The topic of population health has become a presence in health care media and on conference agendas as hospitals and health systems seek to cross the gap from the first curve to the second curve in health care transformation. Accountable for hospital and health system strategic success, trustees must have a solid grasp of the meanings and implications of population health management and why it’s important to the future of their organization and the community as a whole.

What is Population Health?
In the American Hospital Association’s (AHA’s) Signature Leadership Series 2012 report, Managing Population Health: The Role of the Hospital, population health is defined as “a strategic platform to improve the health outcomes of a defined group of people, concentrating on three correlated stages:

- The distribution of specific health statuses and outcomes within a population;
- Factors that cause the present outcomes distribution; and
- Interventions that may modify the factors to improve health outcomes.

Population health resides at the intersection of three distinct health care mechanisms. Improving population health requires effective initiatives to: 1) increase the prevalence of evidence-based preventive health services and preventive health behaviors; 2) improve care quality and patient safety; and 3) advance care coordination across the health care continuum.”

The AHA also notes that a common description of population health is “the health outcomes of a group of individuals including the distribution of outcomes within a group.” Very simply put, population health management means improving the overall health of a population. This includes identifying individuals with the highest-risks (the most acute and complex conditions) and those with chronic conditions, and determining the best means for keeping them healthy. It also means determining and addressing the preventive and wellness needs of the rest of the population.

Why is Population Health So Important?
One of chief drivers behind today’s efforts to manage population health is the shift from a volume-based, fee-for-service payment system to a system based on value. New payment structures with shared savings and risk, bundled and capitated payments, and penalties for low quality of care scores and high readmissions contribute to the rising investment in population health management by health care organizations.

The ability to deliver high quality care and improve health outcomes while managing costs will significantly affect hospitals’ and health systems’ ability to succeed in a value-based health care environment. The Institute for Health Technology Transformation predicts that population health management will be a required core strategy for health care providers, and nearly all hospital CEOs (98 percent) responding to the AHA’s 2012 Annual Survey of Hospitals believe hospitals need to be implementing population health strategies.

(Continued on page 7)
The Arkansas Private Option is Working

Data measures how we’re doing in any situation, and data regarding the Arkansas Private Option (APO) is measuring its positive impact on Arkansas hospitals. Looking at data from the first quarter of the calendar year (the APO went into effect January 1, 2014), Arkansas hospitals can already report a 30% drop in self-pay patients, comparing quarter one of CY 2014 to quarter one of CY 2013. At the same time, the number of self-pay patients presenting to emergency departments for care was down 23%, at a time when overall ED volumes have remained relatively flat. This is huge.

Cuts to Medicare reimbursements and the climbing rate of uncompensated care have been the one-two punch threatening the life of Arkansas hospitals. The latest rounds of Medicare reimbursement cuts that began with the Middle Class Tax Relief and Jobs Creation Act of 2012 and the American Taxpayer Relief Act of 2013, grew under stipulations of the Affordable Care Act and were increased yet again as the results of sequestration continue. They, alone, are stifling.

Add to them the more than approximately $390 million* Arkansas hospitals annually spend providing care for patients without health insurance coverage, and you can see the dilemma. The dual financial burden on hospitals is crushing.

But here’s the good news: the APO is significantly reducing uncompensated care, since many formerly uninsured are now in the ranks of paying patients with healthcare coverage secured through the APO. By reducing hospitals’ uncompensated care (care provided to, but not paid for by, uninsured patients), the APO gives Arkansas hospitals a fighting financial chance to keep their doors open.

The AHA’s work with legislators, helping them understand the APO as Arkansas’s unique approach to helping both patients and hospitals while complying with federal law, has made a difference twice as the required super majority approved the Private Option. It was not an easy vote, with only projections to weigh as deliberation occurred.

However, the projections are now being met or exceeded by incoming data, and we expect having facts in hand will make the next APO appropriation easier for legislators to support.

I ask that you talk to your legislators and thank them for their support of the APO. I also ask that you talk with legislative candidates about the success of the APO and see where they stand on the issue. As November’s elections come we must support those candidates who are behind the APO, and remind them of the importance of this healthcare coverage. It is not only good for Arkansans; it is a positive contributor to our state’s economy.

From the hospital perspective, the APO has proven to do exactly what it was designed to do...cover more Arkansans who were formerly without healthcare coverage, and thereby reduce the burden of uncompensated care on our hospitals. The APO cannot reduce Medicare reimbursement cuts to hospitals nor can it wipe out uncompensated care altogether, but it can reduce (and is reducing) the amount of uncompensated care hospitals must absorb.

As we all know, going into 2014 hospitals faced a dire financial situation. The ability of the APO to help was questioned.

Now, with preliminary data in and more positive, measureable results expected as the year progresses, it is clear and becoming clearer that the APO is working...for Arkansans and for Arkansas hospitals.

Sincerely,

Robert “Bo” Ryall, President and CEO
Arkansas Hospital Association

*2012 data, the last year for which data is available
Becoming a Visionary Board in an Era of Transformation

Time and again in recent years, hospital trustees have questioned how they can be expected to determine a strategic future when so much in health care is changing, and the future is seemingly unknown and unpredictable. But this is precisely the time when the board must be at its visionary best. Forward thinking visionary boards anticipate potential futures. They prepare for and embrace the changes ahead.

In the book Governance as Leadership: Reforming the Work of Nonprofit Boards, the authors define three types of governance: fiduciary governance, strategic governance and generative governance. Fiduciary governance should be a boardroom basic, the cornerstone of the board’s responsibilities. The practice of fiduciary governance includes stewardship of the organization’s assets, responsibility for the organization’s finances, ensuring the highest and best use of resources, monitoring and ensuring legal and regulatory compliance and providing operational oversight.

Strategic governance responsibilities encompass setting a vision and identifying initiatives and strategies for achieving that vision, as well as fulfilling the organization’s mission. Strategic governance responsibilities include allocating the resources required to pursue strategic initiatives and monitoring progress to ensure goals are achieved.

While strategic governance might seem to be closely aligned with being a visionary board, it is actually generative governance skills that must be a priority for trustees in today’s environment, which is characterized by fast-paced change with a hazy view of tomorrow. Boards that practice generative governance make time to question assumptions, they explore areas which lie outside the proverbial “box” and they envision new and innovative ways of accomplishing goals, achieving visions and fulfilling missions.

“What If” and “So What”?
Visionary trustees consistently ask themselves a series of questions, including “What do we know today that we didn’t know yesterday?” By staying well-informed with a continuing flow of new information and evidence, visionary boards can anticipate emerging trends. They begin to envision potential futures by asking themselves “What if…?” For example, “What if our patient volume continues to decline as preventive and wellness efforts succeed in improving our community’s health, as our initiatives succeed in reducing readmissions, and as care continues to shift to outpatient settings?” “What if health care is no longer hospital-centric?” “What if retail pharmacies become a preferred source of diabetic care?” “What if we formed a partnership with…?” “What if we look at this differently?”

Boards move another step closer to becoming visionaries when they also ask: “What could that mean to us? What implications does it have for our hospital?” and “What could or should we do to be prepared?” These are questions that begin to generate deeper understanding of new paradigms and their implications for the hospitals and health systems that boards are responsible for leading. They are the questions that prompt challenges to the assumptions and status quo that may hold organizations back.

By considering a variety of potential scenarios and possible responses, visionary boards are able to carefully consider what possible actions they must take to capitalize on the forces for change. They are better prepared to act quickly, confidently, and on their own timetable instead of being reacting to situations that may be forced upon them.

Challenges to Maximizing the Board’s Visionary Potential

While there are many potential challenges that prevent trustees from maximizing their visionary potential, below are a few of the most common causes that derail boards.

Failing to Stay Well-Informed. Without credible and current information and data, trustees cannot hope to recognize or anticipate the forces, trends and changes happening in the environment around them. They must develop a high level of understanding in the areas most critical to organizational success and performance. Passing knowledge is not enough. Well-informed boards search out opinions, ideas and perspectives that may be different from their own. They listen to a variety of voices outside the organization, engaging the viewpoints of people with unique experiences and perspectives. In doing so, visionary boards expand their knowledge base and open new lines of thinking.

Poor Agenda Planning and Meeting Management. Confronted with multiple challenges and competing priorities, effective boards must focus their time and attention on the issues most critical to achieving the organization’s mission and vision. Board chairs must ensure meeting agendas are structured to allow the board to focus on bigger strategic issues in board meetings. The board chair must manage meetings to engage trustees at a higher level of thinking and planning, enabling and facilitating the inquiry, dialogue, and debate needed to be visionary.

(Continued on page 6)
Price Transparency: The Board Sets the Tone

Most trustees have heard about price transparency. You have likely seen media reports and personal stories about a lack of hospital price transparency, problems with hospital prices and charges, and negative patient billing experiences. As the governing body that drives the direction and sets the tone for the entire organization, boards must proactively take accountability and ownership in addressing consumer demands in today’s transforming health care environment.

Transparency in price and quality is increasingly important to consumers, and ideally are linked together to give consumers a better picture of overall value. Health care is no longer centered around inpatient hospital stays paid for by insurance companies while patients are sheltered from the cost. Growth in consumerism, changes in consumer health plans and shifts in reimbursement approaches mean big changes for hospitals in the way health care is provided, how it is paid for and the information consumers demand.

Although price transparency is increasing in some ways (for example, websites that post hospital charges), hospital trustees should be evaluating the information available and asking critical questions like: How useful and meaningful is the information currently available to everyday consumers? What do consumers care about, and should hospitals pay attention to that? How can patients get information about actual costs in advance of receiving care, and where should those patients get that information? Would the hospital earn value by being patients’ source of price information?

Responding to a Changing Market

Historically hospitals have not catered to consumers like many other industries have. As medical tourism, retail-based clinics, outpatient surgical centers, internet resources, and other forms of non-traditional health care grow, hospitals that will be successful in the long-term are considering a changes to their business model. In today’s transforming environment, the ability to remain mission-focused may require a deep analysis of the organization’s core purpose, vision and strategies.

Patients as Consumers. Patients today are consumers, increasingly vested in comparing cost and quality before making decisions; but confusing and conflicting information or lack of information altogether, leaves consumers feeling frustrated and often unable to determine actual value for what they are paying for. Consumers want to know what their cost will be in advance. They don’t want to know the “charges” that will be negotiated and evolve, but the actual cost they will pay out of pocket. They want to know what they are getting for that cost and they don’t want to see itemized charges for the everyday over-the-counter medications and toiletries they can purchase for a fraction of the price at their local drugstore.

Hospital Pricing is Complex. Displaying hospital price information is no simple task. The American Hospital Association (AHA) observes that sharing meaningful cost information in advance is difficult because there is so much variation. For example, one patient procedure may be simple while another may involve complications. In addition, hospital prices do not include physician and other professional costs, which can be misleading to patients seeking the total cost of care. Even when prices are estimated, those estimates don’t take into account amounts the patient’s insurance company may pay for.

Many Hospitals Don’t Know Their Prices. For many hospitals the challenge is deeper than figuring out how to share prices with consumers. Some hospitals don’t even know what their prices are, or how they compare to their competitors. For example, in a 2013 study published in the Journal of American Medical Association (JAMA), researchers reported that only 3 out of 20 hospitals could tell an uninsured patient how much they would charge for a basic electrocardiogram.

Prices must become more transparent in the future. For hospitals that are just figuring out their actual prices for the first time, there may be significant questions for boards to consider. Can we maintain our market share at the current rate as prices become more transparent? Can we offer the same service and value for a lower price and still make money, or do we need to modify our strategies? For some hospitals, this may require a significant shift in patient care approaches or changes to the depth and range of services offered.

Organizations Taking the Lead

Price information is emerging in a variety of ways. It’s not just insurance companies, and patients—employers also want to
(Continued from page 4) compare prices among organizations, and to incentivize patients to use the best cost-to-value option. For large employers, including many hospitals and health systems, the cost savings have the potential to be significant.

Emerging Web Sources. According to the AHA, 42 states publically report information in some format on hospital charges or payment rates. In addition, in 2013 the Centers for Medicare & Medicaid Services (CMS) released a list of charges for 100 types of hospital care, by facility. While the information isn’t easily usable for average consumers, it has gathered media attention, and highlighted the significant differential in average costs and reimbursement between facilities.

As information has become more readily available, consumer-friendly websites are emerging. Nerd Wallet and ReferMe help patients synthesize information, recommending the best hospital for a particular procedure based on price combined with other indicators, such as patient satisfaction. ReferMe also advertises that it can help compare existing bills against what others are paid to assist in negotiating a hospital bill. Websites like Castlight Health, Change Healthcare, and HealthSparq provide out-of-pocket cost estimates, often taking insurance into account. Castlight Health also incorporates outcome information. By encouraging employees to select lower-cost options with positive outcomes, the company claims to help reduce costs for corporate customers by as much as 10 percent a year.1

Employer Efforts. Employers participating in the Employers Centers of Excellence Network (ECEN) offer particular procedures, such as a hip or knee replacement, free to employees using an approved provider. Employees utilizing in-network facilities have no out-of-pocket costs for care or travel expenses.2 Other employers are implementing “reference pricing.” The most well-known example is the California Public Employees’ Retirement System (CalPERS), which capped what it would pay for hip or knee replacements at $30,000 in 2011. If employees go to a facility that charges more than $30,000, they have to pay the difference out of pocket. At the time, CalPERS reported that hospital prices for the same surgery varied from $15,000 to $100,000 with no discernable difference in quality.3

Opportunities for Boards of Trustees
In a recent interview with Hospitals & Health Networks, Jamie Orlikoff discussed the importance of hospitals taking the lead on transparency, noting that when a patient can get information from their employer or their insurance company but not from the hospital, it marginalizes the hospital. In a consumer-driven market “the source of information is a very powerful market force, and hospitals should want to be the source of information. Otherwise, they run a great risk of being dictated to as opposed to taking control over their pricing.”

At a time when public confidence is eroded by rising health care cost, and scrutiny of hospital billing and collection practices is at an all-time high, hospitals have an opportunity to take the lead on price transparency and simultaneously earn community trust. Some hospitals are doing this through individual efforts, such as telephone price estimates, offering information request forms online, or developing cost estimators on their public website.2 Others are revamping their billing process and looking for better ways to communicate with patients.

The approach each organization takes should be unique to its market and customer base; however, doing nothing has serious implications for hospitals’ long-term survival. One starting point for boards should be reviewing the results of the recent industry-wide taskforce on price transparency, spearheaded by the Healthcare Financial Management Association (HFMA). The report clarifies common definitions and sets guiding principles and recommendations for price transparency for insured patients, uninsured and out-of-network patients, employers, and referring clinicians. While the taskforce acknowledged the “unintended consequences” of too much data being public and the potential impact on negotiated rates, the market direction is becoming increasingly clear. Taskforce recommendations include providing patients with the total estimated price of the service, estimated out-of-pocket costs, and other relevant information such as patient safety scores and clinical outcomes.2,5,6

Sources and More Information

Price Transparency: Questions for Boards to Consider
- Does your organization’s leadership view patients as customers?
- Do you know what your actual prices are?
- Do you know how your prices compare to competitors?
- How do patients typically find out about your prices?
- Does the community trust you to provide fair, honest prices?
- Have you seen a recent hospital bill from your facility? How would you perceive it from a patient perspective?
- Do you have a process in place to help patients understand their anticipated cost before receiving care?
- Has your board reviewed the recommendations from the American Hospital Association’s task force on price transparency in health care, spearheaded by the Healthcare Financial Management Association?
Focus on the Wrong Issues. Boards must continually adjust their attention to deal with the issues of the future, not the issues of the past. Time should be concentrated on understanding trends and priorities, and their implications for the organization, rather than dealing with operational details. The board’s focus should be on generative thinking and visionary-focused dialogue about the challenges, issues and opportunities ahead.

Disengaged Trustees. Board service has never been more challenging. Trustees must know and understand more, and take on greater responsibility than they have in the past. Board members must have the time, availability and discipline to act on their commitment to the board and the responsibilities of trusteeship. They should possess the personal attributes and qualities that ensure the caliber of engagement and contribution required for effective, visionary governance.

Failing to Engage in Deep, Decisive Dialogue. Visionary board members ensure their governance conversations are always vibrant, vital, and focused on purpose and outcomes. Dialogue should be the board’s “social operating mechanism.” Through synergistic discussions, innovative solutions are generated by grappling and grasping with new concepts, ideas and solutions. Without constructive challenges to conventional wisdom and thought, the best solutions may never surface. Visionary boards regularly confront issues by challenging assumptions and exploring alternatives to traditional thinking.

Holding onto the Status Quo. Holding onto the status quo will not push organizations to excel in the future. Improvement and advancement are the keys to future viability in a complex, competitive health care world that will not be the same as it is today. Trustees must lead organizations that can capitalize on new opportunities. Innovation and change must be encouraged and rewarded in all areas and levels of the organization. This requires trustees’ leadership of thought, ideas, creativity, accountability and purpose.

Lack of a Common Purpose. As organizations grow through mergers, joint ventures, partnerships, and collaborations across the continuum of care, all stakeholders must share a common purpose or mission. Nothing is more motivating than a clear picture of a bright and successful future. Accomplishing this demands that the board develop an exciting, shared mission that will stimulate enthusiastic followership.

Attributes of Visionary Trustees
Visionary trustees possess the personal attributes and qualities that ensure the caliber of engagement and contribution required for generative governance. Developing the expertise needed requires motivation, commitment, and time. High-caliber trustees voluntarily seek to be well-informed and knowledgeable, and demonstrate intelligence and quick understanding. Visionary trustees are big-picture thinkers open to new ideas. They think and speak strategically in discussions about complex scenarios and situations. Visionary trustees analyze trends to determine possible implications to the hospital or health system. They display creative and resourceful thinking, considering situations from various angles and perspectives. Visionary trustees use “reasonable inquiry” to pursue new solutions and opportunities, asking thoughtful and insightful questions. Visionary trustees are willing to challenge the status quo and take calculated risks in the interest of moving their organizations forward and fulfilling their missions. These individuals look into the future and imagine what might be achieved.

Visionary boards do not happen by chance. They build on the sound foundation of their organizations’ missions, a good understanding of their communities’ health care concerns and the bigger perspective of how health care is evolving. By asking penetrating questions and engaging in vibrant conversations that explore new possibilities, the board’s visionary focus can stimulate creative thinking, dialogues and debates that help trustees identify and evaluate new and different strategies, overcome challenges and barriers, and encourage calculated risk-taking that leads to visionary futures.

Generative Governance: Where Real Leadership Power Lies
According to the authors of Governance as Leadership: Reforming the Work of Nonprofit Boards, generative governance is where real leadership power lies. It’s where the board has a clear sense of problems and opportunities facing the organization. Meaningful goal setting and direction setting originates from generative thinking, which requires leaders that not only contribute generative insights to their hospitals, but also engage others in generative thinking. It occurs when boards question assumptions, probe feasibility, identify obstacles and opportunities, and determine alternate ways of framing issues.

Generative governance requires a new type of agenda that features ambiguous or problematic situations rather than reports and routine motions, with a goal to frame decisions and choices, not simply make them. Trustees promote robust dialogue around generative ideas and concepts, which stimulates a “culture of inquiry,” creating more substantive and intellectually attractive agendas that create more interesting and productive work, and a more influential role for board members.

(Continued from page 1)

What Is In the “Population”?

One of the first and most important steps in managing the overall health of a population is to define who’s included in the “population,” or group of people whose health is to be “managed.” A population can be defined in multiple ways, including: 1) individuals within a specific geographic area, such as the hospital or health system’s community or service area; 2) a patient population, such as a physician practice group’s patients or a hospital’s discharged patients; or 3) a payer group, including Medicare patients assigned to an Accountable Care Organization (ACO), patients covered under a particular insurer’s benefit plans or employees of a particular employer. A population may also be defined by a particular health condition, such as diabetes, asthma or cardiac conditions.

There are a number of ways to define a group of individuals whose health the hospital or health system wants to best manage and improve. The key is to ensure a clear definition of the population in question from the start. The ability to measure the impact and outcomes of various health care interventions is dependent on knowing exactly what the target population is. Without the ability to establish a credible baseline and demonstrate measured improvement, the hospital will sacrifice financial reimbursement in a value-based system.

What Does It Take?

Many hospitals are already taking steps to improve the health of various populations, including focused attention on improving quality and patient safety, better coordination of care and delivery of preventive and wellness services. The size and resources of a hospital or health system and its community may define the scope of the population health strategies the organization is able to undertake.

Regardless of scale, below are several primary factors to consider.

Common Vision. When the board and the CEO agree upon a common vision for community and population health, and all key players, including the medical staff, are working toward that same vision, the path to achievement becomes a little easier and the outcomes are more effective. To get there, the board and CEO must agree upon and clearly articulate the extent of the commitment and engagement of the organization in community and population health efforts.

Targeted Health Needs. Identifying targeted health needs is a first step in population health management. Hospitals and health systems may choose to target quality and patient safety by selecting an area in which the organization’s health outcomes measures fall short. A hospital or health system may also want to focus its efforts on one or more of the health needs identified in a community health needs assessment, or where it experiences a high rate of admissions. Many organizations are also working to improve the coordination of care between providers.

Interventions. Once a target health care need has been identified, the contributing causes or factors must be identified, and possible strategies for addressing them must be evaluated. Hospitals and health systems must assess and prioritize efforts to pursue. This includes consideration for where the organization can have the most critical impact or influence. It is also an opportunity for trustees to consider the long-term goals for a healthy population, to challenge common assumptions and the status quo, and to seek out new and creative partnerships and collaborations that will engage, motivate and inspire patients and the community.

Partnerships and Collaborations. Multiple factors influence the health of an individual or population, including socio-economic...
Critical Actions for Trustees

Hospital CEOs overwhelmingly agree that hospitals need to implement population health strategies; others in the health care arena predict that population health management will be a required core strategy.3, 4 Are you and other members of your board prepared for this leadership responsibility?

1. Does your board have a good understanding of population health management and its importance to your organization?
2. Does your hospital or health system have the infrastructure necessary for managing population health? If not, what actions does the board need to take to ensure the hospital or health system is able to develop population health management as a competency?
3. Do you know what strategies the organization is pursuing to manage and improve population health? Does the board maintain adequate oversight to ensure successful outcomes?
4. Do you know what efforts others in your community or region are pursuing to manage and improve population health? Are your efforts well-aligned or are they duplicative? Could joining forces create a more successful outcome for the community?
5. Is your organization maximizing its resources, efforts and potential impact through partnerships and collaborations? If “the whole is greater than the sum of its parts,” what opportunities should or could the organization pursue?

Measured Outcomes. To demonstrate improvement and ultimately earn revenue in a value-based system, the organization must have the ability to establish a baseline of measurement and track and measure outcomes and improvements in quality, patient safety and health.

Data and Technology. Data and technology may well be among the most important resources for successful population management. In its report on population health management, the Institute for Health Technology Transformation noted that electronic health records and automation support “essential population health management functions, including population identification, identification of care gaps, stratification, patient engagement, care management, and outcomes measurement.”3

Available Resources. Investment in hospital infrastructure in support of population health comes at a time when hospitals are also facing lower patient volumes, reduced operating revenue and growth in expenses that outpace revenue.6 Hospitals must carefully assess their resources and prioritize health improvement initiatives accordingly. The board must lead the way in establishing partnerships with others who will share the responsibility for improving the community’s health and best maximize the benefit of scarce resources.

How is Success Defined?

Ultimately, the hospital or health system’s board of trustees is accountable for the organization’s success. In a value-based system, success is increasingly defined not only by financial viability, but by the organization’s ability to fulfill its promised mission to positively impact and improve the health of its community.

Sources and More Information