TheAcademy

Population Health Organizational Structures & Investment

Quick-Hitting Survey Results

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Introduction and Methodology

To support health systems' increased participation in risk-bearing contracts, organizations are prioritizing development of and investment in population health structures. To this effect, 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 management and 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

Key Takeaways

1 Risk Arrangements

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

2 Investment

Increased participation in risk-bearing arrangements is the 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 460% from 28 to 158 since the year 2013.

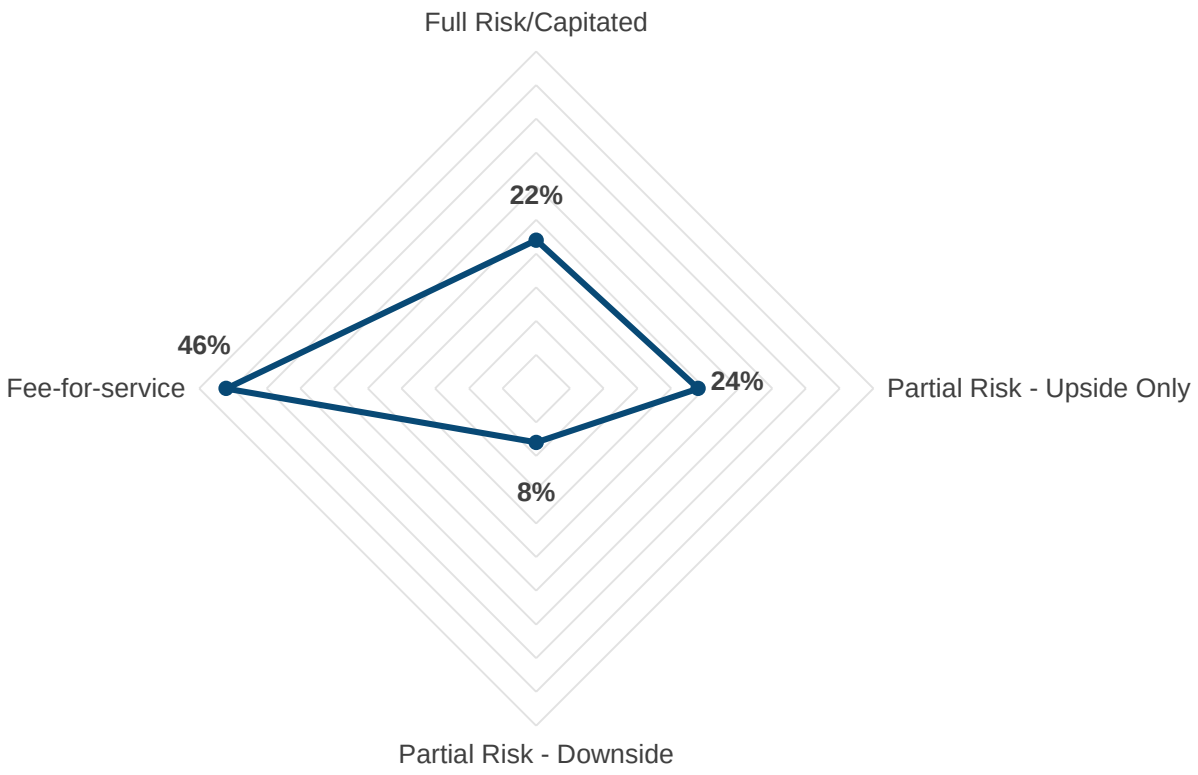
3 Centralization

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

Participation in Risk-Bearing Arrangements

Greater Proportion of Lives Covered Under Risk Arrangements than Fee-for-Service

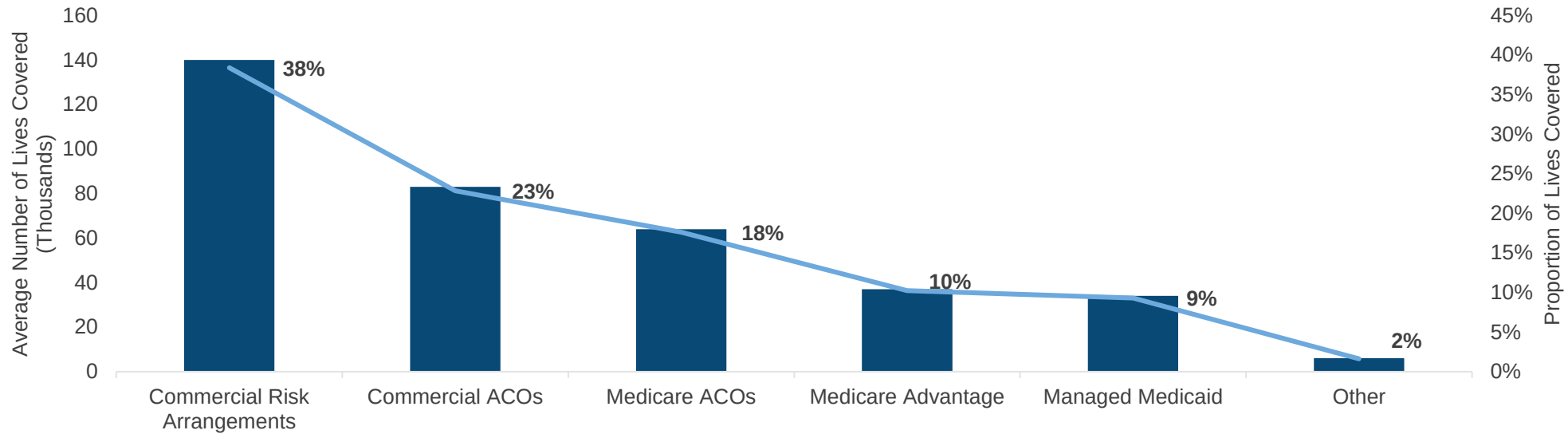
For what proportion of your population does your health system assume some level of financial risk?



- On average, the largest 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 either 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.

More Lives Covered Under Commercial Risk Arrangements

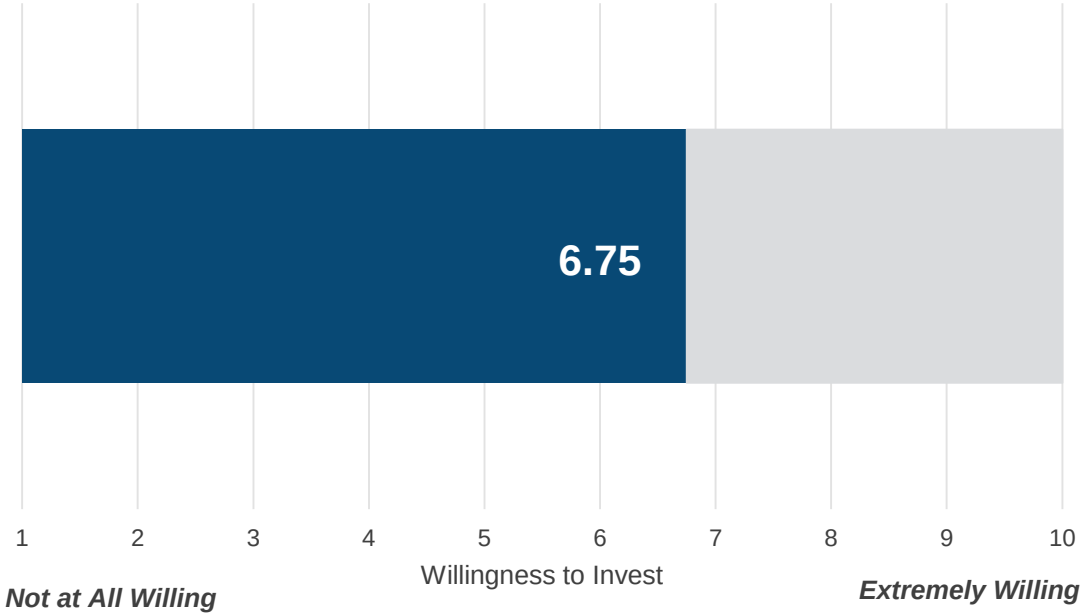
Across your health system's contracts, approximately how many lives are covered under each of the following risk-bearing arrangements?



- Among health systems' risk-bearing arrangements, the largest proportion (38%) of lives are covered under commercial risk arrangements. On average, these commercial contracts cover nearly 140,000 lives per health system.
- Commercial and Medicare ACOs are also common, with 23% and 18% of lives covered under these arrangements, respectively.

Senior Leadership Supportive of Investing in Risk-based Contracts

How would you rate you health system's C-suite and Board leadership's willingness to invest in risk-based contracts?

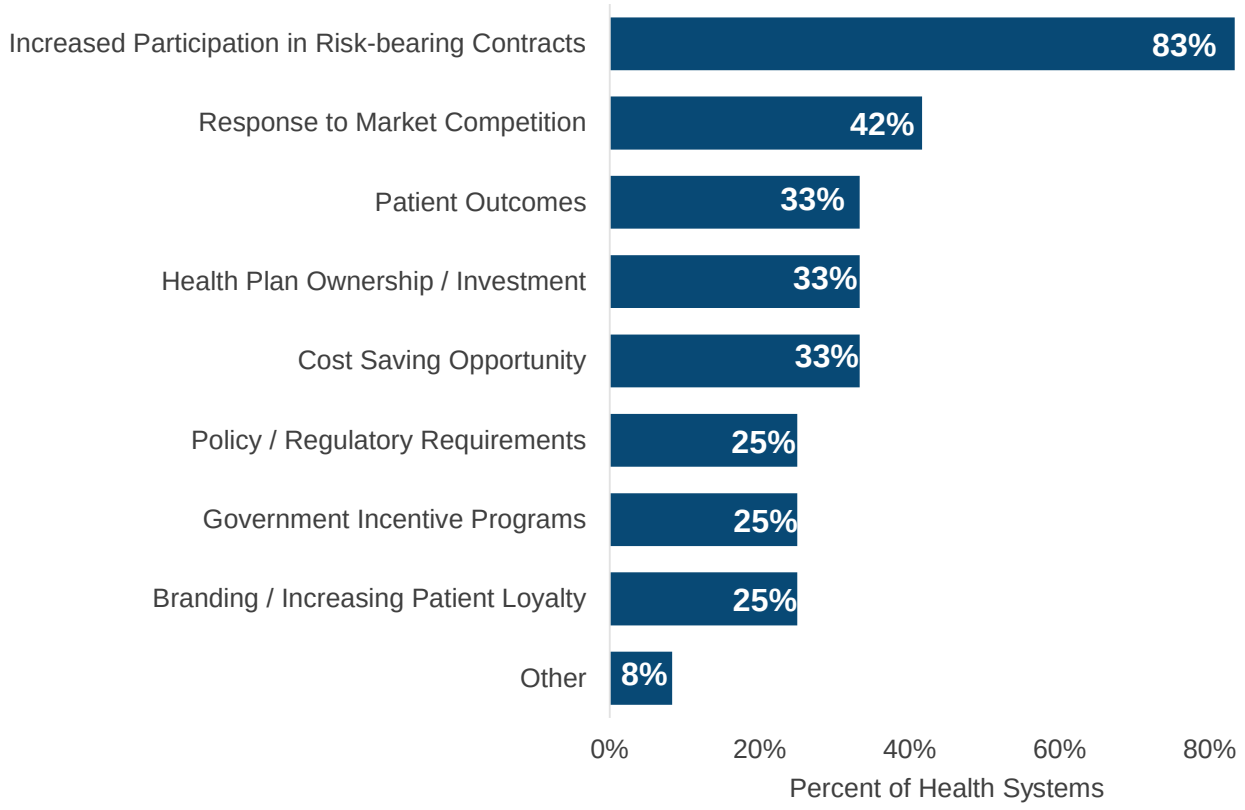


- Overall, executives report their health system's C-suite and Board are fairly willing to invest in the resources, capabilities, and processes to support success under risk-based contracts.
- While executives note general support for moving toward risk-based arrangements, typically cost and organizational 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." – Director, Population Health*
>
> *"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." – Executive Director, Clinical Operations*
>
> *"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." – Chief Contracting Officer*

Risk Arrangements Catalyze Population Health Investments

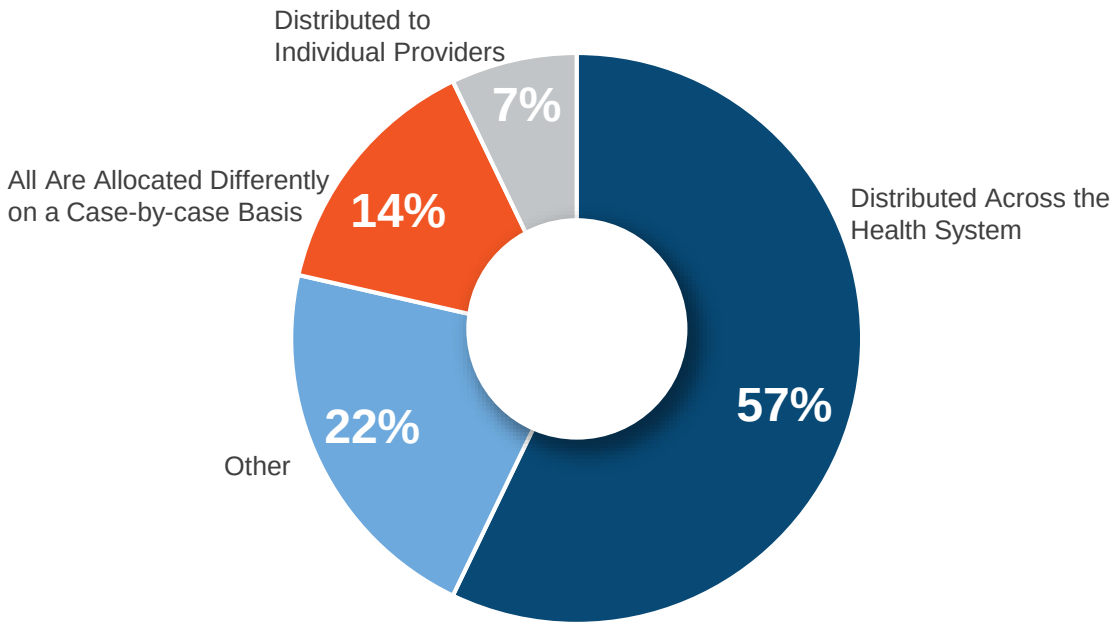
What have been the top three catalysts for population health investment at your organization?



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

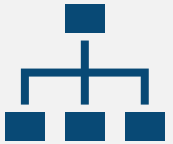
Savings from Risk Arrangements Are Distributed Across the Health System

How does your health system allocate any savings, bonuses, and/or penalties associated with your risk-bearing arrangements?



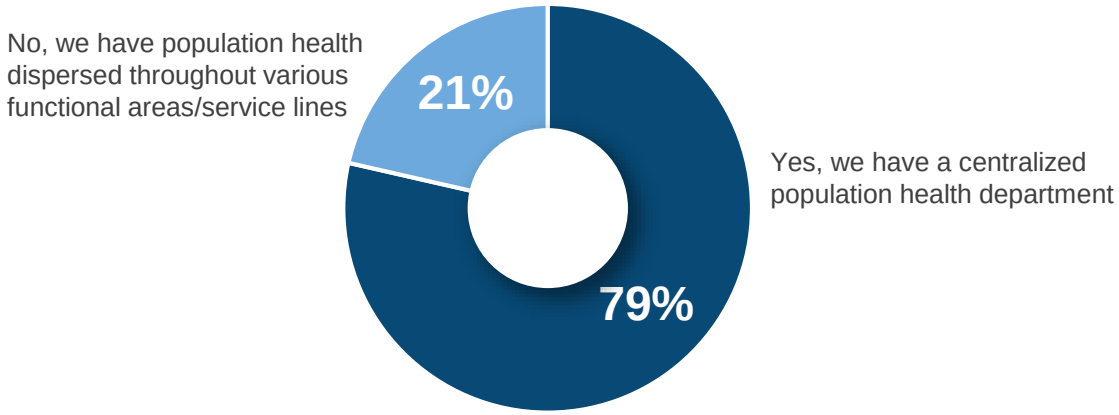
- Commonly alternative payment models will incorporate savings, bonuses, and/or financial penalties for health systems to incentivize organizations to meet required quality and cost objectives.
- The majority of health systems (57%) distribute any savings, bonuses, or penalties across the health system.
- 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.

Population Health Organizational Structure

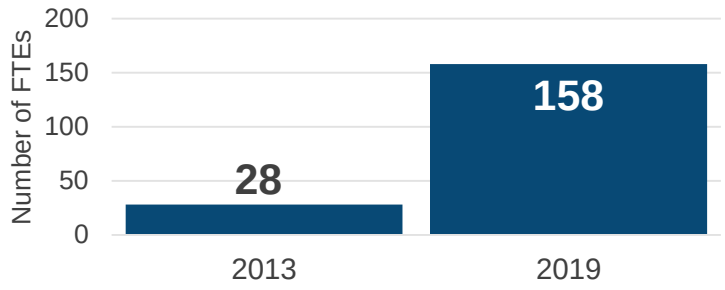


Most Health Systems Have a Centralized Population Health Department

Does your organization have a centralized population health department?

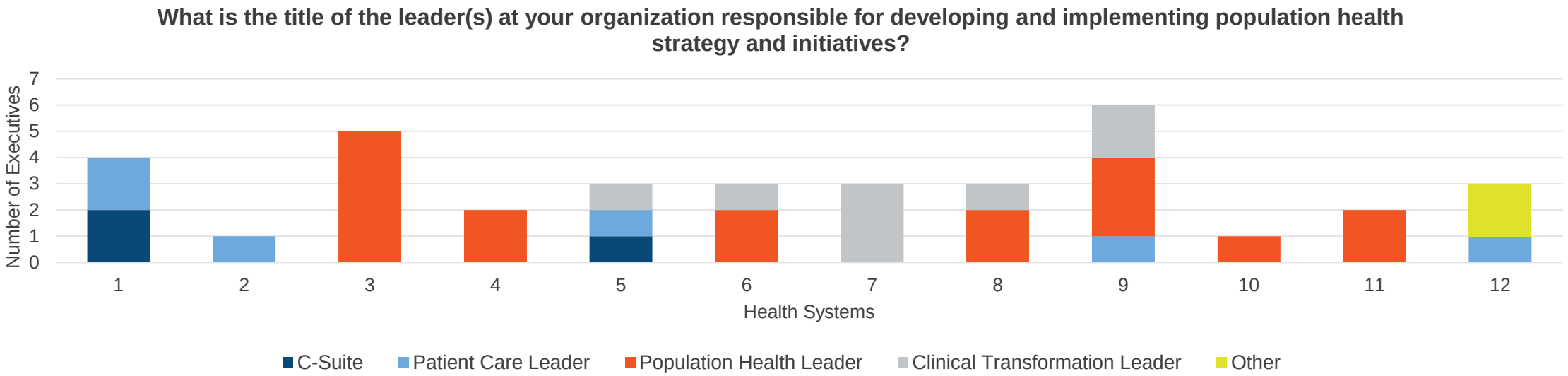


How many FTEs are dedicated to the population health function/department at your organization?



- 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.
- 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.

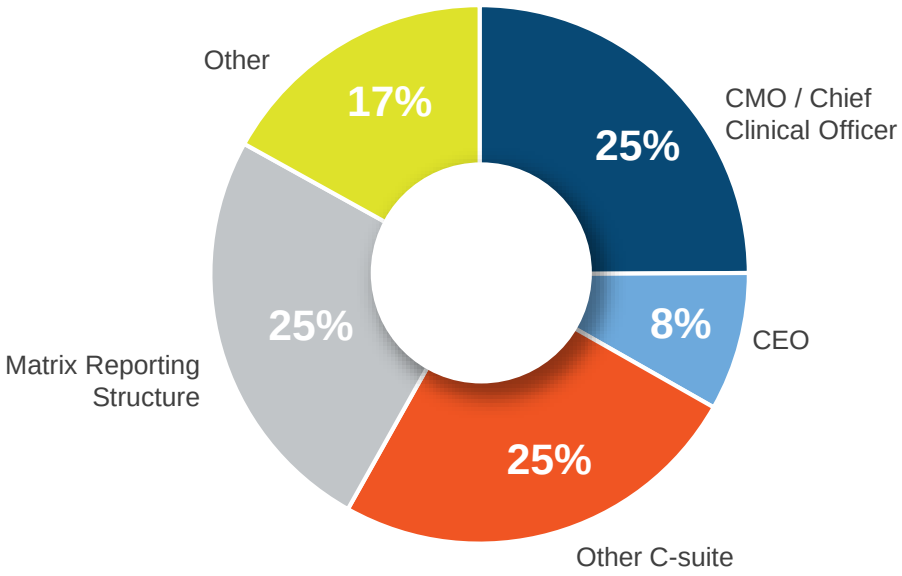
Multiple Executives with Varied Roles Lead Population Health Strategy



- 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 strategies have population health focused roles (e.g., SVP for Population Health, SVP for Clinical Population Health & Health Outcomes, 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) while 17% have a patient care role (e.g., SVP of Medical Group, SVP of Quality and Safety).
- C-suite executives (e.g., Chief Strategy Officer, Chief Medical Officer) make up only 8% of the titles held by population health leaders.

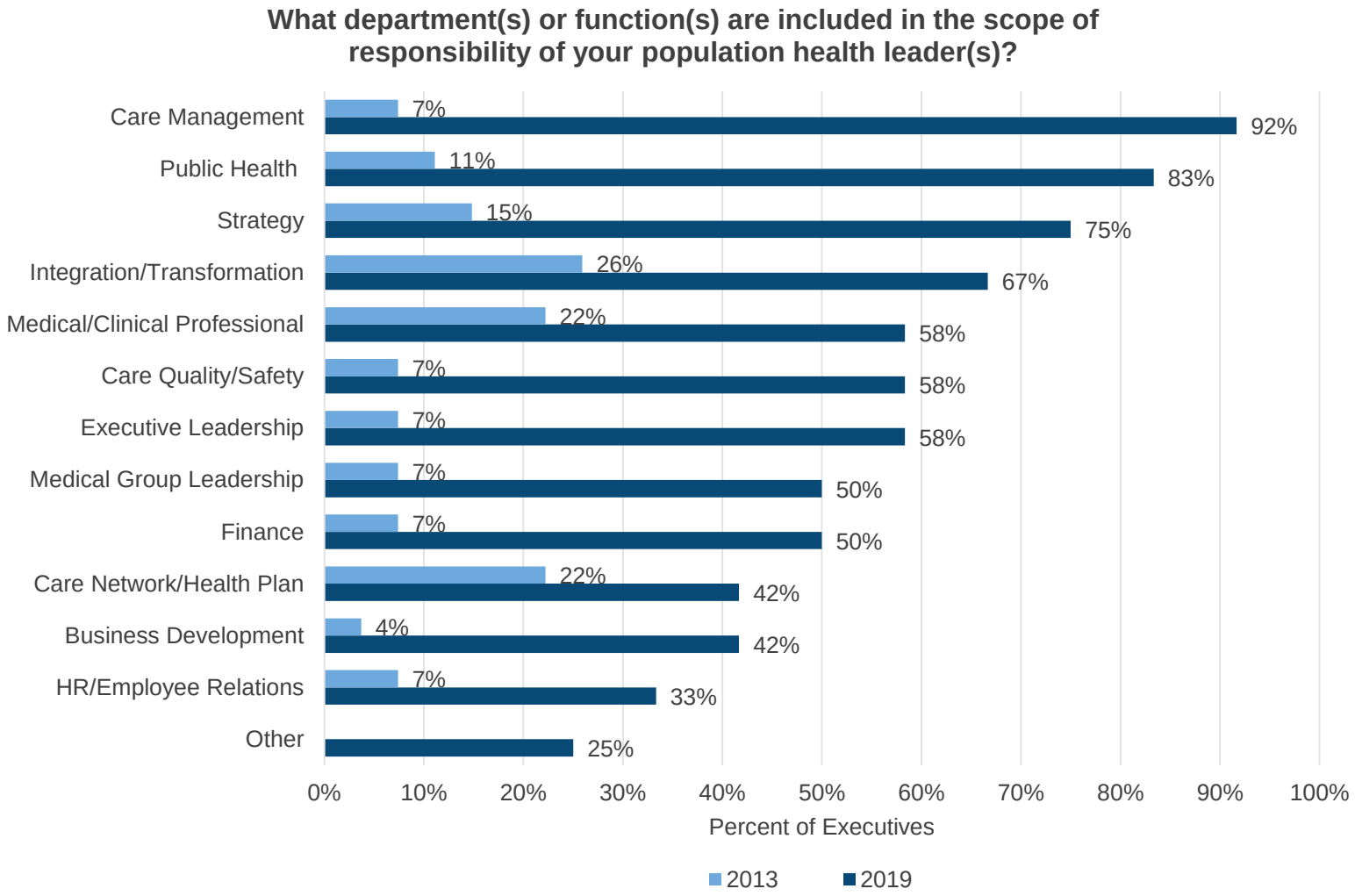
Population Health Management Reporting Structure Varies by Organization

To whom does your organization's population health management leader report?



- Population health leaders most commonly report directly to a C-suite level executive (58%). These roles may include the CMO (25%), CEO (8%), or other C-suite role (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. Contrastingly, there has been an increase in executives reporting to the CMO from 2013, when only 11% of population health leaders reported to the CMO.
- 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.

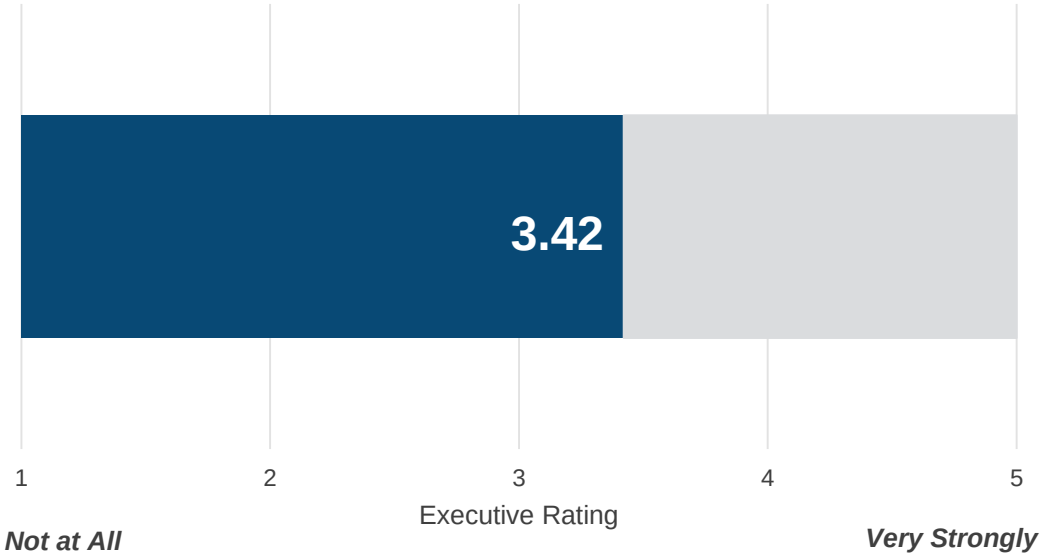
Population Health Leaders' Areas of Responsibility Have Increased



- 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 percentage point increase from 2013 and Public Health which saw a 72 percentage point 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.

Health System Cultures Somewhat Supportive of Population Health

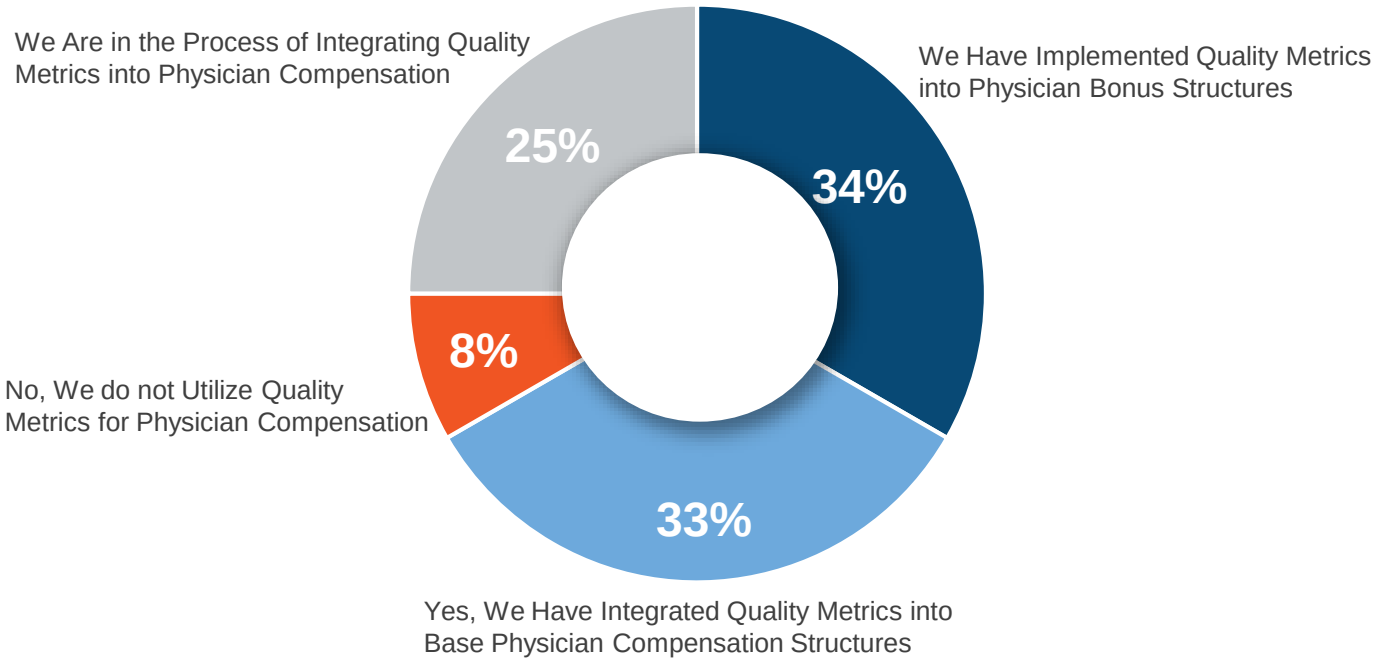
From your perspective, how strongly does your health system's culture support population health?



- 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.”

Quality Metrics Commonly Integrated 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 and drive culture change 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%).