Six Business Imperatives of Population Health Management

Healthcare’s transition to a population health model presents hospitals and health systems with significant business opportunities and challenges. Increasingly, organizations will be responsible for providing defined care to a specific population while managing the population’s total cost of care.

The value-driven approach to care delivery and financing focused on population health management (PHM) alters the established business fundamentals. To succeed, healthcare executives and board members must rethink the scope of their enterprise, including where, to whom, and how their organizations provide services, and which services are most appropriate given the unique needs of the populations they serve.

Significant additional management team and board knowledge and oversight will be needed to arrive at a sustainable “solution set” for managing population health. Some organizations are changing executive and board composition to include physicians and other individuals with expertise in quality improvement, risk management, cost reduction, and other key PHM areas. Other organizations need to move more rapidly to gain needed expertise.

Addressed here are the six business imperatives that should be front-and-center on all leadership radar screens in developing and implementing their PHM strategy. These imperatives are interrelated and interdisciplinary, crossing strategic, financial, clinical, operational, and capital management domains. Sidebar 1 on page 2 provides key questions leadership teams should be considering.

Physician and Clinical Alignment
Improved economic and clinical alignment between hospitals and physicians will be essential to:
- Change the way patient care is delivered
- Enhance patient, family, and provider satisfaction and engagement
- Improve each element of the value equation (i.e., quality, access, outcomes, patient experience, and operating/capital efficiency)
- Succeed under value and/or risk-based arrangements

Developing a solid hospital-physician alignment plan involves recognizing that one strategy will not be appropriate for all physicians, and that hospitals should offer physicians multiple options.

Finding the right incentives to motivate physicians is vital. Incentives should cover dimensions including financial, access, competition and recognition (e.g., quality ranking scores), and patient care (e.g., improved health outcomes). The most important principle is to develop uniform, readily quantifiable, consensus-driven incentive standards and metrics that have a consistent application across clinicians, locations, and specialties.

As health systems start building their physician networks, they typically have more relaxed (or lower threshold) performance criteria. As their experience grows, they tighten the criteria and are able to be more selective with physician participation. Physicians not performing up to defined standards often opt out or are not allowed to continue to participate in the network’s value-based contracts.

Patient Attribution
For success with PHM contracting arrangements, a hospital or health system must have an integrated network of primary care physicians and must ensure accurate attribution of the targeted population segment(s) to this network. Attribution in PHM programs is the assignment of an individual to a specific primary care provider (PCP), typically based on past medical claims.

continued on page 2
Management of attributed patients is one of the biggest challenges nationwide in most types of networks. Without a high-functioning patient attribution and referral management process, patients may directly seek care from an out-of-network provider who is not incentivized or aligned to manage that care. This “leakage” to non-network providers—whose costs are then attributed to the network—can significantly increase the total cost of care while potentially providing lower quality and less coordinated care.

Clinicians need to have a clear understanding of how attribution works so that they recognize the financial impact of PCP assignment and can communicate to their patients the value of choosing and using their PCP network.

Clinicians also will need to evaluate the benefits and drawbacks of a prospective vs. retrospective attribution methodology and the impact this could have on future performance and incentives. Prospective attribution assigns members based on historical claims data, assuming that the patient will use the same provider in the future as they have in the past; retrospective attribution assigns patients based on their actual utilization.

Beyond attribution of patients, an effective care management program that is well understood by clinicians helps to ensure that patients do not seek unnecessary care or care in suboptimal sites.

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**Sidebar 1. Leadership Oversight Questions for Meeting the Six Business Imperatives of Population Health Management**

**Physician and Clinical Alignment**
- What means do we use to ensure alignment with employed and independent physicians?
- What incentive systems are available for our affiliated physicians and other clinicians? Do contractual arrangements clearly delineate the criteria for the distribution of earned incentives and any penalty structures? How do we address the problem of physicians/clinicians who are not performing up to defined standards?
- How is leakage of patients to non-network physicians prevented? Do physicians have a clear understanding of how attribution works so that they recognize the financial impact of primary care assignment and can communicate to their patients the value of choosing and using their network? If not, how can this be strengthened?

**Contracting Strategy**
- What’s our plan for gaining experience in managing risk through contracting arrangements?
- What partnerships might we pursue to accelerate risk-contracting experience?
- What’s our strategy to ensure our inclusion in the key networks forming in the community?

**Network Optimization**
- What role will our organization play in a care delivery network? How are we determining the best combination and location of services and programs across inpatient and outpatient sites, and virtual services?
- How are we learning about consumer preferences and purchasing behavior in our service area? What techniques are we using to engage high-risk patients in their own care?

**Operational Efficiency**
- How are we working with physician practices, post-acute, home care, and other providers to ensure efficiency and deliver value?
- What can we do to transform our cost structure to a much, much lower level?

**Enabling Infrastructure**
- What means are we considering—building, buying, and/or partnering—to gain needed infrastructure quickly?
- What process are we using to make capital investment decisions that support the organization’s role and key initiatives in PHM? What return do we expect from these investments and over what period of time?

**Clinical Management**
- How do/will we prioritize PHM efforts across patient health-risk categories?
- What interventions will we develop and implement, and why? How will we evaluate the success of these interventions and ensure ongoing improvement?

Source: Kaufman, Hall & Associates, LLC
Hospitals and health systems can participate in a variety of value-based or risk contracts, ranging from fee for service (FFS) with incentives (e.g., gain sharing and pay for performance) to partial or full risk models (e.g., global payment, partial capitation, or full capitation). Fully integrated health systems will be able to use all types of contracting arrangements that tie payment to performance and outcomes, while small providers will be more limited in the types of arrangements they can secure (Figure 1).

Contracting for PHM will require consideration of the risks and opportunities related to the health/risk characteristics of the populations served by specific insurance products, design of HMO, PPO, and employer-directed plans, contract terms and conditions, narrow and tiered network requirements, and partnership opportunities related to specific networks, products, and plans. Though descriptions of each of these considerations is beyond this publication’s scope, but organizations should evaluate the populations they want to go at-risk for and the types of insurance products that best serve population health goals.

Care delivery or assumption of risk for particular benefit designs or types of products will be more or less attractive to an organization based on what it can achieve in terms of effectively managing patient care and the associated costs.

The contracting strategy will vary based on populations served. Populations will be insured by different plans with different benefits. Plan benefits will have a significant effect on an organization’s ability to move the needle on such PHM indicators as admissions per thousand, length of stay, and readmission rates. Care delivery or assumption of risk for particular benefit designs or types of products will be more or less attractive to an organization based on what it can achieve in terms of effectively managing patient care and the associated costs.

Additionally, plans and products are changing with increasing use of high-deductible offerings, driving different care purchasing behaviors by consumers and other purchasers. Narrow and tiered networks are another important contracting consideration. Such networks limit patients’ choice of hospitals and physicians to those that the plan administrators define as offering quality services at lower costs.

Direct contracting by self-insured employers with healthcare providers is changing competitive dynamics in many markets and should be considered as health systems look to optimize their networks. Growth in direct contracting models by large employers will depend on whether the contracts deliver the intended results—lower costs and higher quality. Key qualities that a large employer would find attractive in a potential health system partner include positive outcomes and transparency in sharing cost and quality outcomes, geography and access, and aligned incentives through payment arrangements, such as bundled payment.

Hospitals that do not pursue PHM contracting with purchasers soon may find themselves excluded from key networks in their region or may be relegated to the role of a discounted vendor of acute care services.

Network Optimization
Effective and sustainable PHM requires the design and continuance of a high-performance delivery network. This network must cover the care continuum under an optimized contracting strategy, and apply effective approaches to engaging stakeholders, including patients, families, employers, and others. Sophisticated organizations will be developing an optimized network; other organizations will look to participate in an optimized network provided by another entity.

To optimize networks, leaders consider:

- Essentiality and adequacy: The breadth and depth of care desired by the purchaser, and the ability to handle the projected volume of patients across the defined care settings, including access to in-network primary care and specialty physicians, hospital services, and other specified services
- Service distribution right-sizing: The elimination of duplication by reconfiguring the network to be highly efficient, deliver consistent quality across all sites, and manage patients in the least-intensive setting possible while still providing the necessary level of care
- Network growth strategy: The ability to grow the attributed or accessible managed populations to support organizational infrastructure and associated costs

Hospitals and health systems will need to educate and engage physicians, employers, and consumers within their network to maximize the health status and retention of the population under their management. This is true of all organizations participating in population health management.

In particular, consumer engagement ensures both the clinical and business success of managing a population’s health within a network. Effective consumer engagement enables an organization to help shape healthy behaviors, achieve the right level of utilization, and steer individuals to the best site of care.

Operational Efficiency
As an organization’s sphere of influence widens in a value-based environment, its cost/efficiency focus shifts from the traditional view, involving inpatient and physician-centric entities, to a population health view, involving a broader scope of the care continuum (Figure 2).

FIGURE 2. THE WIDENING COST FOCUS
Source: Kaufman, Hall & Associates, LLC

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Broad strategic thinking about the care that patients receive after they leave the hospital’s four walls is required of health system leadership to ensure the right care in the right place, at lower costs and better quality.

Hospitals and health systems that are participating in Medicare Advantage, traditional Medicare, bundled payment, ACOs, and other models, will need to work closely with post-acute, home care, and other providers to deliver value. Efficiency will be vital for health systems that want to be included in value-based delivery networks forming nationwide. Network arrangements will “tier-out” or otherwise exclude higher cost providers by directing patients to competitors that can offer quality services at a lower cost.

Access to traditionally higher cost tertiary and quaternary care is part of network adequacy as defined by regulations, but specialty hospitals, including academic medical centers and children’s hospitals, also will need to focus on cost management in order to remain competitive in their communities.

Cost management in hospitals and health systems historically has addressed marginal improvements in areas including labor, non-labor, supply chain, revenue cycle, and overhead costs. This focus, while important for the FFS business model, is insufficient for the value-based business model and for realizing significant total cost improvement nationwide.

Figure 3 highlights the expanded scope required to realize total cost transformation. Entire publications can be devoted to each box in this figure. Suffice it to say here that business reconfiguration and clinical effectiveness initiatives represent “harder” and “hardest” activities respectively.

**Enabling Infrastructure**
Managing population health involves major clinical and organizational transformation made possible by investment in areas including:

- Management and governance structures that include a high level of physician involvement and cover contracting, risk assessment, and clinical and operational decision making
- A delivery network of sufficient size and scope

**FIGURE 3. TOTAL COST TRANSFORMATION**

Source: Kaufman, Hall & Associates, LLC

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<td>Clinical labor productivity</td>
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<td>Care processes</td>
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<td>Clinical variation</td>
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<td>Innovation strategy</td>
<td>Patient education</td>
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- IT and HIT systems that are able to support clinical care management processes, common electronic health record systems, clinical and predictive analytics, and business functions
- Care management and coordination tools and protocols tied to an enterprise-wide decision support and reporting function
- Contracting and risk assessment and management capabilities
- Patient engagement programs to build loyalty and “stickiness” to the organization

PHM will push hospital leaders to rethink their infrastructure needs and invest and organize in a way that supports the organization’s role and key initiatives in PHM going forward.

**Clinical Management**
Three clinical imperatives apply to all hospitals and health systems, however large or small a role they play in PHM:

- Identify, stratify, and prioritize the patient population along the health-risk continuum: Organizations identify the geography they serve and the contracting arrangements for the patient populations within this geography. They then prioritize their PHM efforts for efficiency and effectiveness across patient health-risk categories.

**Develop and implement interventions to improve health, access, and outcomes, and to reduce costs:** Hospitals understand the impact of technology and care settings, and recognize the importance of consumer engagement, new provider types, collaborative practice, and evidence-based medicine. They then design and implement prevention initiatives based on population health risk categories, spanning wellness, care transitions, disease management, care coordination, care navigation, and end-of-life care, as appropriate.

**Evaluate and refine the approaches and interventions:** Hospitals and health systems understand the big-picture objectives of performance improvement and the on-the-ground challenges of selecting and implementing appropriate measures of PHM progress. They select their targets and start moving toward the end goals of effective and efficient PHM.

Figure 4 provides a framework for these clinical imperatives, indicating population segments, selected interventions, and numerous intervention outcomes that can be evaluated going forward.

**FIGURE 4. FRAMEWORK FOR THE CLINICAL IMPERATIVES OF POPULATION HEALTH MANAGEMENT**

Source: Kaufman, Hall & Associates, LLC
Moving in the Right Direction

The degree and pace at which organizations pursue the six business imperatives described here will depend on a variety of internal and external forces. These include organizational readiness with new competencies of value-based care, overall stage of market evolution, vertical collaboration across health plans and provider organizations, and existing risk contracts and relationships. PHM is the way U.S. healthcare delivery is going, so all healthcare management teams and boards must work to develop the knowledge and skills to move their organizations in the right direction.

In addition to the authors Judy Hill-Mischel (jhill-mischel@kaufmanhall.com), Mark Grube (mgrube@kaufmanhall.com), and Robert York (ryork@kaufmanhall.com), content experts for this publication included Andrew Cohen, Todd Fitz, Anand Krishnaswamy, John Poziemski, and Kalani Redmayne of Kaufman, Hall & Associates, LLC. For more information, please contact the authors at 847.441.8780.

References


Staff Notes

Please join us in welcoming...

John Jennings joined Kaufman Hall as Chief Financial Officer. With more than 25 years of fiscal management experience, his focus is on directing and supporting Kaufman Hall’s strategic corporate growth.

Prior to joining Kaufman Hall, Mr. Jennings was Chief Financial Officer of Fieldglass, a leading cloud technology and professional services provider. His previous experience includes serving as Chief Financial Officer and Senior Vice President of Finance of The Merchandise Mart, Senior Vice President and Treasurer of OfficeMax, and Vice President of Finance of CVS/Caremark Corp. Mr. Jennings holds an M.B.A. from the Daniels College of Business at the University of Denver, and a B.B.A. from the University of Denver.

David Crosswhite joined as a Senior Vice President in the Strategy practice. He has extensive expertise in the areas of consumer-oriented growth strategy development, new product and concept development, innovation, retail and go-to-market strategies, and new business concept commercialization. His more than 20 years of experience in these areas spans multiple industries, including consumer products, durable goods, retail, healthcare, medical devices, insurance, and financial services.

Prior to Kaufman Hall, Mr. Crosswhite was a Managing Partner of ITC Business Group. He is co-author of The Innovator’s Field Guide, which documents frameworks, techniques, and approaches for organizations looking to develop ongoing innovation capability. Mr. Crosswhite earned his M.B.A. at the Kellogg Graduate School of Management at Northwestern University, and holds a B.S. in Engineering from Lehigh University.

Ryan Freel joined as a Senior Vice President in the Financial Advisory practice. His areas of expertise include taxable and tax exempt financings in the public and private markets, derivative transactions, mergers and acquisitions, and enterprise risk management.

Prior to Kaufman Hall, Mr. Freel was a Vice President in the Healthcare Investment Banking Group at Goldman Sachs. His previous positions include serving as Director in the Healthcare Finance Group at Citigroup and Vice President at UBS Investment Bank. Mr. Freel has an M.B.A. from the University of Chicago Booth School of Business and a B.S. in Accounting from Miami University in Oxford, Ohio.

Also in Strategy, Divya Paliwal, M.D., joined as a Vice President, Aleksander Keser as a Senior Associate, and Andrew Bae and Neil Claracay as Associates.

Matthew Jakobovits and Manoj Rana joined as Senior Associates in Financial Planning, and Josh Jelesky joined as an Associate in Strategic Cost Management.

In Mergers and Acquisitions, Hector Torres joined as an Assistant Vice President, and Colin Goelho and Aditi Tripathi as Associates.

In Marketing, Julie Visocnik joined as a Marketing Manager and Kristina Wright as Marketing Coordinator. Prince Manjee joined as a SharePoint Administrator, and Darrell Jones as an Associate Software Engineer, both with IT.

Cathy Kindle and Jason O’Rourke joined as Implementation Consultants with the Software Division. Pat Wongwiwat joined as a Client Service Representative with Software Support and Lourdes Plaza joined as a Sales Analyst on the Global Sales team.

At Axiom EPM, Chad Leach joined as Senior Solutions Engineer with General Industries, and Cynthia Sparling as Business Development Manager with Higher Education. Peter Goostree joined as a Senior Software Engineer in Software Operations, and Courtney Stiven joined as Axiom’s Events Marketing Manager.
Optimizing Capital Allocation and Management Processes

Jess Block, Vice President of Capital Planning Solutions

Faced with increasingly capital-intensive initiatives in an environment of ever-tightening budget constraints, hospitals and health systems should take a comprehensive and structured approach to allocating scarce capital resources. Capital investments made today have the potential to significantly impact an organization's long-term success in the new healthcare era. Having an integrated allocation decision-making and management cycle is more important than ever.

Capital allocation is the process for deploying capital resources for investment in organizational initiatives to meet mission/community-based imperatives, such as new ambulatory development, infrastructure needs, physician strategies, information technology, and others. Capital management is the ongoing monitoring and control function that ensures appropriate and effective capital allocation.

To illustrate the integration of these processes, this article describes how Baylor Scott & White Health refined its ongoing capital tracking.

Identifying the Challenges

Having the right technology is essential to implementing rigorous capital allocation and management processes and ensuring efficient project tracking. It also helps organizations avoid some common challenges in the capital allocation process, such as inconsistency in the information provided in capital requests, missing sign-offs, or lack of transparency.

Prior to its October 2013 merger with Scott & White Healthcare, Baylor Health Care System sought to enhance efficiencies around its capital procurement processes. At the time, the full capital approval, requisition, and procurement processes together took an average of 72 days. The organization sought to reduce cycle time to an average of 50 days by consolidating and eliminating process stages. Through the Lean process improvement methodology, Baylor refined its capital approval, review, requisition, and procurement processes. The organization partnered with Kaufman Hall to enhance its capital management software tool to improve cycle time and user satisfaction, and to maximize touch points for the system's 2,000 users.

A cross-functional team oversaw the effort, including an executive sponsor, a team leader, a certified Lean Six Sigma Master Black Belt, and representatives of functional users in various departments, such as hospital and clinic finance, treasury, information services, supply chain, contracting, biomedical, and accounting.

The team developed a high-level map (SIPOC diagram) looking at every step in the capital approval and procurement processes. The team then developed detailed flow charts to analyze individual steps or touchpoints. They evaluated the system's current state and opportunities for improvement, such as:

- Functional reviewers at the back end of the process
- Sequential approval and requisition system
- Capital vs. Operating not clearly identified early on
- Inaccurate/incomplete quote that doesn't consider all costs
- Too much reliance on Central Financial Administrator
- Technology limitations

The team then developed solutions to overcome these challenges.

Working Toward Solutions

One of the common limitations with Baylor's old system, for example, was that capital requests went through a purely sequential approval and requisition system that caused delays. For the functional review steps (biomedical, imaging support, facility director, etc.), a request had to be approved by one individual before it could move to the next for review, so there often were pauses and reworks as the request moved through different approvers.

The team analyzed data and charted how many days each request stayed with specific approvers. It then defined, tested, and refined potential solutions to determine the most efficient process redesign. Ultimately, the team moved the functional review steps from the end of the process to the beginning, and allowed for simultaneous reviews. These and other changes made the entire system more efficient and reduced the average cycle time by an estimated 30 percent.

Integrating Capital Systems After a Merger

The software redesign and implementation of the new capital management system took about nine months. It was rolled out in September 2013. The next month, Baylor Health Care System merged with Scott & White Healthcare, creating Texas' largest not-for-profit health system.

Consolidating the capital processes of the newly-combined system was a top priority. Before the merger, Scott & White used a paper-based process for capital approvals and requisitions. All appropriate staff had to be trained on the electronic system, and ongoing training was implemented.

A major advantage of the new system is that electronic tracking of capital requests ensures collection of all necessary approvals. The paper-based system sometimes enabled quick approvals, but did not allow for rigorous enforcement of procedures and made it difficult to track the status of a request.

Establishing a Streamlined Process

As part of Baylor Scott & White's annual capital planning process, each of its entities prepare pro-forma financial analyses for threshold projects greater than $1 million. Those analyses are summarized in a custom “capital asset request form” developed to provide key information to executives. All threshold capital requests are compiled and then reviewed by divisional and system leadership at the annual capital allocation meeting, during which they select and prioritize new projects for the next fiscal year's capital plan.

The capital plan is further refined during the five-year strategic and financial planning process and the annual operating budget process, and is approved by the board before the fiscal year start. Large capital projects are reviewed after two full years of operations to compare actual performance to projections.

Having clear, structured, and streamlined capital allocation and management processes helps organizations dedicate capital to the most appropriate projects to support their mission and new era needs, and to routinely review those projects to ensure effective use of limited resources. Such a system also provides transparency into allocation decisions, enabling management to reinforce support for all aspects of the organization's strategy.

Kaufman Hall would like to express appreciation to Karl Bailey, Vice President of Strategic Financial Services, Rachal Reel, Director of Financial Planning & Analysis, and Nathan Smith, Manager of Capital Planning, of Baylor Scott & White Health, for their willingness to participate in the development of this article.

For more information on Kaufman Hall’s software, please contact Russ Anderson at randerson@kaufmanhall.com or 847.441.8780.
Kaufman Hall Proudly Presents the 2015 Healthcare Leadership Conference

We are looking forward to seeing many of you at the 2015 Healthcare Leadership Conference. This year’s event is more dynamic than ever. We’ve added earlybird sessions Thursday morning, and are introducing focused peer-to-peer breakfast discussions on Friday morning. Please be sure to complete your registration and select the sessions you wish to attend for this exceptional educational and networking opportunity. Keynote presentations will include:

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**Farzad Mostashari, M.D., Sc.M.**, describes how an entirely new ecosystem of technology applications and services is creating innovative and effective solutions to healthcare’s most pressing problems.

**Transforming U.S. Healthcare**

**Robert Pearl, M.D.**, explains the four pillars of a better healthcare system and offers hospital and health system executives insights on how to make the difficult changes that are required.

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**Kenneth Kaufman** describes the forces driving healthcare change, lessons from innovators, and the management and leadership imperatives to maintain relevance in a landscape undergoing permanent change.

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- New-Era Planning Analytics for Informed Decision Making
- Designing Your Future Delivery Network
- Playbook for Population Health Management
- Driving Value Through an Aligned Post-Acute Network
- Medicare Strategies for Population Health Management
- Building the Physician Enterprise of the Future: The Moneyball Approach
- Creative Affiliations for Success in the New Era

This year’s Rating Agency Update is titled “Is It Possible to Balance the Risks of Transformation?”

Please be sure to reserve your spot soon, if you have not already.

More information is available at [www.kaufmanhall.com/hlc](http://www.kaufmanhall.com/hlc)
A Population Health Management (PHM) program has been developed by Kaufman, Hall & Associates, LLC, in collaboration with the California Hospital Association for CHA members. The comprehensive, five-part series provides California hospital and health system leaders with the information and implementation tools needed to move forward with PHM. The series is taught by expert Kaufman Hall faculty and features five webinars and issue briefs on the following topics:

- A Framework for PHM
- Business Imperatives of PHM
- Clinical Imperatives of PHM
- Technology for PHM (featuring Pam Arlotto, President and CEO of Maestro Strategies, LLC)
- Leadership and Talent for PHM

The California Hospital Association offered participants who completed the five webinars a Certificate in Population Health Management.

If you are interested in pursuing similar educational programming for your organization, please contact Rob Fromberg at 847.441.8780 or rfromberg@kaufmanhall.com.