Entering a new year affords the customary practice of pausing, reflecting and shifting one’s focus to the year ahead. The convergence of value-based reimbursement, technological innovation and consumerism is catalyzing a revolution in 21st century American healthcare delivery. Most health systems and providers have begun to adopt the principles and practices of population health management in addressing the opportunities and challenges these present. At the forefront of the revolution, a few innovators are beginning to find deeper strategic advantages that are the rewards of doing the hard work of altering their business models, redesigning their care models, forging new partnerships and engaging their workforce in adapting to new realities.

While the recent federal elections portend changes to the insurance marketplace and other aspects of the Affordable Care Act, the transformation of care delivery is well underway and unlikely to fundamentally change course from a delivery system perspective.

Here are some trends to watch out for in 2017:

**Continued Growth in Value-based Contracts**

Payers continue to expand the use of reimbursement models that pay for services based on clinical outcomes that measure quality, access and cost. This shift in reimbursement is a major catalyst for the adoption of population health management (PHM) techniques, including risk segmentation, comprehensive care coordination and data analytics. Accountability for patient activities occurring outside of traditional physician offices and hospitals places increased emphasis on patient activation and engagement. Private and government insurers can be expected to tie more of the payment for healthcare services to outcomes in 2017. The federal Merit-based Incentive Payment System (MIPS) program, which redirects Medicare physician reimbursement to value-based measures, was included in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation and was enacted with strong bipartisan congressional support. It will be unaffected by the expected roll back of some provisions of the Affordable Care Act.

**Traditional Business Models Under Pressure**

Despite the increase in value-based contracting, in most U.S. markets, providers’ business models still depend on fee-for-service revenue. Because effective PHM practices shift the provision of some services to sites of care where unit costs are lower, the value that is created for payers and patients potentially erodes short-term operating margin for providers. Optimizing margin through PHM requires prioritizing and leveraging the implementation of early population health initiatives. Efforts that reduce hospital readmissions and resulting penalties; implementing systems to predict the cost of care for specific populations; profiling physician engagement to enhance performance; implementing evidence-based and effective care pathways that reduce in-patient expense; and managing unwarranted clinical variation are effective methods to mitigate the risk of operating margin erosion. In 2017, health systems and providers will increasingly implement more robust methods of managing and analyzing complex data sets from payers and will continue to bolster their revenue cycle administration and acumen to improve financial outcomes.

**Implementing Operating Models to Enhance Organizational Agility**

Industry consolidation has produced larger health systems, many of which still face residual, post-merger integration opportunities. More than 250 clinically integrated networks (CINs) and 750 accountable care organizations (ACOs) have developed in recent years. These networks and ACOs are often operationally and sometimes strategically disconnected from the rest of a company. For traditional health systems to fully scale their PHM capabilities, existing operating models and organizational structures must not become impediments. Core business support functions, such as budgeting, planning, data analytics, human resources and information technology, are particularly fruitful areas for redefining roles and interactions to support the prioritization and launch of population health initiatives while reducing costs.
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Opportunities to unify clinical management, care coordination and quality oversight are common in recently merged organizations, as well as in clinically integrated networks and ACOs. In 2017, look for continued growth of the PHM infrastructure to be centralized in larger health systems. Payers and providers looking to expand into neighboring regions will increasingly offer management service agreements that provide PHM resources that otherwise might have been beyond the reach of smaller organizations. Similarly, firms who provide PHM services to relatively small physician practices will achieve increasingly offer management service agreements that provide PHM resources that otherwise might have been beyond the infrastructure to be centralized in larger health systems. Payers and providers looking to expand into neighboring regions will increasingly offer management service agreements that provide PHM resources that otherwise might have been beyond the reach of smaller organizations. Similarly, firms who provide PHM services to relatively small physician practices will achieve greater market relevance, often with immediate value-based, managed care contracting opportunities for providers who wish to remain in independent practice. Payers, provider groups and vendors should see growth as they outsource services that effectively link clinical and business units with IT and data analytics to drive the clinical and economic alignment of providers across the care continuum.

The Changing Nature of Partnerships

As organizations seek to improve their population health management competencies to support value-based care, the number and types of partnerships are increasing. Forward-thinking health systems are looking to a variety of partnerships and using a proactive approach to identify their competency gaps, organizational readiness and the relative position of key stakeholders within the market. Provider readiness for value-based care varies widely, as does the ability of health systems to link quality and financial incentives. More capabilities-based mergers, acquisitions and partnerships are expected in the year ahead. The opportunity to improve the performance of CINs and ACOs will result in the increased use of tiered networks of providers, including preferred post-acute providers based on quality and cost performance. In some markets, existing CINs will merge into super CINs to capture scale effects and broader geographical reach. The provider and payer industry verticals will continue to blur.

Expansion of formal and informal partnerships with post-acute care providers and community-based, non-medical providers of care will be an ongoing driver for integrated delivery networks. As the focus shifts to the triple aim, the important role that behavioral health, addiction treatment, transportation, housing and social support play in a patient-centered care model becomes clear; thus, network development activities will continue to build out the connections and preferred relationships to surround patients with a comprehensive, integrated group of services outside of the traditional inpatient and provider practice environments.

Redesigning the Care Model

In recent years, many health systems have deployed new resources to conduct care management. In addition to traditional in-patient care management, many have created transition of care programs to reduce hospital readmissions, introduced emergency department case management to stem overutilization and assigned navigators to service lines to coordinate patient visits or assist with episode of care, bundle initiatives. Ambulatory care management and health coaching programs have been developed or are on the drawing board to bolster CINs and ACOs. These programs are sometimes introduced as stand-alone initiatives that function as silos within organizations. In other cases, both payers and providers may be performing similar care management activities for the same populations. This fragmentation leads to redundancy with resulting excess costs and may be confusing to those receiving services.

Smarter spending, better quality and improved patient and provider satisfaction could be gained by using key design elements to restructure or repurpose disconnected or sub-scale, care management activities. In 2017, expect more health systems and providers to begin implementing value-based, design approaches for key care management activities, such as risk and readiness assessments, resource utilization, care plan selection, patient education and engagement, navigating provider office access and monitoring patients enrolled in care management. Execution strategies that foster coordination, collaboration and brand recognition and draw clear connections across organizational boundaries increase the success of population health and value-based programs.

Digital Transformation

The potential for digital transformation to enhance PHM and healthcare delivery is well recognized. Despite having invested heavily in enterprise-wide IT in recent years, health systems and providers have achieved only modest returns as measured by improved quality, better outcomes and lower costs. Interoperability challenges between disparate legacy enterprise solutions are expensive to overcome and limit care coordination efforts. At the same time, consumer IT has transformed the delivery of services in many industries, including banking, retail and entertainment. People in need of healthcare services expect and are prepared for similar digital experiences.

Leading health systems increasingly partner with consumer health tech companies to provide their patients with consumer apps to improve access to scheduling and on-line payment. Lower cost telemedicine solutions are now available and provide significant population health benefits. Smart phone apps and biometric sensors that provide bidirectional communication between providers and patients with chronic disease management will continue to provide tangible benefits at lower cost. Advances in digital technologies used in manufacturing, such as digital twins; real time, predictive analytics; and robust machine learning are already being deployed in hospitals to improve capacity management and throughput. In 2017, health
systems will continue to formalize their IT and data governance frameworks so that population health IT investments are made with deep business stakeholder involvement and line of site to enabling key strategic goals.

**Governance, Leadership and Workforce Impact**

The amount of organizational change required to transition to PHM at scale requires new leadership development and workforce competencies. The potential pool of C-suite executives responsible for patient experience, IT, data analytics and human resources is already expanding to include individuals experienced with organizational transformation outside of the healthcare industry. Efforts to deepen the bench strength and succession planning of health systems will continue to accelerate.

As millennials begin to assume leadership positions and comprise more of the clinical workforce, hospitals and health systems are promoting new methods of employee engagement. These include using internal communication channels that are similar to the interactions of social media, implementing policies that encourage team-based, problem solving, promoting better work-life balance and implementing new reward and recognition systems. The composition and structure of hospital and health system governance are being reexamined to provide greater expertise and oversight of key population health accelerators, such as data analytics, information technology, consumerism and value-based reimbursement.

Whether it be more value-based managed care contracts, greater adoption of consumer-enabled, healthcare IT solutions or more insights gained from mining clinical data, a constellation of forces continues to drive health systems toward deploying more effective solutions for risk-stratifying populations, personalizing clinical interventions and coordinating clinical care across all sites of service.

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