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What a year 2015 has been for those of us living in the high pressure and constantly changing world of health care! Like teenagers, we have a new set of very popular jargon. If we used hashtags, #populationhealth, #caremanagement, #valuebasedcontracting, #jointventure and #consolidation would be trending.

In the past 12 months we've seen massive consolidation of health plans, health systems and pharma; even our health care consulting firm cousins have gotten in on the trend. CMS doubled down on the transition from traditional fee-for-service to value-based payment. Meanwhile there's been an immense Medicaid expansion and new coverage through the exchange, while employers are increasingly self-funding and engaging directly with large provider systems to aggressively push down risk and offer incentives linked to clear performance requirements.

As we think about all of the changes we've been through and the many more challenges ahead, an old adage comes to mind. It's a story my rabbi, an old WWII army chaplain, told me when I was training for my bar mitzvah:

It was the World Series, bottom of the ninth and if the Yankees could just hold the other team scoreless they would win it all. The batter for the other team hit a fly ball and it was obvious that the outfielder would catch it and end the game. As he saw the ball coming toward him, the outfielder was acutely aware that he was about to be the center of attention. Just then, his hat blew off and he reached out to grab it so he'd look presentable in photos. While he reached for his hat, the ball hit the ground and the Yankees ended up losing the game. The moral of the story, Rabbi Goodblatt told me, is that we always have to keep our eye on the ball and not get distracted by the hat. We're surrounded by hats in health care, and it's very easy to not only take our eyes off the ball but to even lose sight of it completely.

In our industry, the most innovative players are already planning and executing beyond a narrow health care continuum of physicians, hospitals and traditional health care

providers. They are building the systems and competencies needed to become truly expert at managing capitation dollars and succeeding under delegated risk from health plans or direct risk-based contracts with CMS, states and employers, preferably for global prepayment dollars.

Providers and communities today are faced not only with challenges but with unprecedented opportunities and incentives for transformation! They can leverage value-based payment and population health management trends, one-time investments in integration and coordination, and the alignment of incentives to ***enhance wellness***.

So where's the ball? Our team has identified 10 critical success factors for those providers and communities who are committed to elevating the health and wellness of their community and ensuring financial sustainability through the development of not just an integrated delivery network, but a true wellness network in 2016 and the next decade:

1. **A clear vision and strategic plan** – The vision and strategic plan don't just sit on a shelf in a pretty binder, the strategic plan is a roadmap with metrics to measure success and ensure consistent direction en route to the vision. They need to be developed with the active engagement of key stakeholders (including community partners and members) to ensure buy-in. Further, the strategic plan needs annual refreshes and refinement of initiatives to ensure it stays on track.

2. **Commitment to all lines of business, success through more covered members** – We got into health care to improve health, not just for those who have the best coverage, and not just for those who have nowhere else to turn. While most hospitals and other providers still have a "foot in each canoe" with relation to fee-for-service patients and managed care members, true financial sustainability comes with the ability to spread the cost of tertiary, quaternary care and other high-cost services across large populations spanning all lines of business. Customization is related to risk stratification, age, gender and other variables rather than the payer type.

3. **Alignment of incentives through value-based contracting –** Maintain a relentless and consistent focus across the network on quality metrics, member experience and global per-member cost. It's about the reduction of institutional days per 1,000 members and avoiding admissions altogether, not just reducing length of stay. Members of the care and wellness team need to understand how quality outcomes and member experience, key components for profitability under risk-based payment are impacted by what happens not only during provider encounters, but out in the community and at home.

4. **Comprehensive care coordination model** – Spanning across the continuum of care and into the community and home, a comprehensive model must include "boots on the ground" care managers and navigators, as well as a population health management platform bi-directionally connected to EMRs, patient portals and other

key systems. A cohesive coordination model leads to inherent achievement of the Triple Aim (improved clinical quality at a lower cost, with higher member satisfaction and wellness).

5. **Accessible, up to date and actionable member information** – Not just at the point of care, but pushed out to the member, caregivers and members of the care coordination team such that it can be used to plan and achieve both prevention of illness and greater wellness. This, of course, requires that members are identified and attributed the appropriate providers and risk bearing entities to ensure longitudinal, actionable data.

6. **Deep understanding of the social determinants of health** – These determinants have been shown to have the largest impact on total health care costs, acute care utilization, ability to engage in healthy behaviors and wellness activities for specific populations. Providers need to not just understand this, they need to intentionally design access to care and proactive wellness services to overcome barriers that may not be directly related to what we traditionally consider “health care.”

7. **Comprehensive network development and refinement** – Network development with clear and consistent standards, accountability and payment methodologies coupled with consistent partner outreach and engagement to ensure that the right care and proactive wellness services are easily accessible to the member at the right place, at the right time and at the right cost. This includes traditional health care providers, non-medical providers and community based organizations including behavioral health, substance abuse, housing and transportation.

8. **Re-envisioning the roles of hospitals and other traditional acute care facilities** –Hospital campuses have an opportunity to transform to long term care or ambulatory care “villages” that are much more interactive with the community, and are the home to more than just health care services. Hospitals have the potential to be centers for wellness, education and community and member engagement, which requires new and different thinking, incorporating an atmosphere of easily accessible ambulatory services, retail, gym, quality dining, park spaces and other wellness options.

9. **Talent pipeline and training programs** –Transition current team members and onboard new team members into new and rapidly changing roles is important. Also critical is to engage in partnerships that grow the next generation of diverse health care workforce and leaders from within the communities surrounding integrated health systems.

10. **Operational excellence across the continuum –** A balanced scorecard or similar framework that integrates the goals and metrics from the vision and strategic plan down into the organization must be in place. This best-practice helps the clinical care and wellness team to understand their role and how success is measured.

We believe that in 2016 providers and communities will continue to realize who needs to lead the way in managing and coordinating care for populations. *Hint: it's not the large publicly traded health plans.* It's the folks on the ground with the critical local knowledge, credibility and ability to gain trust and align providers and community-based organizations (CBOs) that need to step up in order for us to succeed in achieving the triple aim.

Our national team of mission-driven experts is ready and able to partner with and support you, whether you are a large integrated delivery system, hospital, physician group, IPA or a group of providers. We are committed to your success and have a reputation for strategic excellence, deep expertise and a unique approach to integrated implementation. We work side by side with our clients' teams to help them achieve their population health management goals. We wish to you and yours a wonderful holiday season and a happy, healthy and successful 2016!

About COPE Health Solutions

COPE Health Solutions is a Los Angeles-based health care consulting firm that advises hospitals and health care systems on strategy, population health management, Medicaid waivers and workforce development solutions. COPE Health Solutions provides clients with the tools, services and advice they need to be leaders in the health care industry. Our team has extensive DSRIP expertise that can be combined with years of talent pipeline success for a unique resource of experts to achieve meaningful delivery system transformation.
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