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Population Health: A Business Model for Community Hospitals

Timothy L. Putnam, DHA, FACHE, and Lynn Barr

As healthcare reimbursement transitions from fee-for-service to fee-for-value, more payments from insurers will be based on the total cost of patient care rather than service intensity.

A major payment change came with the Medicare Access and CHIP Reauthorization Act, which essentially froze physician payment rates at 2015 levels with only 0.25 percent and 0.5 percent annual adjustments until 2019 and then no further increases until 2026. Under the Merit-Based Incentive Payment System, physicians could receive an additional 9 percent of payment by taking an equal amount from the lowest performers each year in terms of per capita cost, quality, improvement activities and interoperability.

The Centers for Medicare & Medicaid Services rewards clinicians with higher scores under MIPS if they participate in an alternative payment model; they are exempt from participation altogether if they take more than nominal risk in a qualified alternative payment model. Beginning in 2026, clinicians who participate in a QAPM will also receive a 0.5 percent permanent adjustment to fee schedule payments, resulting in a steadily higher income over their careers.

According to a November 2018 CMS blog outlining the 2017 performance year, the difference between average MIPS scores for APM and non-APM participants was 22 points. Once MACRA is fully implemented in 2021, 30 percent of non-APM participants' scores will be tied to cost. This change will lower scores another 15 points, moving the average MIPS delta from 22 to 37 points between non-APM and APM participants. In practice, this shift is likely to result in a payment differential of 3 to 7 percent of total Medicare professional fees based on participation in risk-bearing models.

The most common APM is the Medicare Shared Savings Program, which included about one-third of Medicare FFS patients, providers and hospitals in 2018, according to CMS. Through the MSSP, providers can coordinate

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LEADING WELL

Developing Leadership Competencies for an Uncertain Future

Leonard H. Friedman, PhD, FACHE, and Wayne Psek, MD, PhD

An important truism in healthcare today is that change is the only constant. The external and internal environments are populated with new rules, regulations, devices and demands. These changes beg the question: How prepared are you to develop a pipeline of leaders for a future we cannot accurately predict?

If healthcare executives are going to flourish in the years to come, senior leaders should start now to strategically develop a workforce capable of navigating today's and tomorrow's changing environment. Through mentoring and executive coaching, senior leaders can help executives adopt five new leadership competencies and personal practices that will help prepare them and the organization for an uncertain future.

Emotional and social intelligence. For too long, some assumed that intelligence as measured by IQ was the critical measure of leadership and

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Top Issues Confronting Hospitals: 2018

Financial challenges again ranked No. 1 on the list of hospital CEOs' top concerns in 2018, according to the American College of Healthcare Executives' annual survey of top issues confronting hospitals. This survey, sent each fall to community hospital CEOs who are ACHE members, asked respondents to rank 11 issues affecting their hospitals in order of how pressing they are and to identify specific concerns within each of those issues. The survey was sent to 1,402 community hospital CEOs, of whom 355, or 25 percent, responded. This year, respondents cited financial challenges as their top concern, giving it an average rank of 2.0 on a 10-point scale. Governmental mandates and patient safety and quality both ranked second, with average ranks of 5.1. Personnel shortages ranked third, with an average rank of 5.2. The survey results are shown below.

Issue	2018	2017	2016
Financial challenges	2.8	2.0	2.7
Governmental mandates	5.1	4.2	4.2
Patient safety and quality	5.1	4.9	4.6
Personnel shortages	5.2	4.5	4.8
Behavioral health/addiction issues	5.3	—	—
Patient satisfaction	6.1	5.5	5.5
Access to care	6.2	5.9	5.8
Physician-hospital relations	6.6	5.9	5.9
Technology	7.7	7.0	7.2
Population health management	8.1	7.3	6.6
Reorganization (e.g., mergers, acquisitions, restructuring, partnerships)	8.3	7.5	7.8

The average rank given to each issue was used to place the issue in order of how pressing it is to hospital CEOs, with the lowest numbers indicating the highest concerns.

The survey was confined to CEOs of community hospitals (nonfederal, short-term, nonspecialty hospitals).

Specific Concerns Within the Top Issues

Within each of these 10 issues, respondents identified specific concerns facing their hospitals. Following are those concerns in order of mention for the top three issues identified in the survey. (Respondents could check as many as desired.)

Financial challenges (n = 355)[1]	
Increasing costs for staff, supplies, etc.	70%
Medicaid reimbursement (including adequacy and timeliness of payment, etc.)	68%
Reducing operating costs	59%
Bad debt (including uncollectable emergency department and other charges)	56%
Competition from other providers (of any type—inpatient, outpatient, ambulatory care, diagnostic, retail, etc.)	50%
Managed care and other commercial insurance payments	50%
Medicare reimbursement (including adequacy and timeliness of payment, etc.)	49%
Government funding cuts (other than reduced reimbursement for Medicaid or Medicare)	48%
Transition from volume to value	48%
Revenue cycle management (converting charges to cash)	43%
Inadequate funding for capital improvements	37%
Emergency department overuse	31%
Moving away from fee-for-service	30%
Pricing and price transparency	29%
Other	n = 17

Personnel shortages (n = 355)[1]	
Registered nurses	67%
Primary care physicians	62%
Physician specialists	53%
Technicians (e.g., medical technicians, lab technicians)	52%
Therapists (e.g., physical therapists, respiratory therapists)	37%
Physician extenders and specially certified nurses (physician assistants, nurse practitioners, certified nurse midwives, etc.)	29%
Other	17%

Governmental mandates (n = 355)[1]	
CMS regulations	70%
Regulatory/legislative uncertainty affecting strategic planning	61%
Cost of demonstrating compliance	59%
State and local regulations/mandates	50%
CMS audits (RAC, MAC, CERT)	46%
Other	n = 17

Patient safety and quality (n = 355)[1]	
High price/insufficient reimbursement for medications	57%
Engaging physicians in improving the culture of quality/safety	56%
Engaging physicians in reducing clinically unnecessary tests and procedures	51%
Redesigning care processes	50%
Lack of availability of medications	45%
Redesigning work environment to reduce errors	40%
Public reporting of outcomes data (including being transparent, fairness of measures, reporting burden)	39%
Compliance with accrediting organizations (e.g., Joint Commission, NCQA)	37%
Pay for performance	32%
Leapfrog demands (i.e., computerized physician order entry, ICU staffing by trained intensivists and evidence-based hospital referral—moving patients to facilities that perform numerous surgeries or treat high-risk neonatal conditions)	31%
Medication errors	14%
Other	n = 4

[1] If number of respondents is fewer than 50, only numbers are provided.

ACHE wishes to thank the hospital CEOs who responded to this survey for their time, consideration, and service to their profession and to healthcare management research.

Weathering the Storm When Emergencies Strike

Thomas R. Siemers, FACHE, is president and CEO, Dosher Memorial Hospital, Southport, N.C. A collaborative leader, he uses the relationships he has built with both internal and external members of the healthcare community and the Dosher Memorial Hospital Board of Trustees to make strategic decisions in the best interest of the hospital. Siemers has been in his current position since 2012. Previously, he served as the president and CEO of Ottumwa (Iowa) Regional Healthcare Center.

Siemers served as the ACHE Regent for Arkansas from 2001 to 2002 and on numerous ACHE committees throughout the years. He is an active member of the North Carolina Hospital Association and the Coastal Carolinas Healthcare Alliance, and he recently helped form the Brunswick Wellness Coalition with a grant from The Duke Endowment's "Healthy People, Healthy Carolinas" initiative to improve the overall awareness of health and wellness in Brunswick County, N.C.

He has a master's degree from the University of Iowa and a bachelor's degree from Michigan State University.

In September, Hurricane Florence caused severe damage in the Carolinas. How did the storm affect Dosher Memorial Hospital?
We're a critical access hospital on the Atlantic coast. Hurricane Florence came ashore 30 miles north of us. Structurally, the hospital sustained no major damage. However, roof damage and leaks were an issue throughout the facility. Operationally, the biggest challenge we faced was breaks in county and city water mains that cut off our water supply. Financially, we experienced a 40 percent drop in revenue, which is devastating to a small hospital.

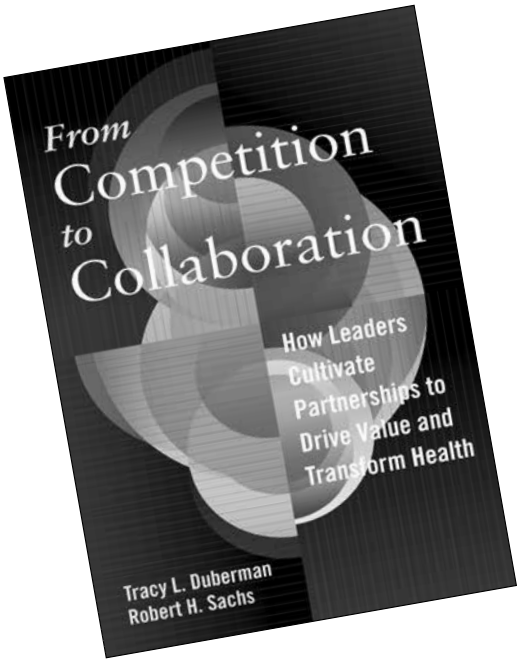
How did your organization prepare for the hurricane?
We knew the hospital itself could safely weather the projected winds but that we would have to scale back our offerings. We decided to keep the ED open along with diagnostic services to support it, and staffed accordingly. We closed services such as surgery and physician clinics and transferred inpatients to hospitals out of the storm's path.

What leadership attributes does an executive need to keep employees focused during emergencies, including severe weather events?
There's no substitute for on-site leadership. The CNO, CFO, four physicians and I were among the 30 people who stayed at the hospital around the clock for seven days. When we lost power and the air conditioning shut down, we were sweating alongside our front-line staff. Having leadership on-site enabled us to react to issues immediately—day or night. Communication was vital for both our on-site and external teams, as was maintaining close contact with our city emergency operations center. Each day, the North Carolina Healthcare Association held a conference call with front-line hospitals, including Dosher. I sent a daily email to board members, physicians and department leaders of the day's challenges and events along with photos of the team and building. I later learned how much others appreciated these updates.

What elements in your organization's emergency response worked well, and where did you discover room for improvement?
Morale was high. Our staff were great—they remained focused and available to help wherever needed. We treated over 150 patients; two patients probably would have died had our team not been present. Our biggest challenge was figuring out where to get water tanks and how to transport them around flooded roads because we did not preposition them on the hospital campus.

What advice would you offer other healthcare leaders regarding emergency preparedness?
It is difficult to overstate the importance of planning. We planned for a hurricane blowing through—not for a hurricane that would stall over our area for days. Water clearly was an issue. We also did not anticipate that Southport would be cut off due to road closures and the termination of ferry services. Staff could not return to work for days.

RECOMMENDED READING



From Competition to Collaboration: How Leaders Cultivate Partnerships to Drive Value and Transform Health

The U.S. health system needs improving, but the path to real change remains unclear. In *From Competition to Collaboration: How Leaders Cultivate Partnerships to Drive Value and Transform Health,* Tracy L. Duberman, PhD, FACHE, and Robert H. Sachs, PhD, explain how healthcare leaders can navigate issues that arise when organizations from different sectors and with different operating models, objectives and cultures, work toward a shared purpose.

This book focuses on how using the collaborative health ecosystem leadership model can create healthier communities and develop new leadership competencies.

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ACHE Management

TREND TRACKER

Several strategic areas fuel the transformation of healthcare organizations, and in turn, these areas depend on effective clinical leadership, according to a recent B.E. Smith update on clinical leadership trends. Specifically, value-based care demands a focus on three key drivers:

Patient centricity. "Putting the patient first" reflects the rise in patient consumerism and the influx of nontraditional care providers. This is leading to care quality improvements, reduced costs and the promotion of wellness.

Clinical integration/care coordination. Merging organizational silos and coordinating the care offered are key to patient outcomes and cost reductions.

Population health management. Preventative medicine and related strategies prove that good health depends on socioeconomic, environmental and behavioral factors, in addition to access to quality care.

These strategies depend on physician and nurse leaders. However, despite the growing importance of these roles, there are challenges to broader participation:

- Only five percent of C-suite-level positions are occupied by clinicians and 14 percent by CEOs.
- While nurses make up the largest workforce sector, only about 5 percent of hospital boards include a nurse trustee.
- There is an average of two physicians per board—about 15 percent of the total board.
- Some boards prefer to limit the number of employees as trustees.

www.besmith.com

Following the 2018 midterm election, Americans continue to cite

healthcare as a primary concern. Last November, PwC's Health Research Institute issued a report examining the impact of the election results on U.S. healthcare, including five key policy issues for 2019. Following are ways healthcare providers can prepare for them:

- *Greater adoption of Medicaid expansion.* Develop an in-depth understanding of the "new patient population" and reinforce physical and personnel resources where necessary.
- *Restrictions and scrutiny of short-term, limited-duration and association health plans.* Enhance care for patients and lessen operational risk by considering the social determinants of health, like education, income, nutrition and housing.
- *Scrutiny of Medicaid 1115 work requirement waivers.* Maintain regular contact with Medicaid beneficiaries to ensure they understand work requirements and report accurately to avoid losing benefits.
- *Increased attention to opioid prescribing and delivery regulations.* Watch for shifting compliance measures regarding more oversight and administrative burdens if you prescribe opioids for certain conditions, particularly in the area of telehealth.
- *Delivery system reform.* Scale up value-based payments, fold in additional risk gradually and cultivate networks that appreciate new evaluation metrics. New payment models will continue to drift from traditional fee-for-service toward fee-for-value.

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Developing Leadership Competencies for an Uncertain Future (continued from Page 1)

organizational success. While leaders must be competent at the technical part of their work, managing and leading well requires mastering psychosocial behaviors. There are five key elements to emotional intelligence: knowing one's emotions, managing emotions, motivating oneself, recognizing emotions in others and handling relationships. The field of social neuroscience—how biological mechanisms influence psychological and social behavior—is also expanding our understanding of social interactions or what some consider our "social intelligence." To help other leaders develop these skills, encourage mentees to reflect on why they do certain actions or say certain things and how to adapt their behavior and communication in social contexts. Given the centrality of human interactions at all levels in healthcare, each of these skills is vital for healthcare leaders.

Thinking big picture in terms of systems. Too often, each group, department or division within healthcare organizations operates independently to optimize their world without considering how others might be affected.

The challenge for highly effective healthcare leaders is to create organizations where the hardened walls of operational silos are transformed into "semipermeable membranes" that allow for the free flow of information and best practices out of

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care by forming accountable care organizations. ACOs can receive up to 75 percent of the savings if quality standards are met and per capita costs grow more slowly than the national average. Although ACOs operate in an FFS environment with no restriction of patient choice, reduced costs averaged 1.1 percent in the 2017 performance year, according to the Medicare Payment Advisory Commission.

CMS is increasing ACO accountability in its new "Pathways to Success" program to earn these benefits. Previously, ACOs could proceed risk-free for up to six years, but new ACOs may soon have to take risk by the third performance year, and established ACOs by the second year. By the fifth year, ACOs would risk 4 percent of total Medicare spend on attributed patients—an average of $441 per patient, per year, and $68,000 per primary care provider, per year, based on 2017 average MSSP per capita spend, according to data from Caravan Health and CMS. Based on a survey of 127 ACOs, the National Association of ACOs predicts that 36 percent of ACOs would leave the MSSP under the proposed rule, while CMS estimates 20 percent would exit the program. The remainder would have to quickly assume risk, which poses significant statistical challenges given the size of most ACOs, the amount of savings achievable in an FFS environment, and the inherent variability of healthcare spend.

Size Matters

A May 2018 *Health Affairs* blog uses Medicare data to illustrate the inherent variability of Medicare spend by ACO size to determine the minimum sample size needed to reliably see 1–2 percent savings and avoid paying penalties due to statistical risk. The analysis shows that the minimum loss rate that determines whether an ACO is required to pay back losses does not cross the 99 percent confidence interval until 100,000 lives. This phenomenon is also seen when observing reported savings and losses in light of ACO size: Only large ACOs show similar results to actual savings and losses.

Unfortunately, most ACOs are too small to confidently take risk; 74 percent of ACOs have fewer than 20,000 lives, according to CMS. Most small ACOs that have improved quality scores each year have seen their savings differ greatly due to the variability associated with having fewer than 100,000 lives. In short, ACOs must increase the number of lives to have predictable and sustainable savings.

How Hospitals Can Succeed

Regardless of size, hospitals are uniquely positioned to succeed under these models. Many are accustomed to collaborating for mutual benefit through hospital associations and local networks. Furthermore, they employ many of the nation's physicians, and are affiliated with almost all of them. They are experienced in quality and risk programs, and they have the most to gain from aligning and supporting both employed and aligned physicians through increased referrals. Hospitals also employ nurses who can deliver and

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one part of the organization into another. By demonstrating through your own actions that collaboration and cooperation are key to highly effective systems, senior leaders can help develop systems thinking across organizations, as well as competencies in how to build health systems that are capable of learning.

Change management. Effective healthcare leaders accept the fact that when encountering change, everyone is giving up something, no matter how large or small. This sacrifice automatically triggers an emotional response that varies depending on the scope and intensity of the change at hand. Key elements of effective change management are ensuring staff are given a compelling reason for change, a clear sense of hope and optimism for the outcome of change, and adequate time to integrate the new change into their routine.

While change is constant, the human response to change is also constant. By sharing insights and experiences, senior leaders can help cultivate other leaders' abilities to lead change with the understanding that change management is an ongoing and continuous process.

Adaptability to chaos and complexity. Some days our organizations can be chaotic and complex. This observation aligns with how the universe actually works: Chaos and complexity are the norm. Organizations try to manage chaotic and complex behavior by imposing rules and regulations or policies and procedures. But how well are those working?

There is a compelling body of scientific and organizational literature that suggests over-controlling a complex system, such as a healthcare organization, has little chance of lasting success. An alternative is to present a few simple rules that apply throughout the organization and then consistently put them into operation. You can help up-and-coming healthcare leaders adopt this perspective and get all staff moving in the same direction and working with a common purpose by offering guidance on how to create a plan, or by demonstrating how you have handled similar situations. Share examples of how such actions have helped build resilience and allowed organizations where you have worked to maneuver through challenging times that were difficult to anticipate.

Open-mindedness and introspection. The future will bring new ways of experiencing the world around us, disrupting our models of the way the world works. Challenge leaders you are mentoring or coaching to consider how individual and social definitions of identity and diversity are morphing and how they will need to adapt to evolving patient and staff expectations. Emphasize the importance of letting go of preconceived ideas and biases and adopting new lenses to view the world. Self-reflection is a necessary competency to understand one's values, biases and mental models. Encourage early or mid-careerists to avail themselves of self-assessment instruments to gain greater self-awareness. Completing a competencies assessment can have a powerful impact on a leader's transition from good to great.

The challenge for senior leaders is how to teach these competencies. What's more, how do we continually demonstrate and improve upon these competencies in our own daily practice? The consistent execution of these competencies and sharing them with future leaders will make a profound difference in the performance of healthcare organizations now and in the future.

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bill for certain population health services, and they have access to capital to underwrite risk.

Population health management and clinical integration have led to higher patient loyalty, increased referrals and new revenue streams that are focused on disease prevention. Hospitals deploy nursing staff to focus on population health services, which creates more of the right kind of revenue and prevents costly interventions later. Providing chronic disease care management, annual wellness visits, and behavioral and mental health support fulfills a common hospital mission of improving the health status of the people it serves, while also generating hundreds of dollars per patient, per year, to sustain population health programs.

At Margaret Mary Health in Batesville, Ind., the cultural change is evident. Population health goes beyond improving quality; it focuses new discussions around helping patients lead healthier lives. Leaders get excited about high influenza and pneumonia vaccine rates, not flu and pneumonia admissions. That attitude translates to the clinical staff and reinforces the authenticity of the hospital's mission: improving the health of its community.

Regardless of size, hospitals are uniquely positioned to succeed under these models. Many are accustomed to collaborating for mutual benefit through hospital associations and local networks.

Historically, managed care reduced the cost of inpatient care by 20–30 percent, but that is no longer the case. A June 2018 MedPAC report to Congress states, "While ACOs may eventually have some effect on admissions, it appears to date that ACOs have not caused a large reduction in inpatient admissions."

As healthcare delivery in the United States transitions to fee-for-value, payments will slowly increase over time for physicians and hospitals that prove they can deliver efficient, effective and high-quality care. ACOs can succeed at improving care for patients and decreasing cost of care delivery, but savings generated by ACOs of less than 100,000 lives will be subject to great variability. Hospitals that form large cooperative groups focused on preventive care, increased quality of services, wellness and knowledge of patient needs through claims data can succeed under risk-bearing ACO models. Lastly, clinicians affiliated with these programs will experience reduced regulatory burden, increased income and protection from downside risk when support services are provided by population health staff working at the top of their license.

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