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Population Health Organizational Structures & Investment

Quick-Hit Survey Results

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Introduction & Methodology

To support health systems' increased participation in risk-bearing contracts, organizations are prioritizing development and investment in population health structures. In light of this prioritization, The Health Management Academy (The Academy) conducted a quantitative assessment of population health executives to understand the current structure and prioritization of population health across Leading Health Systems (LHS).

Methodology

In August 2019, The Health Management Academy conducted a quick-hitting survey of Leading Health Systems (LHS) to better understand the current organizational structures for population health and health system participation in risk-bearing arrangements.

The 12 responding population health executives represent a range of titles including Executive Director of Analytics, Medical Director of Value Based Programs, Director of Population Health, Medical Director of Population Health, Chief Contracting Officer, SVP of Population Health and Business Transformation, VP of Care Transformation, Executive Director of Clinical Operations, VP of System Primary Care, Chief Operating Officer, and VP of Business Development.

Profile of Participating Health Systems

12 Unique Health Systems

$5.7 billion Average Total Revenue

139 Total Hospitals Owned & Operated

1.7 million Total Admissions per Annum

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Key Findings

1

Centralization

The majority (79%) of health systems have a centralized population health department with a defined budget. The scope of the population health department is broad, and is typically lead by multiple senior leaders.

2

Investment

Increased participation in risk-bearing arrangements is most common catalyst for increased investment in population health, with 86% of executives responding in kind. Reflective of the increased investment, the average number of FTEs dedicated to population health has risen over five-fold from 28 to 158 since the year 2013.

3

Risk Arrangements

Over half (54%) of health systems' populations are covered under some form of risk arrangement, although the level of financial risk varies. With this, health system C-suite and Board leadership is generally supportive of investing in the processes and capabilities needed for risk-based contracts.

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Population Health Organizational Structure

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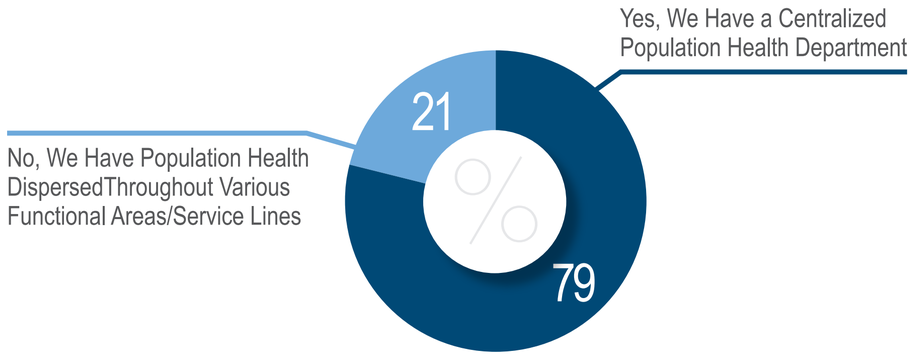
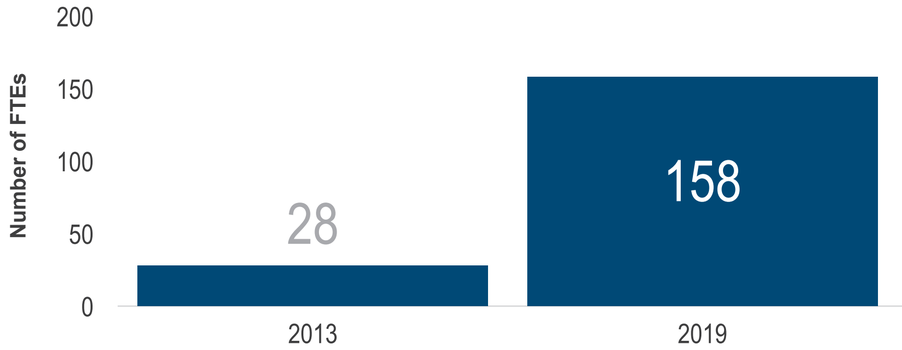
Most Health Systems Have a Centralized Population Health Department

- The majority of health systems have a centralized population health department for the organization.
- Only 21% of health systems have population health dispersed throughout various functional areas and service lines across the organization.
- All health systems that report having a centralized population health department also have a defined budget for population health. No health system with decentralized population health has a defined budget for this function.
- Along with centralizing the population health function, health systems have expanded their population health departments over time. In 2013, the average number of FTEs dedicated to population health was 28. In 2019, health system dedicate an average of 158 FTEs to population health – a five-fold increase from 2013.

Does Your Organization Have a Centralized Population Health Department?



How Many FTEs are Dedicated to the Population Health Function/Department at Your Organization?



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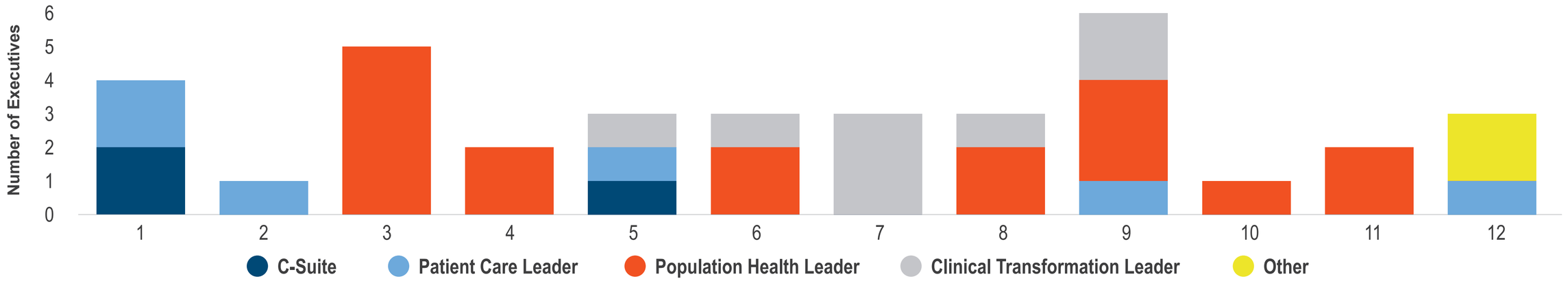
Multiple Executives with Varied Roles Lead Population Health Strategy

What Is The Title of the Leader(s) at Your Organization Responsible for Developing and Implementing Population Health Strategy and Initiatives?



- Most health systems 83% have more than one executive responsible for developing and implementing population strategy. On average, health systems have three leaders responsible for this function.
- Approximately half (47%) of executives responsible for developing and leading population health strategy and initiatives have population health focused roles (e.g., SVP for Population Health, SVP for Clinical Population Health & Health Outcomes, VP of Population Management, Director of Population Health Operations, Medical Director of Population Health & Post Acute Care).
- One-fifth (22%) of population health leaders have a clinical transformation role (e.g., SVP of Clinical Transformation, SVP of Population Health Business Transformation, VP of Care Transformation, AVP Transition Management) while 17% have a patient care role (e.g., SVP of Medical Group, SVP of Quality and Safety, Executive Director of Clinical Operations, Director of Quality Improvement).
- C-suite executives (e.g., Chief Strategy Officer, Chief Medical Officer, Chief Contracting & Managed Care Officer) make up only 8% of the titles held by population health leaders.

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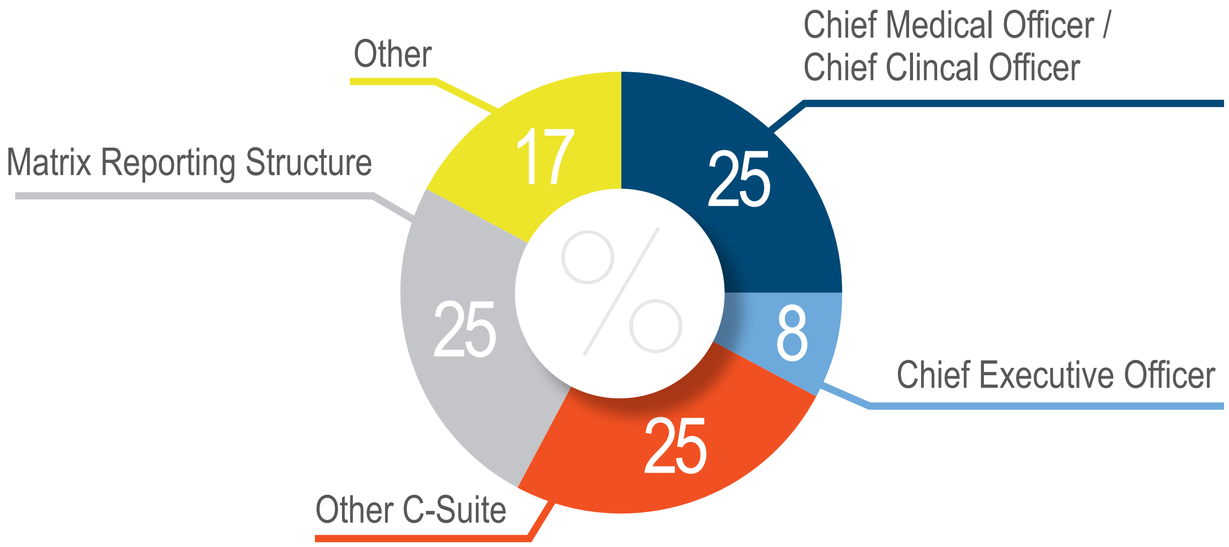
Reporting Structure Varies by Organization

To Whom Does Your Organization's Population Health Management Leader Report?



- Most commonly, population health leaders report directly to the CMO (25%). This is a considerable increase from 2013, when only 11% of population health leaders reported to the CMO.
- Population health leaders also may report to other C-suite roles (25%), such as the Chief Integration Officer, Chief Contracting and Managed Care Officer, or Chief of the Integrated Delivery Network.
- A quarter (15%) of population health leaders have a matrix reporting structure, in which they report to multiple senior executives (e.g., COO and CMO, CSO and COO).
- Population health executives reporting directly to the health system CEO has decreased drastically in recent years, down from 37% in 2013 to only 8% in 2019.
- Additionally, while 7% of population health leaders reported to the CFO in 2013, no responding health system responded that this was the case in 2019.

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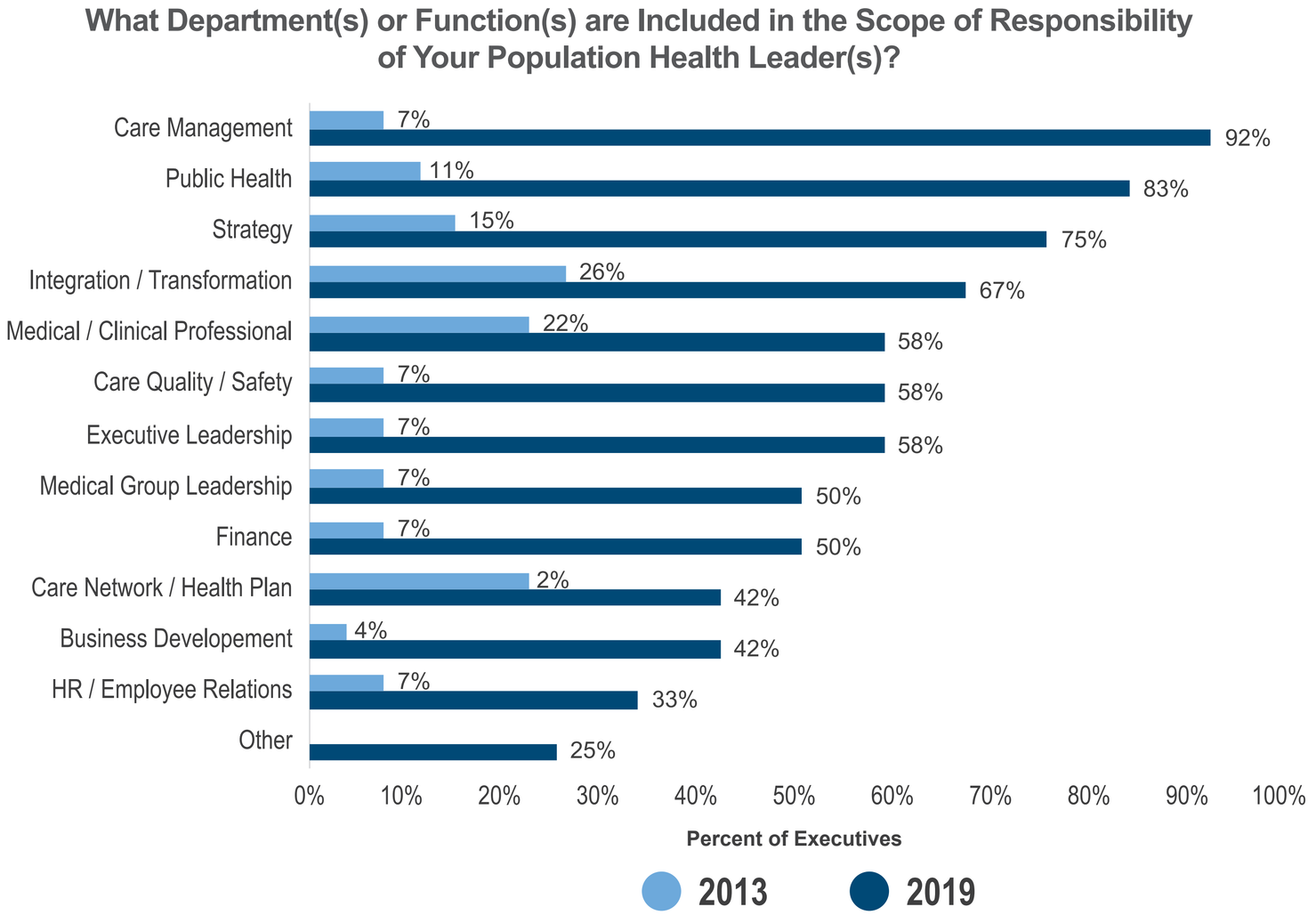
Population Health Leaders' Areas of Responsibility Have Increased



- The scope of responsibly of population health leaders has increased considerably since 2013, aligned with health systems' expansions of population health departments.
- Some of the largest areas of increases in population health leader responsibility are Care Management seeing an 85% increase from 2013 and Public Health which saw a 72% increase over the same period.
- Other areas population health leaders are responsible for include value-based care, credentialing, contracting, as well as the organization's accountable care organization and clinically integrated network.

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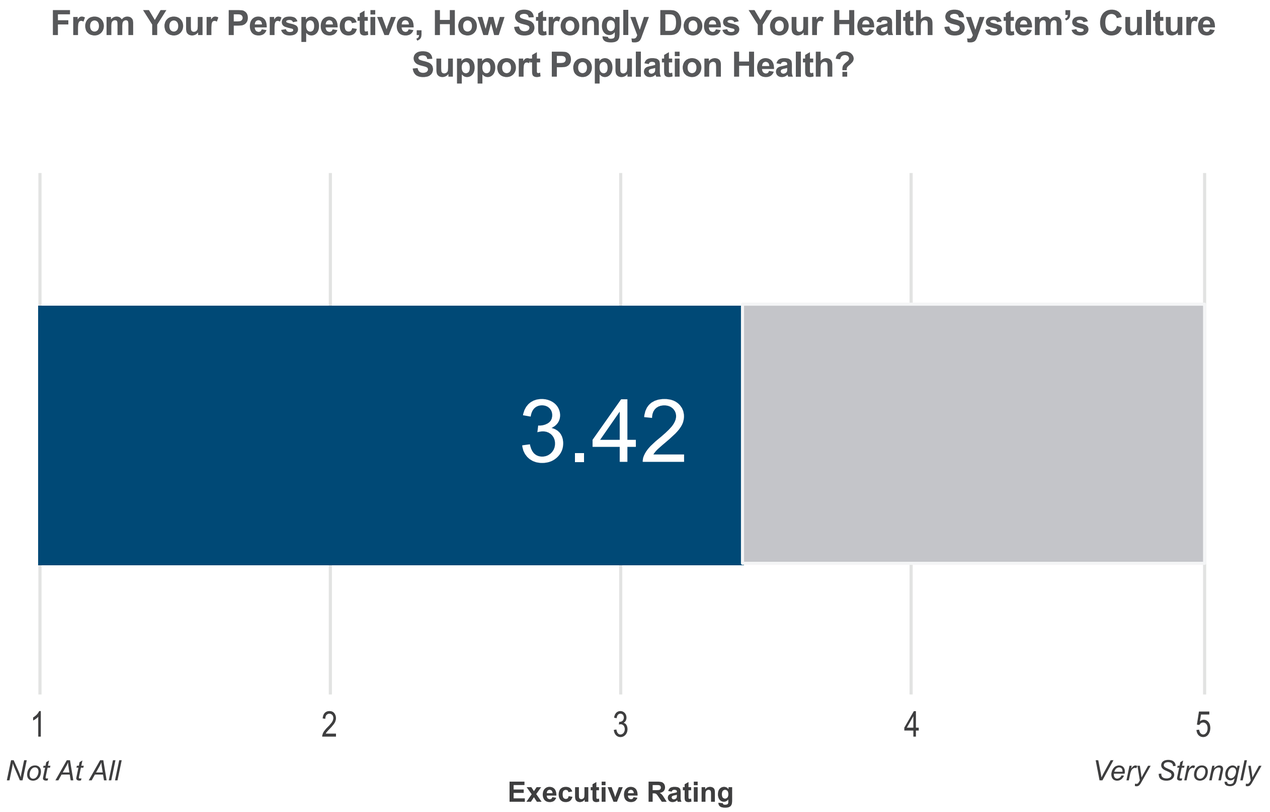
Health System Cultures Somewhat Supportive of Population Health



- Despite robust organizational structures around population health, executives report their current health system culture is only somewhat supportive of population health.
- Executives report that although leadership may be supportive of population health, buy-in has yet to penetrate all departments. In particular, executives note challenges in engaging specialist clinicians who have historically operated in a heavily fee-for-service environment.
- In order to support the transition to a population health-centered approach, executives believe that improvements need to be made in operating infrastructure, contracting and analytics. Additionally, in order to aide in the culture transformation, one population health leader commented, "There is a great deal of education going on at the provider and department level."

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Participation in Risk-Bearing Arrangements

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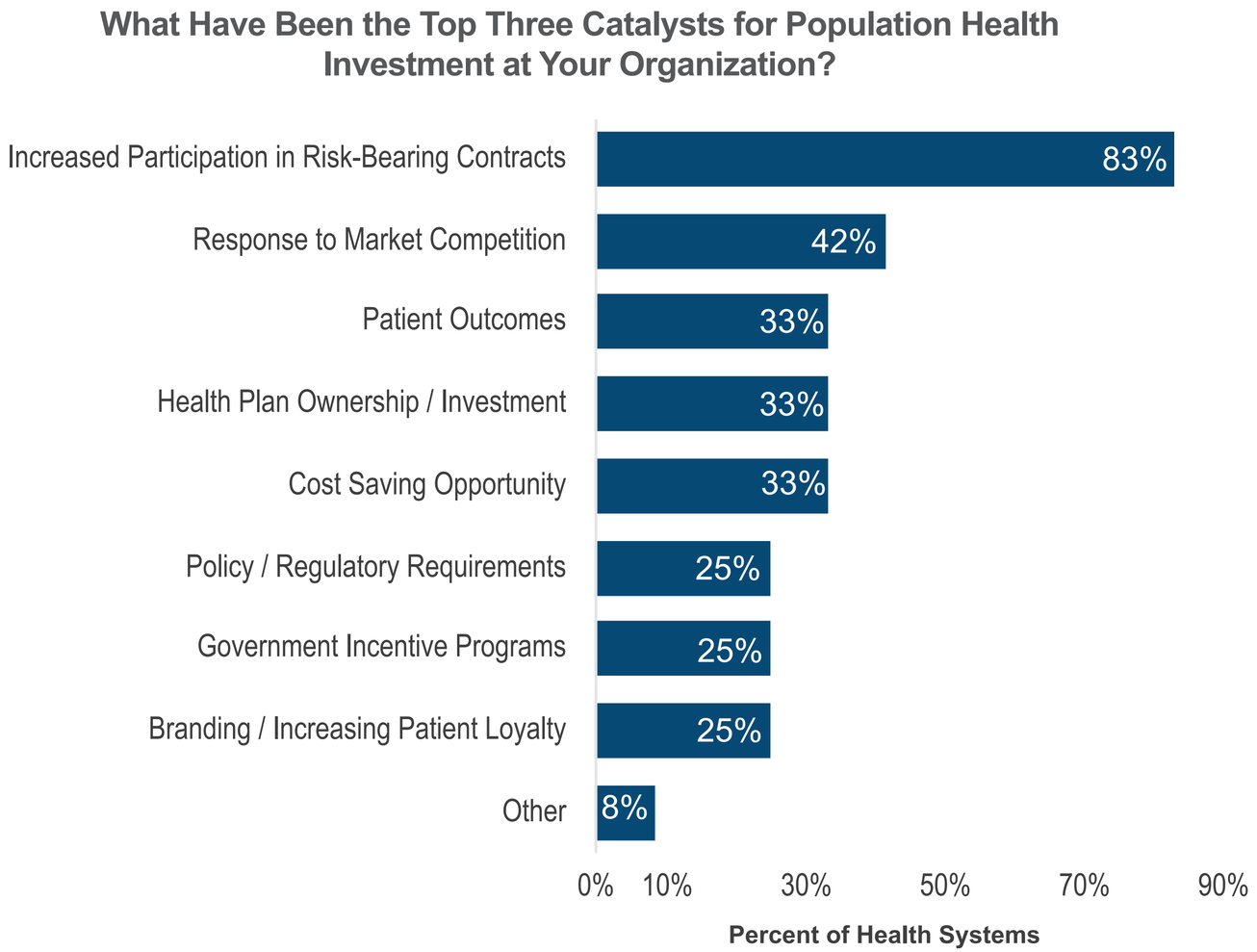
Participation in Risk Arrangements Driving Population Health Investment



- By far the most common catalyst for increased investment in population health among LHS is increased participation in risk-bearing contracts (83%).
- Additionally, health system executives cite market competition (42%) and patient outcomes (33%), health plan ownership/investment (33%), and cost saving opportunities (33%) as catalysts for increased population health investment.
- Other catalysts for increased population health investment include Medicaid conversion to Managed Care and the health system's mission.

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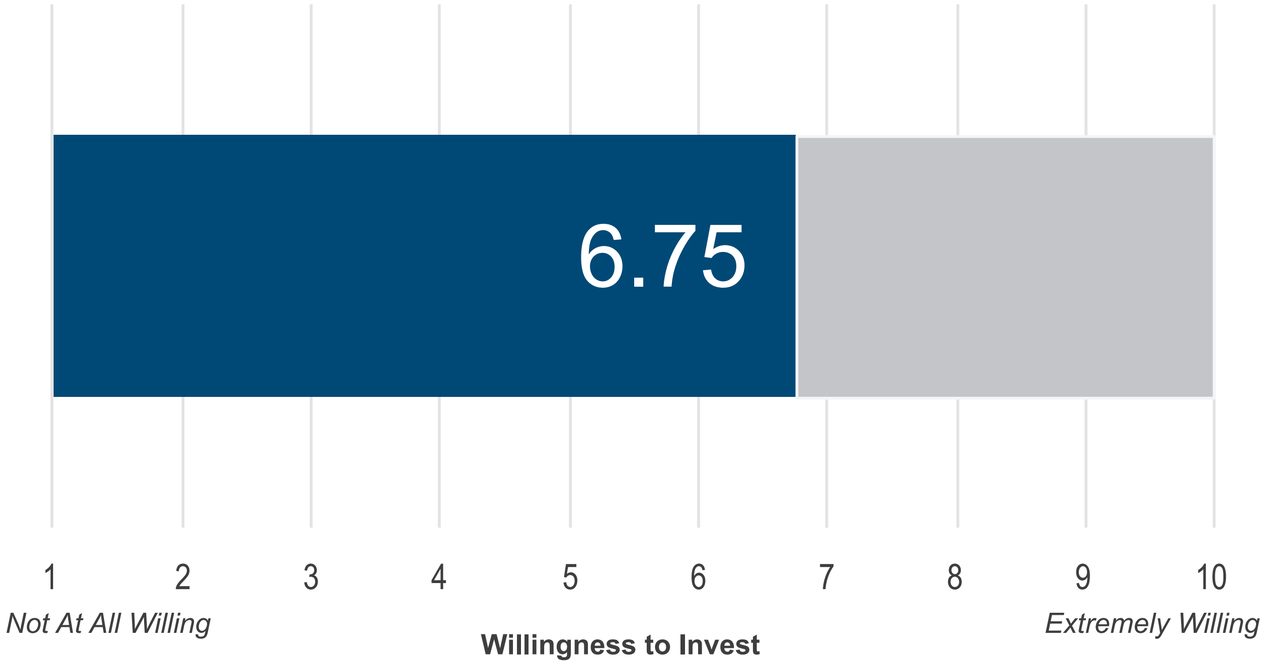
Senior Leadership Supportive of Investing in Risk-based Contracts

How Would You Rate Your Health System's C-Suite and Board Leadership's Willingness to Invest in Risk-Based Contracts?



- Overall, executives report their health system's C-suite and Board are fairly willing to invest in the resources, capabilities, and processes to support risk-based contracts.
- While executives note general support for moving toward risk-based arrangements, typically cost and organizational alignment are barriers to investing in this transition.

"There is definite interest and willingness, but cost is a factor when making the investments therefore sometimes population health investments are prioritized lower."

"We continue to build alignment among our senior leaders regarding the pace of migration to risk based arrangements. There is appetite for narrow projects, but there is a concern about getting ahead of market dynamics in our geography. I would say our appetite and comfort is accelerating."

"The C-Suite understands the importance of value-based programs and managing risk. However, it is a massive culture shift and transformation for us to play in this space."

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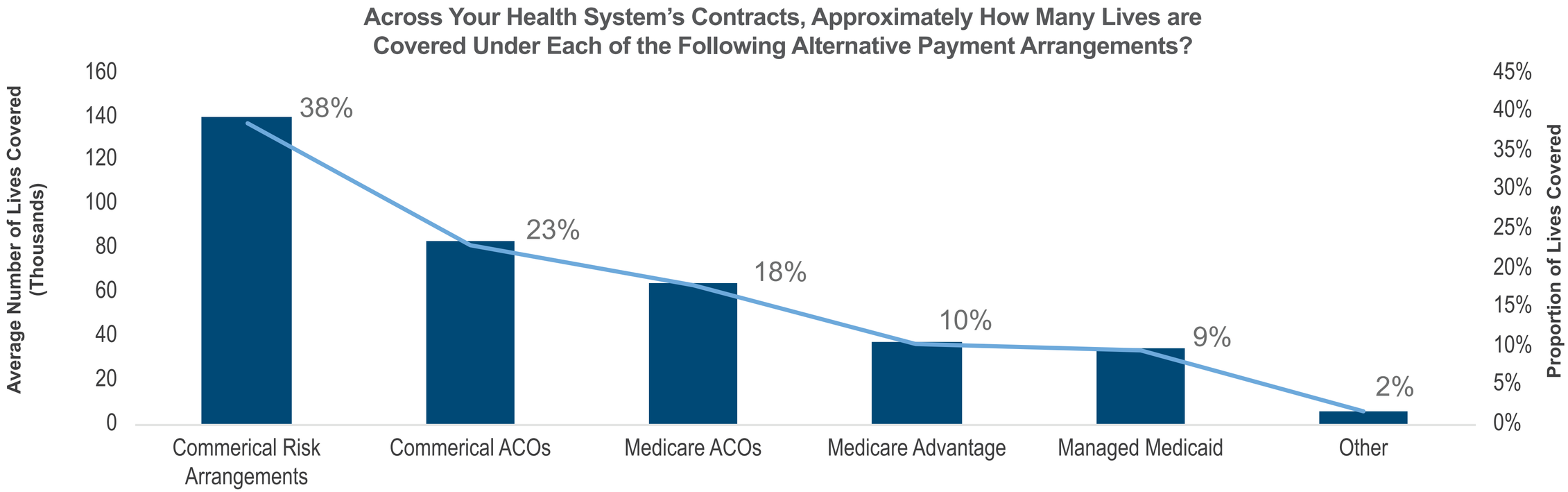
Senior Leadership Supportive of Investing in Risk-based Contracts



- Among health systems' alternative payment arrangements, the largest proportion (38%) of lives are covered under commercial risk arrangements. On average, these commercial risk arrangements cover nearly 140,000 lives per health system.
- Commercial and Medicare ACOs are the next most prevalent at 23% and 18% of covered lives, respectively.

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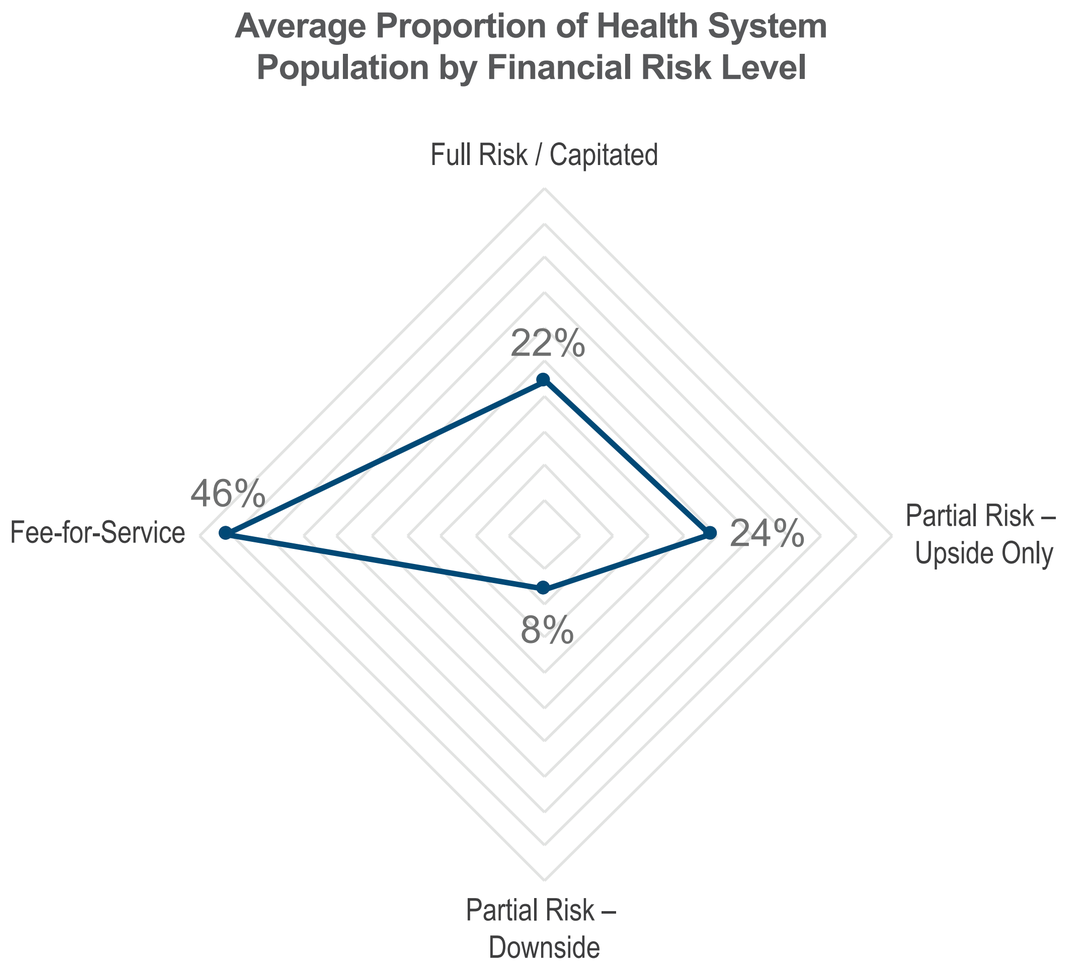
More Lives Covered Under Some Risk Arrangement than Fee-for-Service



- While, on average, the largest single proportion of lives covered fall under a fee-for-service payment arrangement (46%), over half (54%) of covered lives among LHS are under some variation of risk-bearing arrangement.
- Among risk-bearing arrangements, the plurality of lives are covered under partial risk arrangements in which the health system has only upside financial risk.
- Notably, health systems are commonly at-risk for a large majority of their population (>70% of the population), or are primarily fee-for-service organizations that have a very small (<40% of the population) at-risk population. Few health systems are evenly participating in risk-bearing and fee-for-service arrangements.

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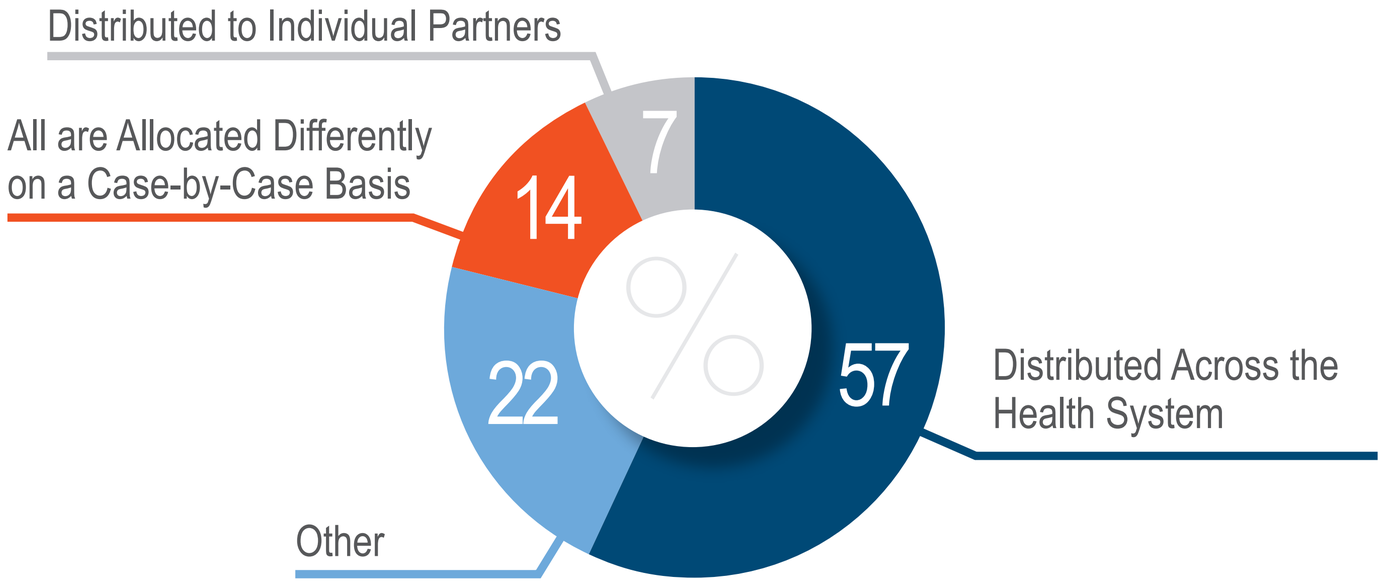
Savings from Risk Arrangements are Distributed Across the System

How Does Your Health System Allocate Any Savings, Bonuses, and/or Penalties Associated with Your Risk-Bearing Arrangements?



- Commonly alternative payment models will incorporate savings, bonuses, and/or financial penalties for health systems to incentivize organizations to meet required quality and cost objectives.
- The majority of health systems (57%) distribute any savings, bonuses, or penalties across the health system.
- Fewer health systems distribute these savings, bonuses, or penalties to individual provider (7%), and only some allocate on a case-by-case basis.
- Other models include using the bonuses to pay for medical group overhead or having no formal allocation structure in place.

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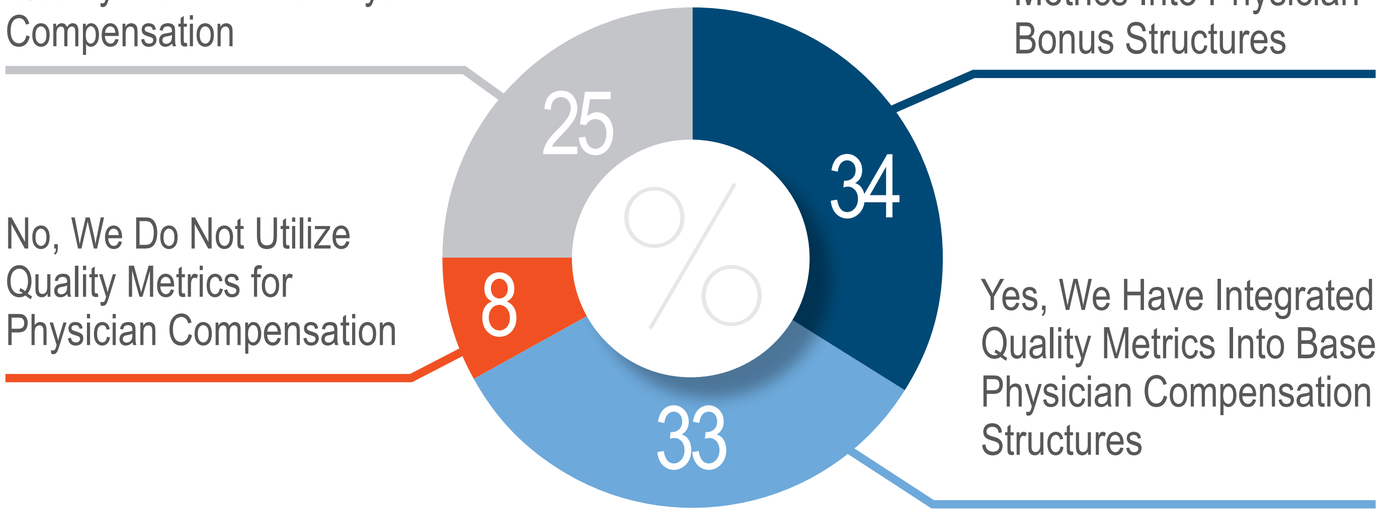
Common Integration of Quality Metrics into Physician Compensation

Does Your Health System Integrate Quality Metrics as Part Of Physician Compensation?



- As health systems participate in alternative payment models and take on increasing levels of financial risk, it is critical to ensure physician alignment with the cost and quality measures of success under these payment models. Commonly, health systems look to ensure this alignment by integrating quality metrics into physician compensation structures.
- The vast majority of health systems (92%) have – or are in the process of implementing – quality metrics as part of physician compensation.
- Integration of these metrics takes various forms, however most commonly health systems will integrate quality metrics as part of physician bonus structures (34%) or part of base physician compensation (33%).

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