.

[3] Medicare Shared Savings Program

Copyright © 2019 Numerof & Associates

7. The potential threat of financial loss is increasingly seen as a significant roadblock

Respondents indicated numerous challenges in moving their organizations to population health. The leading concern is the threat of financial losses by moving to a new model (23%), followed by difficulty in changing the organization's culture (14%), and issues with internal systems like IT, tracking, and management (14%) (see Figure 12).

Figure 12: Primary barriers to pursuing population health

Barrier	%
Potential threat of financial losses by moving to a new model	23%
Difficulty in changing the organization's culture	14%
Issues with internal systems (e.g. IT, tracking, management)	14%
Unsure of when to make the transition from the current model	11%
Difficulty in modeling the cost of care across the continuum	10%
Lack of clear evidence that a population health model will succeed	7%
Resistance/lack of buy-in from executive leadership in the organization	6%
Resistance/lack of buy-in from physicians in the organization	5%
Lack of leadership/accountability in the organization for population health	3%
Lack of robust cost accounting system	3%
Lack of appropriate skills/capabilities among the organization's employees	3%
Negative results with at-risk models in the past	1%
Resistance/lack of buy-in from the board of directors in the organization	0%

Concern around the threat of financial loss may be due in part to uncertainty around how population health models will impact margins. It seems that many are unable to meaningfully assess the implications of payment models that incorporate financial risk related to cost and quality and their bottom line.

There were only two substantial changes in rankings between 2018 and 2017. In 2018, the challenge of changing the organization's culture jumped from 5th to 2nd place, and the lack of appropriate capabilities among employees fell in rank from 6th to 11th. With regard to organizational culture, an executive at one health system expressed that much of their leadership is still resistant to population health and value-based care saying she, "Spent most of 2018

Copyright © 2019 Numerof & Associates

Share this report

lecturing on population health, ACOs and the penalties for not meeting goals – a lot of people have no idea. I am amazed by the resistance to accountability."

The pace of change to population health models remains an obstacle for many providers. The president of one of the nation's largest healthcare networks shared that, "We are advanced in the area of value-based payments and yet knowing what the pace of our transition should be is challenging given that this is determined in part by market trends." The ultimate question he is left with is, "Is there a safe place for us to land once we make the transition?"

This was echoed last year by the director of population health at a large academic system. She noted that, "While we have done a lot of work with targeted populations, especially employees and Medicaid, and have shown progress and some results, we have struggled to extrapolate that to a place that leadership feels comfortable. Leadership does not see a clear path to population health accountability without potential risk for losses given that our system and geography are still heavily fee-for-service."

All of 2018's top five concerns remained the same as in 2017. Clearly, the risk of financial losses during the transition to alternative payment models remained at the top of the list. As a Chief Innovation Officer at one healthcare system noted, "A value-based model is a double-edged sword. The question we have internally is, 'Do we take a bath in the short-term (on a new model)? Or do we wait until we *have* to make the move?' We are considering investments in new models of care that have more risk, but these models can become a direct hit to our revenue … when risks are not mitigated properly."

Technology continues to be a major hurdle for organizations in their move toward population health. As the current landscape evolves, one chief executive of a global academic leader in healthcare shared that their biggest challenge is "building a population health platform that sits above all EHRs and health plan systems. Population health analytics has been a challenge because we sit in the middle of a health plan and a provider environment." Her comment illustrates the challenge of technology platform interoperability that health systems face.

As has been true in prior-year comments, many view technology and other internal systems as a key hurdle in understanding costs. There are situations where a lack of timely data and a lack of IT system interoperability create additional challenges. This was elaborated on by the CMO at a leading academic system, who shared that, "We need to figure out how to better manage patients that have been assigned to us, particularly those who

Copyright © 2019 Numerof & Associates

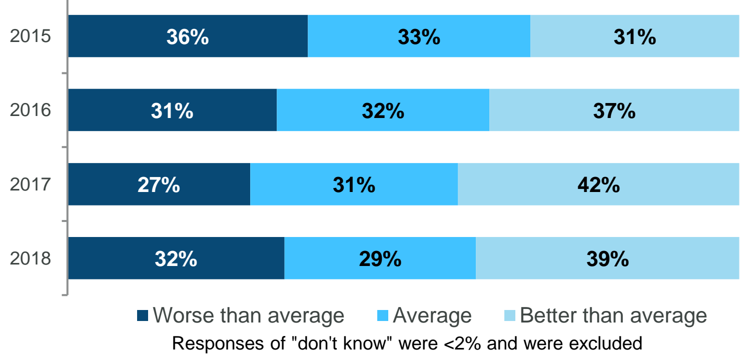
haven't visited our practice or are dead, as the data is at least seven months old."

8. Organizations' ability to manage variation in clinical cost and quality, and meet the growing demands of population health, is mixed

Making population health work requires a dual focus on improving clinical costs *and* patient outcomes. Many organizations have a high degree of variability in both areas.

Respondents still see a need for better management of cost variation. A clear majority of respondents (61%) rated their organization's ability to manage variation in cost at the physician level as "average" or "worse than average." In the context of the past four survey administrations, this represents a break in the pattern of small annual improvements (see Figure 13).

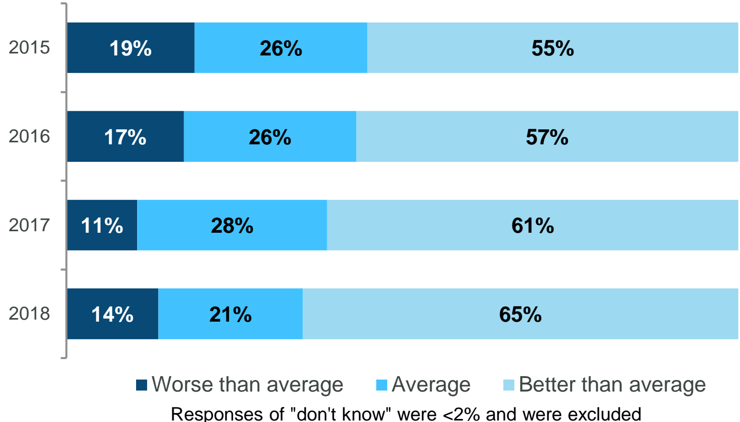
Figure 13: Organizations' ability to manage variation in clinical cost at the physician level is not on pace with the demands of population health



In this fourth year of our survey, progress in the management of variation in clinical quality continues to show small incremental improvement. More than 1 in 3 respondents (35%) view their organizations' ability to manage variation in quality at the physician level as "average" or "worse than average" (see Figure 14). This continues the pattern of small improvements seen over the past four years.

Copyright © 2019 Numerof & Associates

Figure 14: Organizations are slowly improving in their ability to manage variation in clinical quality at the physician level



In 2017, respondents overall reported slight progress in their ability to manage variation in cost *and* quality, highlighting the challenges they have faced when trying to make improvements, most notably “living in a FFS world but inching toward more quality metrics.” The decline in managing cost variation reported in 2018 reflects the difficulty administrators perceive in having these “hard conversations” and taking a more systemic view.

The CIO of a major healthcare organization noted that, “The operations side of our organization looks at population health from an item-by-item perspective rather than taking a holistic approach. Our people in operations need to have a grand view in order to use tools we have developed to effectively reorganize how they operate.”

Another senior executive at a major regional healthcare system echoed these organizational challenges. He shared that, “Our small network of physicians (relative to other competitors) makes it harder to get doctors to modify their processes. This makes managing out-of-network referrals a challenge.”

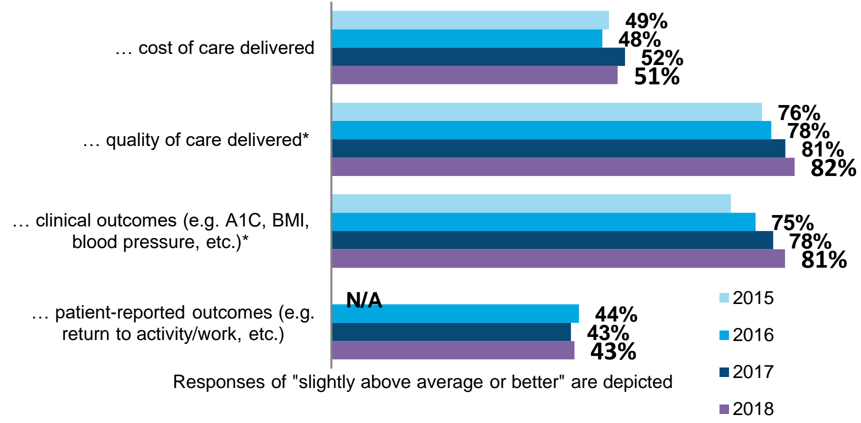
One Chief Clinical Officer representing a very large IDN described the value of using data to drive down cost by, “looking at the specific factors contributing to cost variation.” Their process involved developing data visualizations that provide line of sight into service lines, utilization and ambulatory services. Similar strategies enabled this organization to, “identify two nursing units with widely different costs driven by variation in how doctors write medication orders.” After working with doctors to standardize the administration and documentation of medication, they were able to save money, saying, “If you work with doctors the right way and provide them with good data, they'll respond to it.”

Copyright © 2019 Numerof & Associates

9. Organizations are slowly improving their benchmarks for measuring quality and outcome metrics

Respondents reported a fourth year of improvement in their ability to track quality metrics (see Figure 15). In 2018, 4 out of 5 respondents viewed their benchmarks and metrics for tracking quality of care delivered (82%) and clinical outcomes, like A1C, BMI, and blood pressure (81%), as “average” or above.

Figure 15: Organizations are slowly improving in their ability to track benchmarks/metrics related to quality



While organizations are improving in the metrics used to track quality and clinical outcomes, improvement is needed on the benchmarks and metrics used to track patient-reported outcomes like return to activity/work. Less than half of respondents (43%) rated their organizations “average” or above when it comes to tracking patient-reported outcomes.

As most alternative payment models do not require tracking of patient-reported outcomes, we are not surprised to see use of this type of metric lagging other quality metrics. However, organizations that have embraced population health initiatives for improving the overall health of their patient population recognize the value of capturing, tracking, and benchmarking metrics that patients care about.

Success in this area requires leveraging data to enable change. One senior executive was able to improve quality by “adding quality metrics to doctor

Copyright © 2019 Numerof & Associates

scorecards across regions. We have to have the tools in place so people can do the work."

The Chief Clinical Officer of another major healthcare organization found success stating that "dashboards for individual doctors and their outcomes were key. We are now focusing on eliminating preventable disparities in health outcomes across different populations."

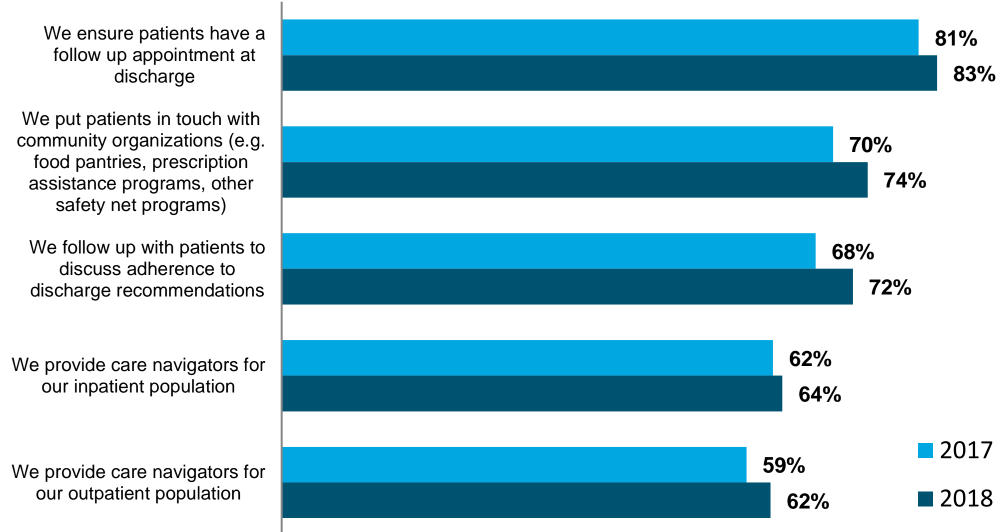
10. Many organizations are working to address social determinants of health

Behavioral choices and social determinants – poverty, homelessness, behavioral illness, substance abuse, food insecurity, low education, lack of access to transportation, etc. – are important drivers of health outcomes. While hospitals and systems simply can't be responsible for addressing these factors, healthcare organizations have an important role as a convener of services and a leader of community engagement efforts.

Many organizations have established collaborations between healthcare providers, payers, and community resources to identify health needs, develop solutions, and maintain accountability for outcomes (see Figure 16). For example, nearly 3 in 4 respondents indicated they put patients in touch with community organizations (74%) and follow up with patients to discuss adherence to discharge recommendations (72%). Modest increases since 2017 are seen in the routine administration of all 5 practices found in Figure 16.

Copyright © 2019 Numerof & Associates

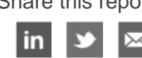
Figure 16: Many organizations engage in care coordination and community outreach to address social determinants of health



These modest increases are consistent with an observation made last year by an executive at an urban academic medical center who said, "Connecting patients with the right services they need to improve their overall health is core to the hospital's mission, but success will require significant changes to processes." High risk patients need to be identified while they are "in the building and connected to the services they need before they get out the door." As was true before, nurse navigators, hospital case managers, social workers, and community health workers need to become familiar with each other as well as the resources available to make the right referrals. Here, scarce resources and inadequate data connectivity create obstacles.

A senior executive of population health of a leading academic health system understands the importance of "developing solution sets with our community partners who are addressing social determinants of health issues. Part of this strategy includes sharing relevant data with community-based organizations."

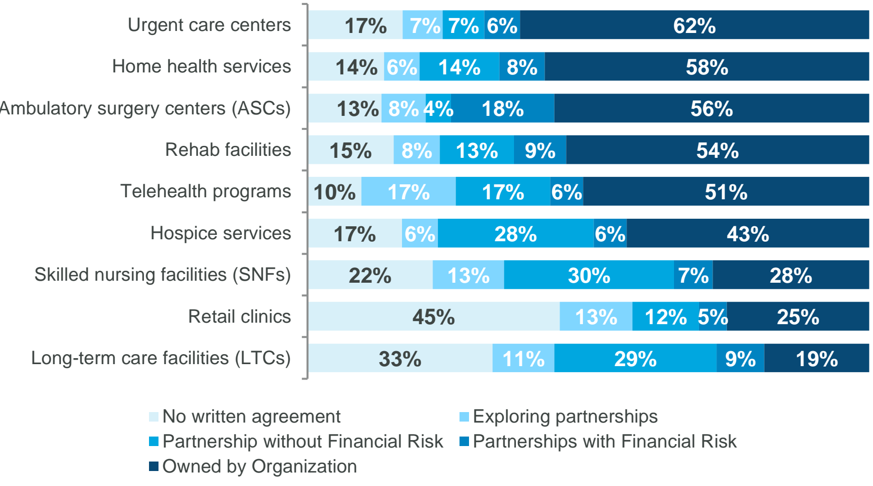
Copyright © 2019 Numerof & Associates



11. Organizations are engaged in partnerships across the care continuum

Achieving lower costs and better health outcomes requires ensuring patients are getting the right care, at the right time, and at the right place in the care continuum. Recognizing this, many hospitals and health systems have acquired or partnered with organizations that provide these services (see Figure 17). These partnerships have remained stable over the past year.

Figure 17: Coverage across the continuum through partnerships and acquisitions



Care coordination across the continuum remains central to providers' success in their population health efforts. One academic health system executive shared their experience in partnering with SNFs to better manage patients. This partnership involved "assessing SNF utilization to create a collaborative program … to improve SNF cost and quality." This collaboration was enhanced by "hiring case managers and social workers to manage the transition of patients between hospitals and SNFs while also spending more time on patient education."

Copyright © 2019 Numerof & Associates

Accelerating the Journey

The purpose of this research is to formally explore the progress that's been made by provider organizations toward population health management. Our findings suggest that although some progress has been made over the last four years, most providers have yet to make a substantial commitment to the population health model.

The lack of significant progress is a result of many converging factors. Uncertainty regarding which direction Washington will go has resulted in many hospital administrators pushing "pause" on their population health efforts. At the same time, executives that had engaged in pilot programs with positive results faced challenges in scaling their initiatives.

Many providers continue to struggle with key prerequisites of population health management, notably managing variation in cost and quality at the individual physician level. Other significant challenges include developing the right systems, platforms, and benchmarks to facilitate the shift to this new model; determining the timing of the transition; and creating a culture that embraces real change.

The threat of financial losses will remain a barrier until organizations gain meaningful experience in implementing value-based contracts where they see both ROI and improved patient outcomes. We recognize this fear is not likely to abate anytime soon as most organizations remain fairly limited in their exposure to these agreements. In addition, despite their predictions 2 years ago, institutions have not increased the amount of revenue they have at risk.

Through this survey, as well as through our work with clients across the healthcare sector, we hear a growing acceptance of the inevitability of population health models. Yet organizations broadly remain in a holding pattern – waiting for a tipping point in the market before increasing their population health efforts.

Despite transient changes in political focus, population health management will occupy a significant place in the future of healthcare. For many, the journey is formidable. The new business model will involve contracting with entities outside of an organization's direct control, developing clear processes for these facilities to meet contractual obligations, establishing deep relationships with payers and employers, developing compelling value stories for products and services offered by the organization, and identifying, collecting, and analyzing data to support value claims. It's a daunting task!

Copyright © 2019 Numerof & Associates

Ultimately, organizations that go down the path to population health will be building the capacity to effectively manage their operations under the next healthcare paradigm. These are not pointless lessons, but instead create a critical foundation that organizations will depend on as their business models evolve.

This new paradigm may be more imminent than many delivery organizations think. While the Administration's drive toward a market-based model of healthcare is subject to political pressure, new competitors like Amazon, JPMorgan, Berkshire Hathaway, Apple, Google, and others are not so constrained. The promise of a $3 trillion industry with a deeply dissatisfied customer base is attracting a wave of innovation from nontraditional players with the potential to redefine the rules rapidly. Conventional providers would be well advised to accelerate their progress up the learning curve lest they find themselves scrambling to play catch-up.

Copyright © 2019 Numerof & Associates

Insider knowledge. / Outsider perspective.

Numerof & Associates guides businesses across the global healthcare sector to compete and win. Bringing cross-industry expertise and a tailored approach, we develop and operationalize strategies that help clients define, demonstrate, and deliver value.

Strategy Development & Implementation | Organizational Infrastructure | Analytics