

HFMA'S VALUE PROJECT

The Value Journey

Organizational Road Maps for Value-Driven Health Care

PHASE 2
RESEARCH



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ORGANIZATIONS THAT INFORMED THE FINDINGS IN THIS REPORT

HFMA's Value Project research team acknowledges the extensive assistance provided by the following hospitals and health systems. Research for each cohort area—academic medical centers, aligned integrated systems, multihospital systems, rural hospitals, and stand-alone hospitals—was assisted and guided by 35 participating organizations. Researchers for HFMA's Value Project conducted in-depth site visits with two organizations within each cohort and discussed site-visit findings with the broader cohort participants to develop the road maps featured in this report. Participating organizations are featured below.

PARTICIPANTS IN DEVELOPING ROAD MAPS FOR HEALTH SYSTEM CHANGES

Academic Medical Centers	Aligned Integrated Systems	Multihospital Systems	Rural Hospitals	Stand-Alone Hospitals
New York-Presbyterian Hospital	Billings Clinic	Advocate Health Care	Andalusia Regional Hospital	Elmhurst Memorial
Partners HealthCare	Cleveland Clinic	Baptist Health South Florida	Copper Queen Community Hospital	Enloe Medical Center
Rush University Medical Center	Dean Clinic	BJC HealthCare	Crete Area Medical Center	Holy Spirit Health System
University of Alabama at Birmingham (UAB) Hospital	Geisinger Health System	Bon Secours Health System	Franklin Memorial Hospital	Longmont United Hospital
Vanderbilt University Medical Center	Group Health Cooperative	Catholic Health East	New Ulm Medical Center	Platte Valley Medical Center
	Scott & White	CHRISTUS Health	Whitman Hospital and Medical Center	Winona Health
	Spectrum Health	Dignity Health		
		Fairview Health Services		
		OSF HealthCare		
		Novant Health		
		Nebraska Methodist Health System		

EXECUTIVE SUMMARY

The value journey's destination is clear. As healthcare costs have begun to outpace improvements in the quality, a value gap has emerged. Healthcare provider organizations must work to close the value gap by improving quality while reducing the total cost of care to the purchaser.

As part of its Phase 2 Value Project research, HFMA has worked with a group of 35 hospitals and health systems to better understand their road maps to value. These organizations have been divided into five organizational cohorts:

- Academic medical centers
- Aligned integrated systems
- Multihospital systems
- Rural hospitals
- Stand-alone hospitals

HFMA's research has identified common challenges that all healthcare providers will face in the value journey, as well as common capabilities, strategies, and tactics that will help them on their way. It also has identified unique challenges and opportunities that define cohort-specific road maps to value.

COMMONALITIES

Virtually all healthcare organizations are working to clarify and communicate their value proposition. They are trying to build more agile organizations to adapt to a rapidly changing payment environment and are seeking to build greater alignment with physicians. They are making these efforts against a backdrop of expected diminution of future revenues, uncertainty about future payment models, and concerns over patient engagement as health care transitions to care delivery models emphasizing population health and the prevention of illness.

This report provides a common road map for value, identifying action steps organizations should take to build competencies and skills within the four value-driving capabilities of people and culture, business intelligence, performance improvement, and contract and risk management identified in HFMA's Phase 1 Value Project

research. The common road map in turn serves as a starting point for the cohort-specific road maps also presented in this report. Readers are advised to begin by reviewing this report's discussion of the common road map before turning to cohort-specific discussions.

COHORT-SPECIFIC ROAD MAPS

This report offers separate discussions of challenges and opportunities, strategies and tactics, and key recommendations for each of the five organizational cohorts. These discussions are summarized in cohort-specific road maps provided throughout the report.

In brief:

Academic medical centers should work to align complex organizations around the goals of value improvement, reducing overall cost structures while improving care processes.

Aligned integrated systems should work to prove the value of integrated care delivery models while aligning network providers to their systems and approaches to clinical practice.

Multihospital systems should reevaluate the proper balance between centralized and decentralized elements within their systems while continuing to add scale as they expand across a broader continuum of care.

Rural hospitals should plan for potential reductions in revenue while seeking the appropriate balance of primary care and specialty services to meet community needs.

Stand-alone hospitals should pursue opportunities to improve scale and seek to differentiate themselves through superior clinical and financial performance.

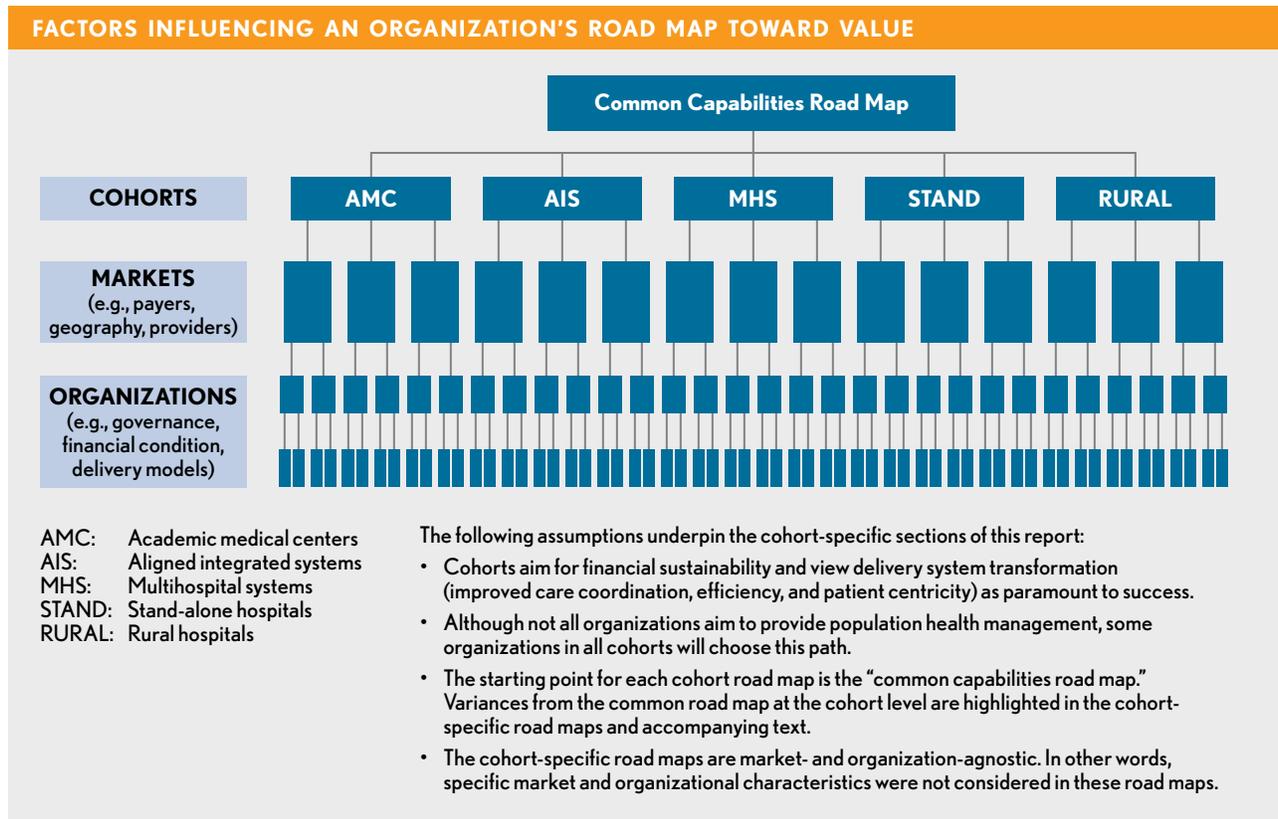
HFMA recognizes that many organizations have operations or facilities that extend across multiple cohorts. Readers are encouraged to read across the different cohort discussions to gain a better understanding of the multiple road maps available to organizations as they undertake their value journeys.

INTRODUCTION

When HFMA launched the Value Project in 2010, the idea of “the value journey” immediately surfaced in interviews with organizations participating in the project. The destination was clear. An unsustainable trajectory of rising healthcare costs and continued fragmentation of care delivery—driven in part by fee-for-service payment—called for new payment methodologies that rewarded better coordination and quality of care at a lower total cost of care to the purchaser (including individual patients, employers, and government programs). These improved quality and cost outcomes in turn would call for new business models for healthcare provider organizations, as well as new ways of measuring both the quality of care delivered and the total amount that purchasers were spending on that care.

But if the destination for the value journey was clear, so was the distance that would have to be traveled and the challenges that would have to be addressed along the way. Two years into the Value Project, some organizations are just beginning their journey; some have taken significant strides along the path toward value, while others are leading the way in the pursuit of higher-quality care at a reduced total cost to the purchaser. No single hospital or health system has completed its journey toward value, but all need to get on the road.

What are the key strategies and initiatives required for healthcare providers to demonstrate enhanced value for purchasers and the communities they serve? What are sustainable business models that support the pursuit of value? To what degree are the strategies and initiatives for achieving value common among healthcare providers, and how do they differ?



HFMA's Value Project, together with the support of 35 healthcare organizations and representatives from McManis Consulting, recently examined the internal and external challenges that hospitals and health systems face along the road toward providing greater value, the strategies and capabilities that are required to close the *value gap* (wherein rising costs outpace improvements in quality of care), and the commonalities in approaches that could benefit all providers throughout this journey.

Through a series of in-depth site visits and interviews with providers across the country, HFMA's Value Project discovered a number of commonalities related to the challenges and opportunities that hospitals and health systems face in achieving the value equation and the capabilities that are required to more fully demonstrate value. But there are also distinctions in these areas that vary by type of provider. For this phase of its Value Project research, HFMA has formed five organizational cohorts: academic medical centers, aligned integrated systems, multihospital systems, rural hospitals, and stand-alone hospitals. An examination of how providers in these cohorts are preparing for the transition from fee-for-service to value-based payment reveals not only these commonalities, but also distinctions by cohort.

It is important to understand the unique challenges and opportunities that each type of healthcare provider faces not only in preparing for a system of value-based payment, but also in seeking to drive sustainable improvements in the quality and total cost of care.

Numerous dynamics will shape the transition toward value for a particular organization. In addition to cohort-specific influences, market forces, such as how aggressive or reticent commercial carriers are in pushing value-based payment mechanisms and metrics, how active state governments are in overseeing healthcare price increases, and the competitive dynamics of the provider community may be the most influential factors shaping a provider's plans. Further, within cohorts, organizational characteristics will affect what capabilities are required to demonstrate enhanced value, how these capabilities are sequenced, and the speed with which initiatives that strengthen key capabilities are executed.

By considering the common and cohort-specific analyses in this report as well as their unique marketplace and organizational characteristics, hospital and health system leaders can better chart their course on the road toward value.

A COMMON ROAD MAP TO VALUE

There are four common organizational capabilities defined in Phase 1 of HFMA's Value Project research, that healthcare providers should cultivate to adapt to a value-based business model:

- People and culture
- Business intelligence
- Performance improvement
- Contract and risk management

Over the course of its Phase 2 Value Project research, HFMA has developed a common road map for developing the capabilities to achieve greater value. This common road map is the starting point for the cohort-specific road maps that will be presented and discussed throughout this report.

Healthcare leaders can judge an organization's progress in developing a particular capability by viewing the action steps related to each capability and pinpointing whether their performance would be positioned in the beginning, middle, or advanced stages of the continuum shown.

COMMON ROAD MAP TO VALUE

LOWER ←

ORGANIZATIONAL CAPABILITIES

People/Culture

Governance	Review Governance	Adjust Board Composition
Strategy and Structure	Review Strategy by Segment	
Management	Align Executive Leadership	Develop Common Plans and Goals
Physicians	Educate	Assess Performance
Staffing and Skills	Assess Needs	Plan Attritions
Communication and Culture	Deliver Value Message	Educate

Business Intelligence

Clinical Information Systems	Implement Electronic Health Records (EHRs), All Settings	Establish Alerts
Financial Reporting and Costing	Directional, Limited	Precise, All Settings
Performance Reporting	Core, Process Measures	Strategic Measures
Analytics and Warehouses	Review Data Governance	Integrate Clinical, Financial Data

Performance Improvement

Process Engineering	Identify Methodology(ies)	Establish Cross-Functional Forum
Evidence-based Medicine	Patient Safety	Readmissions and Hospital-Acquired Conditions (HACs)
Care Team Linkages	Measure Primary Care Access	Expand Primary Care (PC)
Stakeholder Engagement	Create Transparency	Educate Patients

Contract and Risk Management

Financial Planning	Rolling Calendar	Update Cash Flow Planning
Financial Modeling	Maintain Short-Term View	
Risk Modeling	Analyze Profit/Loss	Estimate Financial Exposure
Contracting	Negotiate Prices	Partner with Quality

For example, under the category of people and culture is a subcategory for management. Organizations that have begun to align executives to common tactical plans and goals are in the beginning stages of developing this capability. Organizations that have aligned staff and physician incentives to their plans would be demonstrating greater progress. Those that are actively managing their organizations to performance on metrics defined in their tactical plans would be at an even more advanced level.

Tailoring the road map to an organization's unique characteristics and market is the right approach for hospitals and health systems in an era of reform, but doing so in a way that is sustainable is the challenge for many. Some organizations are positioned to move quickly or are already well along. How leaders coordinate, fund, and implement initiatives in the common road map will help determine whether they are successful in positioning their organizations for the future in a financially sustainable way.

Degree of Care Transformation & Financial Sustainability		HIGHER	
STRATEGIES & INITIATIVES			
Educate Leadership		Augment Governance	
Assess Mergers and Alliances		Bend Cost Curve	
Align Incentives		Manage to Measurement	
Align Compensation	Develop Leaders	Lead Strategies and Initiatives	
Add Staff Strategically	Educate	Align Incentives	Enhance Leadership
Engage Stakeholders	Experiment with Payment, Care Delivery		Take Risks
Establish Disease Registries		Develop Data Exchanges	
Longitudinal		Complete Per-Member, Per-Month (PMPM) Costing	
Outcomes		Population Based	
Develop Analytics	Expand Databases	Support Real-Time Decisions	
Initiate Efforts	Utilize Data	Expand Cross Department	Expand Cross Continuum
Standards, Protocols	High-Risk Care	Chronic Conditions	Wellness
Right-Size Specialty	Partner Strategically		Manage Care by Setting
Share Decision Making	Engage the Community		Establish Patient Accountability
Update Capital Budgeting and Capital Access Planning		Quantify and Allocate Initiatives	
		Conduct Multifactorial Scenario Planning	
Utilize Predictive Modeling		Develop Risk Mitigation Strategy	
Experiment with Value-Based Payment (VBP)	Partner with Payers	Prepare for Second-Generation VBP	

COMMON INTERNAL AND EXTERNAL CHALLENGES

H FMA's Value Project found that nearly all organizations face common internal and external challenges related to achieving value.

Key internal challenges that most providers face on the road to demonstrating value include the following.

A vague value proposition. Organizations interviewed for this report indicated that refining, clarifying, and communicating their organizations' value proposition is a significant challenge. For example, in light of future financial challenges facing Franklin Memorial Hospital in Farmington, Maine, leaders of this rural hospital have critically examined how to best position the hospital: as a primary care operation that refers out for specialty care, or as a facility that offers select specialty services. Academic medical centers are considering what balance to strike among the research, academic, and care delivery components of their organizations, and more specifically, the role of primary care in their future. At Billings Clinic, an aligned integrated system based in Billings, Mont., one of the primary challenges is the need for better data to demonstrate to purchasers how the health system's integrated model improves outcomes and reduces inpatient utilization and the total cost of care.

Clarifying an organization's value proposition may be most important for those providers that extensively subsidize across operations or patient populations. In an environment of greater transparency, tightened revenues, and payment methodologies that require demonstration of value, it is unlikely that large-scale subsidization across payers and operations will be a sustainable approach.

Inflexible cultures and organizational structures. Across the provider cohorts, participants noted the significant need to create more agility within their organizations to prepare for the emerging value-based payment environment. An area of particular emphasis in all cohorts is improving the alignment and engagement of physicians in organizations' efforts to improve value.

Difficulty aligning physicians to organizational goals and initiatives. A common challenge across the organizations interviewed is aligning physicians to help lead and accomplish organizational goals and initiatives. Organizations are experimenting with ways to improve employed physicians' involvement in key care delivery and cost-cutting initiatives,

including incentive structures. Organizations are also aiming to improve network physicians' alignment with financial and clinical performance efforts. Providers in states with corporate practice of medicine restrictions face particular challenges in improving physician engagement and alignment in strategic and initiative-level leadership.

In addition to these internal dynamics, common external challenges include the following.

Expectations of diminished future revenue. Tightening state budgets and Medicaid funding are immediate revenue-related concerns. Healthcare organizations also face lower rates of increase in Medicare reimbursement as well as more severe cost pressures related to commercial insurance rates. They can expect heightened pressure to reduce utilization of more expensive specialty and acute care services, which will put further downward pressure on revenue. Leaders at numerous organizations cited the need to perform at "break-even" points on Medicare rates.

Uncertainty about the future payment model. Although representatives from each of the organizations surveyed universally believe that revenues will tighten, what is less clear is the shape of the predominant payment model of the future. As noted in the HFMA Value Project report *Defining and Delivering Value*, it is likely that over the next several years the industry will see a period of experimentation in payment methodologies to determine which are most effective in driving better value. Participants noted that uncertainty regarding the future payment model can inhibit the sense of urgency and direction necessary to move their organizations forward.

Lack of patient accountability. Several leaders expressed reservations about the lack of patient accountability built into certain payment models, such as the Centers for Medicare & Medicaid Services' (CMS's) shared savings arrangements for accountable care organizations (ACOs).

Leaders expressed optimism about their ability to address these concerns while positioning for improved financial and clinical performance. These challenges help to frame the common road map of capabilities, strategies, and initiatives that organizations across cohorts should consider following as they develop value-based business models of care.

COMMON STRATEGIES AND INITIATIVES FOR ACHIEVING VALUE

The common strategies and initiatives that all hospitals and health systems should negotiate in the transition to value-based business models fall under the key competencies of people and culture, business intelligence, performance improvement, and contract and risk management.

PEOPLE AND CULTURE

The people and culture capability encompasses numerous strategies and issues, including governance, strategy and structure, management, physicians, staffing and skills, and communication and culture.

Governance. HFMA Value Project research validates that organizational leaders are taking steps to review the governance of their organizations as an important step in transitioning to a value-based business model. Hospitals and health systems are adjusting the composition of their boards to add expertise in community relations, business intelligence, and care management to prepare for the transition. Organizations also aim to develop boards comprised of leaders that understand the complexities of the emerging payment environment and are able to make difficult decisions that may diverge from past courses of action. Particularly for rural hospitals and stand-alones, boards are an important tool in shoring up local support and loyalty for the community hospital.

Organizations are also working to augment their governance structures. Many multihospital systems are centralizing some board functions that were more decentralized in the areas of both quality and finance. Many academic medical centers are also considering redesign of board and other governance structures to better centralize decision making.

All hospitals interviewed as part of the Value Project stated the need to educate their boards about emerging market dynamics and the potential financial implications to their organizations, and have taken advantage of educational opportunities offered by regional and national organizations specializing in governance issues.

Strategy and structure. The single most common strategy providers have utilized in the transition toward value has been to focus on their organization's cost structure.

An emphasis on provider cost reduction is not a new strategy, but it is being pursued as an urgent strategy in conjunction with value-based payment. For value to be realized, efforts to reduce providers' costs must ultimately improve the relationship between the quality of care and the total cost of care to the purchaser.

At most organizations, cost-cutting efforts begin on the inpatient side with examination of vendor contracts. Next, opportunities to reduce costs related to supplies and then staff are examined. Finally, organizations turn to process improvement as a means to better contain costs. Attention must now shift to outpatient settings. Outpatient settings are critical to management of chronic conditions, which the Centers for Disease Control and Prevention notes account for more than 75 percent of U.S. healthcare costs. They are where most of the excess spending in U.S. health care occurs.

Related to this, providers are reassessing their ability to cross-subsidize services, business units, and other components of the system. They are beginning to review strategies by key population segments, evaluating the needs and values of each segment relative to the healthcare organization's ability to deliver on them. For example, what is the organization's strategy for chronic care patients, patients who use the emergency department for nonurgent care, or even for those who are well much of the time? Hospitals also are forming strategies around providing care and service for specific ethnic communities and socioeconomic groups. They are also developing more refined strategic and tactical plans specific to each population segment to accomplish longer term, segment-specific financial performance.

Additionally, providers are reassessing ways to achieve economies of scale. For many, the question of possible mergers, alliances, and other forms of linkages between systems is a central determinant of future strategy and structure. Stand-alone and rural hospitals will face particular challenges in pursuing a value strategy without some form of linkage with other organizations. For academic medical centers, such linkages are a way of tying the referral base closer. Meanwhile, for multihospital systems, linkages provide a unique opportunity to add still more scale.

Management. It is important that organizations align their executive leaders around the goals of their strategic plans prior to rolling out value-based business model initiatives more broadly. For example, leaders at healthcare organizations that have made significant strides along the journey toward value-based business models are translating their strategic plans into tactical plans and goals that are shared organizationally. Winona Health organized its key strategic goals around the Triple Aim, emphasizing patient satisfaction, quality and cost indicators, and community health. The health system has attached performance metrics to each component of its strategic plan, the results of which are broadly communicated. Other leading organizations are tying physician and staff incentives to performance on the strategic plan, either at the outcomes level (e.g., patient satisfaction, operating margin) or in relation to key initiatives.

Organizations are developing the capabilities needed to collect and report on the metrics called out in the strategic and tactical plans, and to manage to these measures. At Winona Health, for example, managers regularly report on progress on key measures, and share with senior leadership ideas to improve performance on activities that are off track from plan. Senior leadership meets on a regular basis to review measured performance and to shift resources as necessary to ensure success on the organization's highest priority initiatives.

Physicians. Physician leadership is key to the success of efforts to create value. For most organizations, physician leaders are being educated and elevated within management to support initiatives that will enhance the organization's value capabilities with respect not only to care delivery, but also to aspects of affordability and other organizational priorities.

Many organizations are beginning to invest in and formalize processes for developing physician leaders. This process begins with education around key marketplace dynamics and implications, and continues on into diverse areas including financial management and change leadership. Leaders should expect physician education to be a lengthy process that will require multiple communication strategies and techniques to deliver the message.

Physician dashboards are being deployed to help educate physicians and assess their performance, and incentive structures for employed physicians are being modified to reward high-quality care and effective care delivery. Earlier Value Project reports have described the importance of

moving away from purely productivity-based compensation models, which contribute to overutilization in a fee-for-service environment, toward compensation structures that are based on dimensions of performance rather than productivity. For example, Nebraska Methodist Health System uses dashboards to assess individual physician adherence to clinical protocols, while Billings Clinic anticipates that its upcoming investment in an improved decision support system will enable better analysis of utilization by physician. Tying performance measures directly to compensation bolsters the impact of individual performance reports.

Increasingly, health systems' physician networks are combinations of employed and private practice physicians. Under value-based business models, physician networks should be held together with a compensation model that includes incentives tied to performance on quality and cost. For example, Dean Health, an aligned integrated system in Madison, Wis., is using contractual terms to hold network physicians accountable for key metrics of importance to the health system, including patient satisfaction, total cost of care, and clinical quality.

Staffing and skills. As organizations develop more refined strategic plans, they need to assess the types of staffing and skills that will be necessary in the future and develop transition plans that take these assessments into account. Many organizations, such as Franklin Memorial Hospital in the rural cohort and Billings Clinic, an aligned integrated system, have developed plans related to staff attrition, using retirements as opportunities to redeploy available positions in more strategic ways. Across the cohorts, organizations are planning to add staff strategically, with an emphasis on analysts, care coordinators, and physician extenders. Like all staff, the individuals who fill these positions should be educated on and have their incentives aligned to the top goals and initiatives of the organization. Leadership development among staff also is important, as effective nonphysician leaders will play a key change leadership role going forward.

Communication and culture. In response to the dynamic market environment and to traditionally risk-averse, slow-to-change internal cultures, participants in HFMA Value Project interviews are laying the groundwork to foster more flexible organizations. The cohort-specific road maps reveal nuances at each cohort level regarding how organizations

are developing a value-driving staff and culture, but in general, providers are taking the following action steps.

- *Delivering a value message around quality, particularly patient experience and cost improvement.* Some organizations downplay the emphasis on cost in their internal messaging to more effectively engage clinicians while seeking to validate that higher quality can be achieved at a lower total cost of care.
- *Educating staff and physicians about emerging marketplace, financial, and other factors.* These factors provide context for a strong value message.
- *Engaging staff and physicians in the planning and execution of initiatives to improve value.* Many organizations, such as Billings Clinic and Holy Spirit Health System in Harrisburg, Pa., seize on opportunities to pursue performance improvement projects in which physicians have expressed interest.
- *Experimenting with payment models to learn and become more comfortable with change.* Nearly all participants are encouraging risk-taking by proactively experimenting with different models of value-based payment. From small rural facilities to large organizations, providers are proactively pursuing payment experiments such as bundled or shared savings arrangements—often despite uncertainty regarding the financial impact of their efforts—to learn what capabilities are required to be successful in these arrangements. Some cohort members, such as Geisinger Health System and Cleveland Clinic, have already figured out how to succeed financially in certain bundled arrangements, and have incorporated what they have learned from those experiments into their operations.
- *Experimenting with care delivery approaches.* Across the provider cohorts, leaders are embracing change by establishing patient-centered medical homes (PCMHs). These models require clinicians—especially physicians—to make a substantial number of adjustments to practice style and patterns relative to traditional office-based practice. Additionally, PCMHs leverage physician extenders significantly. This can increase organizations' agility with respect to staffing, but may also require a change in mindset for primary care physicians who may not be accustomed to a team-based approach to care.
- *Learning to “fail.”* Increased risk taking and comfort with failure as a source of learning is central to the participants' efforts to improve strategic agility and requires time, practice, and reinforcement.

BUSINESS INTELLIGENCE

In addition to tackling governance, alignment, and compensation issues, all of the cohorts are also focusing on building capabilities related to understanding internal costs, integrating clinical and financial data, and using the data to optimize care delivery and drive value improvement efforts. Investments in business intelligence also are expected to facilitate physician engagement and improve provider contracting capabilities.

Clinical information systems. In nearly all organizations involved in Phase 2 of HFMA's Value Project, investment in clinical information systems, such as electronic health records (EHRs), has already occurred or is in process. Organizations are also focused on improved costing capabilities, although this is often secondary in terms of both priority and expense to clinical information systems.

For both clinical and costing systems, the initial focus is typically inpatient, followed by outpatient and then other components of the organization. Leading providers are considering organizational goals regarding episode-of-care management, chronic disease care, population health management, and research when planning their ongoing clinical information system and data investments. Organizations dealing with more than one electronic health record (EHR) or costing system within their operations are actively moving toward common (or, in some cases, integrated) information systems and data definitions. The goal is for care teams and finance teams to have access to patient-specific data over time, across all care settings, and integrated across clinical and financial domains. Across cohorts, organizations are developing health information exchanges in partnership with other community health providers, a strategy that could help improve the opportunity for strategic alliances and access to a broader set of longitudinal data.

Financial reporting and costing. Although participating organizations employ varying approaches to costing systems, in general they are taking steps to move beyond “directional” data to more precise information. According to Franklin Memorial Hospital's CFO Wayne Bennett, “The focus of healthcare leaders is no longer on determining which services are profitable and unprofitable; it's on reducing costs everywhere in the organization. We have to track and reduce costs even in profitable service lines.” Payment methodologies such as capitation, bundles, and shared savings will require providers to understand costs across care settings.

Performance reporting. Initially, providers are tracking all of the core and process measures required by CMS and other payers. A step forward would be to determine and highlight those critical strategic measures that have the potential to have the greatest impact on financial performance and efforts to enhance care delivery. For example, BJC’s “Best in Class” quality scorecards standardize and prioritize the most important quality metrics across all facilities in the system.

As reported in the Value Project’s *Defining and Delivering Value* report, given the strong interest that CMS, employers, and other payers have in outcomes measures, leading organizations should develop ways to measure and track performance on outcomes. Organizations aiming for population-based shared savings or capitation should develop capabilities for population-level performance reporting.

Analytics and warehouses. In addition to investing in clinical and costing systems, leading organizations are focusing on the development of data warehouses that typically contain clinical and financial data, with some organizations seeking to add information related to claims, patient satisfaction, and socioeconomic and demographic data over time. They also are investing in decision-support systems to assist with extraction, reporting, and analysis of the data.

Many organizations reported ambiguities related to data governance—that is, who defines the data, determines which data flow into the warehouse and decision support systems, and continually maintains the data to ensure they are clean, complete, and accurate. University of Alabama at Birmingham (UAB) is putting a cross-functional oversight committee into place to tackle this function related to its new decision-support system.

Some providers that are exploring options for decision support have not yet tackled the question of how analysts will be resourced to extract and use the data. Those that have generally either decentralize analytics throughout the organization or provide a centralized analytical team. At UAB, John Turner, director, financial management, described two types of end-users: “One is starved for data and loves IT, while the other is scared of IT.” UAB decided to roll out the new functionality to a “super user” group of experienced data analysts throughout the organization who have been trained on the new system; over the next year, less experienced and infrequent users will gain access to and training on the system. At Dean Health in Wisconsin,

a team of business analysts in the finance department, in partnership with clinical leaders, is responsible for the analysts who use the organization’s decision-support system.

Integrated, timely, complete, and precise clinical and financial data are an important enabler of demonstrating value to purchasers, and leading organizations are focused on making information stored within these data warehouses actionable. Nebraska Methodist Health System mines data to compare physicians’ performance on diabetes-related metrics. The system will soon begin mining patient data on hypertension, heart failure, asthma, and coronary disease. Nebraska Methodist expects to use the reports to reduce clinical variation. Such approaches are built into the care processes of Geisinger, Cleveland Clinic, and other aligned integrated systems. Ultimately, healthcare organizations’ investments in data warehouses and analytics should allow them to provide information demonstrating quality outcomes and total cost of care per patient or across populations.

PERFORMANCE IMPROVEMENT

The crux of the changes that providers will need to make to transition to the emerging payment environment lies in care delivery. The following areas of focus center on improving the coordination, efficiency, and patient centrality of care delivery.

Process engineering. Providers should determine what process engineering methodologies (e.g., Lean, Plan-Do-Check-Act) they intend to utilize to optimize care delivery, reduce variation, achieve administrative simplification, and improve the patient experience and allocate resources appropriately. Further, organizations should establish a cross-functional forum to identify and select which process improvement initiatives will be undertaken. Dean Health and Bon Secours Health System of Richmond, Va., have developed proven approaches that involve clinical, financial, and administrative leadership.

To secure physician buy-in, many providers first pursue process improvement projects in which clinical leaders have expressed interest. An example is a perioperative surgical home initiative at UAB Health System. “We thought we’d get major pushback from the surgeons,” says Art Boudreaux, chief of staff, UAB Medicine. “However, what they found was that if they are relieved of this duty, it gives them more time to focus on their surgical operations. Now, the surgeons are totally on board.”

As data warehousing capabilities are improved, organizations should use clinical and cost data, such as utilization variances within similar cases, to identify opportunities for improvement. Further, providers will advance their performance improvement capabilities when they move from department-specific efforts to cross-department and, later, cross-location projects. Finally, as organizations gain experience with process improvement projects, they should hone their abilities to quantify the financial impact and other outcomes of these efforts and build those results into budgets.

The process improvement efforts of hospitals and health systems that were studied for this report often appear imbalanced, with a much heavier emphasis on inpatient than outpatient care and service. The predominant reason seems to be the willingness of administrative hospital leaders to drive process improvement efforts and the relative reluctance of physician outpatient leaders to do so in an ambulatory setting. Other factors include the lack of an EHR or costing capabilities in an outpatient setting and lack of payer interest in designing bundled payments focused on outpatient care. Of the participating organizations, Winona Health and Geisinger, both of which employ physicians, are leaders in tackling process improvement within an outpatient setting. At both organizations, this has required persistent physician leadership, data and analytics, and a significant investment of time.

Evidence-based medicine. The term *evidence-based medicine* is broad, and it includes more concepts than are depicted in the common road map. In general, as organizations progress in instilling the use of evidence-based approaches in care delivery, they are moving beyond a narrow focus on patient safety-related concerns toward other areas of emphasis, including standardized order entries and protocols, factors affecting readmissions, and hospital-acquired infections. From there, organizations can apply evidence to high-risk care, chronic conditions management, and, ultimately, population care, including wellness.

Care team linkages. Across provider types, leaders are considering how realistic and appropriate population management and attendant shared savings arrangements are for their organizations in the short- versus long-term. In some cases, such as when a hospital lacks the scale or

scope of services to enable population health management, hospital or health system leaders are not pursuing population health or shared savings arrangements in the near term. Instead, these providers are considering the ways in which bundled payment arrangements could deliver consistent, competitive pricing for a narrower band of services. Another example where active pursuit of population health management may not make sense in the near term is when organizations lack key foundational elements—such as strong centralized governance, sufficient IT capabilities, or a sufficient primary care base—to support this approach. Although population-based risk arrangements may not be appropriate in all cases in the near term, some providers across all cohorts are beginning to position themselves for this type of payment arrangement.

Providers aiming for shared savings arrangements or population-based capitation should assess the sufficiency of their primary care function by measuring access, determining and acting on needs to expand primary care, and adding care coordinators and physician extenders to enable a team-based approach. As noted, nearly all organizations involved in this research have established or expanded their use of PCMHs.

For organizations that today lack a strong foundation of primary care, most organizations that are leading the way on the road toward greater value are laying the groundwork to bolster this arm of care delivery. Holy Spirit Health System, for example, is investing in primary care. “We need both more physicians and more locations to position us for population health management and value-based payment,” says medical director Peter Cardinal.

“Right-sizing” specialty services alongside the expanded primary care function is an important step in developing care team linkages. Across cohorts, and particularly for rural hospitals, organizations should assess carefully the type and number of specialty services and providers required.

Organizations also should consider pursuing innovative partnerships with other providers, particularly those that are aiming to build population management capabilities more quickly. Longmont United Hospital in Colorado has formed a coalition with several neighboring facilities and medical groups to serve the needs of local self-insured school districts, with the hope of expanding to include other self-funded employers.

An advanced capability related to linking care across a continuum is the ability to ensure delivery of care in the most cost-effective and appropriate setting. This requires clinical analytical abilities and actuarial skills as well as longitudinal clinical and cost data.

Stakeholder engagement. Providers across cohorts should pursue opportunities to effectively engage patients in their own health care. A starting point is improved transparency—making it easier for patients to understand the organization’s performance in key areas. Organizations should experiment with shared decision making in the exam room, moving from the traditional “compliance” approach to a more collaborative interaction with patients. Shared decision making is a key initiative at Partners HealthCare that leaders believe will improve quality, satisfaction, and cost structure. Highly transformed organizations will experiment with other mechanisms to engage patients, such as partnering with insurance carriers to design benefits that enable selection of evidence-based care pathways.

Another approach to bolstering patient accountability is to strengthen the organization’s ties to the community. For example, Winona Health developed “Live Well Winona” in partnership with other leading local businesses and care delivery organizations to reposition itself as a health-promoting organization, rather than solely a provider of care in times of sickness, and to strengthen the health system’s position within the community.

Ultimately, improved patient engagement sets the stage for greater patient accountability for health status and outcomes. There is no easy way to ensure patient accountability, but organizations are experimenting with different approaches to determine what is most effective with different patient populations. Examples include efforts to improve care transitions by investing in care coordinators and case managers to work with chronic-disease patients or those in need of specialized healthcare and social services, and efforts to work with insurance carriers to design benefits that encourage patient utilization of coordinated care networks.

CONTRACT AND RISK MANAGEMENT

Another area of emphasis for organizations across cohorts as they aim to optimize clinical and financial performance is improving contract and risk management capabilities. Specific areas of focus include financial planning and modeling, risk modeling, and contracting.

Financial planning. Organizations across cohorts are moving toward development of multiyear cost containment plans. Dean Health, an aligned integrated system, is in the process of establishing a rolling calendar of initiatives that are built into budget planning processes. New York-Presbyterian Hospital, an academic medical center, has established a similar approach. Partners HealthCare is also planning value-based initiatives over multiple years.

A consistent problem—and yet an essential component—tied to transformation of care delivery is the continual updating of cash flow models capital budgeting, and capital asset planning that is required as changes unfold. Most of the organizations interviewed for this study reported a limited ability to quantify the financial impact of care delivery improvements. It is important that organizations learn how to quantify the financial implications of care delivery improvements and attribute savings across customer segments. This capability helps providers hone their strategic planning efforts, assists in budgeting processes, and will ultimately help determine the extent to which savings can reduce the total cost of care to purchasers.

Bon Secours Health System is relatively advanced in its ability to quantify the financial impacts of care delivery changes. Its approach is to determine a focus area, such as fixed costs, and apply consistent, systemwide methodologies and principles to determine the financial impact of its efforts. Resources from financial planning assist clinical initiative leaders in this process.

Financial modeling. A few of the organizations that were studied through HFMA’s Value Project are enhancing their longer-range (e.g., five-year) financial modeling

efforts to account for numerous scenarios involving payer mix, revenue, utilization, and other types of changes. One example is UAB Hospital, an academic medical center that is partnering with a vendor to develop a much larger financial model that encompasses all components of UAB Medicine as well as to incorporate scenarios related to shifting revenues and payment. Another is Crete Area Medical Center in Nebraska, a rural facility where leaders are discussing immediate, intermediate, and long-range steps the organization could take if it loses critical access funding. Sharpened financial planning capabilities of this nature will support refined strategic and tactical planning efforts.

Risk modeling. Many provider contracting functions today model risk on the basis of contract-level profit/loss analysis, which is a traditional approach to rate negotiations. As organizations invest in producing more complete, timely, and precise quality and cost data, negotiators will have access to better information.

As contracting functions advance, actuarial experts might get involved in negotiations. Eventually, leading organizations will employ predictive modeling, particularly related to shared savings and capitated contractual terms, to forecast likely utilization and cost patterns among defined patient sub-populations and to develop risk mitigation strategies based on payment methodologies and care management strategies.

Healthcare provider organizations should, however, take a cautious approach to assumption of insurance risk. Aligned integrated systems are in a position to do this only because they have owned health plans for many years and have the necessary expertise in house. Other organizations may face significant challenges in building this expertise.

Contracting. The emergence of value-based payment methodologies is causing an evolution in contracting functions in the cohorts. Contract managers are beginning to work in partnership with quality and clinical leaders to establish pay for performance or other value-based payment methodologies that are consistent with the goals of

the organization. Contracting leaders are also working with CFOs to pursue payment experiments with payers.

Across cohorts, organizations are pursuing ways to offset the cost of investments necessary to transform care. Some have established partnerships with payers in which insurance carriers help pay for value improvement initiatives, such as the infrastructure costs related to establishment of PCMHs. Billings Clinic, an aligned integrated system, is one of two providers in Montana working with Blue Cross on PCMHs. Holy Spirit Health System, a stand-alone hospital, has partnered with Highmark Blue Cross to pilot PCMHs at two of its primary care sites, part of a program initiated by the governor of Pennsylvania's Chronic Care Commission. Holy Spirit received funding to hire a PCMH development nurse and a transitions development nurse. Highmark pays a per-patient visit fee, with additional reimbursement available to sites that obtain PCMH certification.

Some organizations may be well positioned to partner with self-insured employers. As noted, Longmont United Hospital, a stand-alone hospital, is in a unique arrangement with a local, self-funded school district. Cleveland Clinic, an aligned integrated system, has established an exclusive arrangement with Lowe's, a national, self-funded employer, to provide select specialty services at negotiated rates. Lowe's incorporated a unique travel benefit to incentivize employees to use Cleveland Clinic for these clinical services. Franklin Memorial, a rural facility, worked closely with the state of Maine (the state's largest employer) to ensure that it continues to meet the performance expectations required of a preferred provider in the state's insurance plan.

Ultimately, provider contracting functions should prepare for a second generation of value-based payment approaches. As noted in *Defining and Delivering Value*, the emerging payment environment has been described by stakeholders as a period of experimentation and learning. Providers should expect industry learning to further shape new payment experiments in the future.

ACADEMIC MEDICAL CENTERS

The emergence of value-based payment methodologies and the increased emphasis on transparency will have profound implications for academic medical centers. How do academic medical center leaders align and structure their organizations in a financially sustainable way? What types of strategic partnerships will be important on the road toward value-based business models? What key changes to care delivery should be considered if academic medical centers are to achieve greater value?

For purposes of this discussion, an academic medical center (AMC) is characterized as a teaching hospital, usually with a faculty practice plan and a medical school (which may or may not be part of the same legal organization). AMCs pursue a three-part mission: teaching, research, and clinical care.

As part of HFMA's Value Project research, five AMCs—New York-Presbyterian Hospital, Partners HealthCare, Rush University Medical Center, UAB Hospital, and Vanderbilt University Medical Center—were studied (see the exhibit on page 21). These centers are geographically dispersed, serve various types of markets, have different delivery models, and are of varying size in regard to the number of physicians in faculty practice plans and number of staffed beds maintained by each organization. Most are in markets dominated by a Blue Cross Blue Shield health plan. Medicaid revenue currently ranges from 8 to 28 percent in these organizations, and Medicaid budgets are tightening.

Two AMCs were selected for site visits: Partners HealthCare in Boston and UAB Hospital, part of UAB Health System in Birmingham, Alabama. There are some significant differences between the organizations. First, Partners HealthCare is substantially larger in terms of revenue and endowment. Also, the organizations' market environments are dramatically different. Boston is among the markets moving most quickly toward value-based payment and cost containment; in contrast, in Alabama, Blue Cross is the major commercial payer, and it is not yet actively pursuing value-based payment methodologies. However, UAB Hospital leaders anticipate mounting cost pressure as the state of Alabama considers conversion to managed care for Medicaid. Additionally, leaders are

KEY RECOMMENDATIONS

Academic medical centers should consider the following action steps as they position themselves for value-based business models:

- Align incentives across research, teaching, and care delivery functions of the academic medical center.
- Centralize governance.
- Develop primary care physician referral networks.
- Reduce the organization's overall cost structure and improve care processes.

concerned that carriers could make the AMC a "second tier" provider in their PPO plans, disadvantaging the organization in a way that could affect patient volume and revenue.

The organizational models of the two organizations also differ. Partners includes two teaching hospitals—Massachusetts General Hospital (MGH) and The Brigham and Women's Hospital (The Brigham)—six community hospitals, a rehabilitation hospital, and several other system components. The vast majority of the physicians practicing at MGH and The Brigham are employed. Most are also on the faculty of Harvard Medical School; however, Harvard Medical School is a separate legal structure. The UAB Hospital and UAB School of Medicine are part of UAB Medicine. However, the faculty practice plan is a separate organization.

Distinctions in delivery models also are evident. Partners HealthCare has a substantial primary care base that increasingly coordinates with specialists in the system. At UAB Health System, there are only 20 primary care physicians; these physicians are not positioned to serve as a "front door" to the organization.

CHALLENGES AND OPPORTUNITIES

Along the road toward greater value, AMCs have unique attributes that represent both opportunities to be leveraged in the emerging payment environment and challenges to be overcome as they move toward value-based business models.

Opportunities. Relative to most stand-alone and rural hospitals, AMCs are relatively well positioned financially. AMCs generally have enough cash flow and capital to enable them to invest, take risks, and overcome mistakes.

A superior brand reputation provides AMCs with leverage in several ways. First, it aids AMCs in discussions with payers, which are motivated to keep AMCs as preferred providers. Second, it can help promote strategic partnerships directly with self-insured employers and community leaders. Third, AMCs have the opportunity to build on their brands to secure referral streams from other providers. Often, academic medical centers are of sufficient size and reputation to have the opportunity to influence payers and the community. For example, even though UAB Health System is smaller than Partners HealthCare, both are the largest employers in their states. Size represents clout and the potential for partnerships and influence.

Challenges. A key challenge for AMCs lies in their complexity. Governance is often decentralized with separate mission statements and leadership in key functions (e.g., clinical care, research, education). Many AMCs also have a strong culture of consensus building that slows and diffuses decision making.

Physicians, who are often attracted to the academic medical center due to prestige and the opportunities it presents to teach and conduct research, may not be as involved in care delivery. This focus could complicate or slow care delivery transformation, which is key to success in the transitioning payment environment. Physician compensation models often vary widely across clinical

departments in an AMC and are often not designed in a way that encourages care delivery or improved care coordination.

Although the AMCs participating in HFMA's Value Project research enjoy a strong brand reputation in their markets, all acknowledge being at risk for erosion of brand in a more transparent marketplace. AMCs question comparisons of their quality data with data from other providers because of concerns regarding insufficient risk adjustment for the higher-acuity patients that AMCs often treat. Additionally, the patient population served by the AMC, particularly the portion of this population who receive unique, subspecialty care, is distinctly different from other providers' patient panels, which makes it difficult to compare AMC patient populations with those of other providers. And quality data may reveal deficiencies in performance that are difficult to accept within the AMC community, making it harder to drive the internal changes necessary to achieve and sustain superior performance. As a physician leader in an AMC noted, "Our brand is based on history. If the data do not say that we're excellent, we struggle with that. We need to get over ourselves."

DIFFERENCES IN APPROACHES AMONG AMCS

There are a number of key market-specific and organizational-specific differences among AMCs, including the following:

- Some AMCs are the major safety net resource for their region.

UNIQUE CHALLENGES AND OPPORTUNITIES FOR ACADEMIC MEDICAL CENTERS

Challenges

- High cost structure
- Cross-subsidization from clinical to education and research; subsidization across payers; vulnerability to research funding and state budget cuts
- Decentralized governance structure with separate mission statements (could be slower to change, less aligned)
- Some physicians spend more time on research or academics than on care delivery
- Loss of referrals to competitors (e.g., other networks seeking to reduce leakage, lack of primary care physicians)
- Other providers adding services and competencies to compete
- Brand threat from "partial transparency" (different patient populations and case intensity; inaccurate or incomplete data)
- Splitting a smaller pie of research dollars (winners and losers)
- Less flexible cost structure (e.g., integration of clinical and academic; faculty contracts)

Opportunities

- Enhance financial strength.
- Develop a culture of innovation.
- Create a strong brand.
- As large employers, identify opportunities to influence market direction.
- Leverage to form strategic partnerships.
- Leverage relationships with payers.
- Build on brand to secure referral streams from other providers.

- Some are the sole providers of NICUs, burn units, and transplant services in their communities, and these services are often underreimbursed.
- Some AMCs are independent, while others are part of larger, multihospital systems.
- Some AMCs have developed stronger centralized governance across major organizational components (e.g., teaching, research, and care delivery), while others have highly decentralized structures.
- Some AMCs have a well-developed primary care base, while many rely on a widely spread, less-closely-linked referral base.
- AMCs have differing revenue balances among clinical care, academic, and research functions, and differing endowment levels.
- Degrees of competition for physician employment differ among AMCs as well.

THE ROAD AHEAD: STRATEGIES AND INITIATIVES

AMCs recognize that the emerging payment environment will have a significant impact on their organizations. AMC leaders are striving to reshape their organizations by developing stronger centralized governance to enable more effective and timely decision making. They aim to retain all three major operational components—education, research, and care delivery—with an emphasis on shoring up care delivery, which they see as most critical for financial viability.

AMCs strive to:

- Create awareness of the emerging payment environment across key organizational components, including teaching, research, and care delivery
- Restructure to develop strong centralized governance, financial transparency, and improved alignment across the organization

ACADEMIC MEDICAL CENTER ROAD MAP TO VALUE

LOWER ←

ORGANIZATIONAL CAPABILITIES

People/Culture

Governance	Educate Leadership	Improve Transparency
Strategy and Structure	Review Strategy by Segment	
Management	Align Executive Leadership	Develop Common Plans, Goals
Physicians	Educate	Assess Performance
Staffing and Skills	Assess Needs	Plan Attritions
Communication and Culture	Articulate Value Message	Educate

Business Intelligence

Clinical Information Systems	Implement EHR, All Settings	Establish Alerts
Financial Reporting & Costing	Directional, Limited	Precise, All Settings
Performance Reporting	Core, Process Measures	Strategic Measures
Analytics and Warehouses	Review Data Governance	Integrate Clinical, Financial Data

Performance Improvement

Process Engineering	Identify Methodology(ies)	Establish Cross-Functional Forum
Evidence-based Medicine	Patient Safety	Readmissions and Hospital-Acquired Conditions
Care Team Linkages	Measure Primary Care Access	Expand Primary Care
Stakeholder Engagement	Create Transparency	Educate Patients

Contract & Risk Management

Financial Planning	Rolling Calendar	Update Cash Flow Planning
Financial Modeling	Maintain Short Term View	
Risk Modeling	Analyze Profit/Loss	Estimate Financial Exposure
Contracting	Negotiate Prices	Partner with Quality

- Revisit cross-subsidization across payers and organizational components
- Work to build a flexible and engaged organization
- Strengthen ties with physicians
- Develop and achieve a plan to improve care processes and reduce overall cost structure
- Develop primary care networks/referral strategies.
- Pursue strategic partnerships with payers

AMCs, like other types of providers, need to coordinate a number of initiatives to position for success under value-based payment, as described in the common road map. Some initiatives that AMCs need to tackle are unique to this type of delivery system or are of particular emphasis for AMCs. These initiatives are highlighted in bold in the AMC road map.

Create organizational awareness. AMCs often have different boards, leadership structures, and mission statements governing each of their teaching, research, and care delivery

functions. These distinct governance structures make it challenging for AMCs to make decisions nimbly and strategically as a larger organization. Further, many AMCs report the absence of dialogue among academic departments, specialists, the hospital, and other potential elements of a coordinated, detailed approach to care management. The CFO of one academic center noted, “We are using the possibility of a bundled payment project not because we think it will be a big winner for our system, but just to get an early dialogue going between the key elements of our system.”

AMCs that were studied for this report are educating leaders across the different components of the AMC and their boards about the emerging payment environment and other significant environmental dynamics. It is important that AMC leaders be transparent about financial transactions within the system, to provide a baseline for developing a workable financial plan aimed at the tripartite mission of the AMC.

Degree of Care Transformation & Financial Sustainability				HIGHER
STRATEGIES & INITIATIVES				
Develop Centralized Structure		Streamline Decisions		
Develop Strategic Plan		Bend Cost Curve		
Align Incentives		Manage to Measurement		
Align Compensation	Develop Leaders		Lead Strategies and Initiatives	
Add Staff Strategically	Educate	Align Incentives	Enhance Leadership	
Engage Stakeholders	Conduct Payment/Care Delivery Experiments		Foster Innovation	
Establish Disease Registries		Modify EHR	Develop Data Exchange	
Longitudinal		Complete Per-Member, Per-Month Costing		
Outcomes		Population Based		
Deploy Research-Related Analytics		Support Real-Time Decisions		
Initiate Efforts		Utilize Data	Expand Cross-Department	Expand Cross-Continuum
Standards, Protocols		High Risk-Care	Chronic Conditions	Wellness
Right-Size Specialty	Partner Strategically		Manage Care by Setting	
Share Decision Making		Establish Patient Accountability		
Update Capital Budgeting and Capital Access Planning		Quantify and Allocate Initiative Impacts		
		Conduct Multifactorial Scenario Planning		
Utilize Predictive Modeling		Develop Risk Mitigation Strategy		
Experiment with Value-Based Purchasing (VBP)		Partner with Payers	Prepare for Second-Generation VBP	

Restructure to develop strong centralized governance, financial transparency, and improved alignment across the organization. This initiative involves capabilities spanning strategy and structure, and management.

To position for the emerging payment environment, AMCs may require a redesign of organizational structure and governance. The goal of this effort is to develop a centralized leadership structure that can make critical decisions on behalf of the AMC. UAB is taking a step in this direction: A centralized structure exists, but leaders need greater authority to make decisions on behalf of the system. Additionally, UAB's system leaders require more agile decision-making capabilities. Like other academic medical centers, UAB is instituting a funds-flow model that combines all revenue from clinical practice and hospitals into one operation. Key benefits of this approach include:

- Streamlining of decision making
- Ending the practice of clinical departments directly contracting with outside entities
- Enabling the development of an integrated financial planning process

Partners HealthCare operates within an active state governmental and legal environment and is an example of how many elements of an AMC may need to change over time to form a more highly integrated organization. For example:

- Partners has a single board with responsibility for all key aspects of clinical care—including all hospitals, faculty and nonfaculty employed physician practices, and other elements of the continuum of care.
- The systemwide strategy envisions coordinating a broad group of evidence-based care activities across hospital, specialty, and primary care.

The Partners strategy also envisions:

- Cutting costs and containing the rate of cost increases to the rate of inflation
- Enhancements to care access
- Changes in reporting relationships
- Changes in physician and other incentives structures
- Revised reporting and dashboards (patient satisfaction and financial dashboards)
- Leveraging Partners' new EHR system
- Movements of selected patient populations out of the academic medical centers to other, less resource-intensive care settings

Additional mechanisms to bolster centralized leadership are to develop a common strategic plan and to determine management-level goals and incentives that help align the care delivery, research, and academic functions of the AMC. Both of the AMCs that were the focus of site visits are moving this direction. For example, UAB is being assisted by an outside consulting group to help align its goals, initiatives, and communications.

Revisit cross-subsidization. Because AMCs are likely to be cross-subsidizing not only across major organizational functions (e.g., care delivery, research, and education), but also across payers, strategic planning by segment is of particular importance.

Some AMCs may choose to aim for a price position well above market. In that situation, it is important for the organization to have the business intelligence capabilities necessary to demonstrate to customers that the higher price is justified by superior performance on quality, lower total cost of care, or demonstrably higher complexity of cases treated. Such capabilities are likely to include the ability to define and measure various dimensions of quality, including outcomes, and slice quality and financial data on a payer, population, and patient basis, to a per-member, per-month level.

Work toward a flexible, engaged culture. Like the other cohorts in a value-based payment environment, AMCs often strive to create an agile culture willing to accept risk and occasional failure. Education of staff and physicians about emerging market dynamics and organizational implications is key to creating a foundation for cultural change and engagement. Inviting—and even requiring—staff to participate in clinical improvement initiatives is a tactic many organizations are employing to facilitate engagement.

Some AMC managers believe they can capitalize on AMCs' overall culture of innovation. The UAB Hospital established an innovation board, chaired by a physician. This board seeks to fund small, quick innovative proposals—up to \$5,000 per project, with results expected within 60 to 90 days.

Strengthen ties with physicians. Physician leadership of care delivery improvement efforts in AMCs, as in other cohorts, is paramount to success. However, it can be particularly difficult in an AMC setting to engage physicians in efforts to transform care delivery. Physicians may be drawn to the academic setting to teach and research more than to deliver clinical care. Also, compensation models often do not reward physicians optimally for care delivery or care improvement efforts.

Improving physician engagement and leadership is of special importance to academic medical centers. The process often begins with educating physicians about market dynamics and internal revenue and funds flow, using multiple communication modalities.

Physician compensation structures should be retooled to reward productive care delivery and engagement in key organizational initiatives. UAB Health System is just beginning this process, and faces the challenge of a hodgepodge of compensation structures to reformulate. Partners HealthCare has already tackled this challenge. At Partners, physician compensation is based on a relative value unit system, with 2 percent of primary care physicians' compensation tied to risk-adjusted panel size. "We made this change two years ago, so that physicians who attended to more complex patients could see an increase in compensation," said Tim Ferris, vice president of population health management at Partners. "This small increase resulted in massive changes in attitudes and the culture. It sent a message."

Some form of individual physician performance assessment, such as scorecards that demonstrate a physician's practice patterns and patient satisfaction results relative to peers, is another tool to engage physicians. Tying performance measures directly to compensation would bolster the impact of individual performance reports. An additional step may be formal leadership education programs for future AMC leaders.

Develop plans to improve the overall cost structure. Many capabilities shown on the AMC road map relate to improving cost structure, among them strategy and structure, process engineering, and evidence-based medicine.

For AMCs in highly competitive or cost-sensitive markets, like Partners in Boston, controlling costs is a dominant issue and is a central component of strategic planning.

Partners agreed to lower its annual increase in costs for its three major health plan customers from 6 percent per year to 3 percent, a plan representing hundreds of millions in cost containment at the organization. Leaders across the organization are aligned around this effort. "We all have the same goal: to cut costs effectively, without fundamentally harming the viability and mission of the system. But what is critical is that we have the right glide path to get there," says Gary Gottlieb, MD, Partners president and CEO.

Some AMCs are pursuing opportunities to contain costs in inpatient settings, such as vendor contracts, supplies,

and staffing. Others are moving forward to both inpatient and outpatient care delivery-focused initiatives, which can offer an opportunity to focus on cost containment in ways that also favorably impact quality. An important early step is establishing a physician-led, multi-disciplinary forum with accountability to identify opportunities to reduce clinical variation and standardize care processes.

For example, Partners' cost-containment plan is predicated on improving how care is delivered. Foundational to its plan is a redesign of care delivery, with multi-disciplinary teams responsible for defining process standards for priority medical conditions. Leaders at Partners are finalizing approaches to instill protocols and standards at the point of care as well as processes to review care delivery for medical appropriateness. These steps can be challenging in an academic setting, in which physicians often are accustomed to having a high degree of discretion at the point of care.

AMCs also can use business intelligence to determine which efforts will be pursued. As more complete and integrated databases are implemented, organizations should be positioned to utilize clinical and cost data to identify opportunities for improvement, such as clinical services with high degrees of variation in outcomes or cost. Further, providers will advance their performance improvement capabilities when they move from department-specific efforts to cross-department and then cross-location projects.

Strengthen primary care. One reason to strengthen primary care is that AMCs with little or no primary care are increasingly concerned that they are at risk of losing referrals as competing organizations take steps to reduce "leakage" to specialists outside their own delivery networks.

Additionally, AMCs and other providers aiming for shared savings arrangements or population-based capitation are assessing the sufficiency of their primary care function by measuring access, determining and acting on needs to expand primary care, and then adding care coordinators and physician extenders to enable a team-based approach.

Partners HealthCare and UAB Health System are both bolstering primary care, although their starting points are different. At UAB, there are very few primary care physicians. The CEO of UAB Health System has established a joint goal with the leader of the medical school to better retain more of the primary care physicians that they train, and is pursuing other longer-term strategies as well.

In the near term, UAB is pursuing ways to tighten referral relationships with community primary care physicians. Partners, which has roughly a 50/50 split in physicians between primary and specialty care, is focusing on integrating care coordinators into primary care.

Pursue strategic partnerships with payers. An area of opportunity for AMCs, given their typically strong brand reputations and market leverage, is strategic partnerships with health plans and employers. Across cohorts, organizations that are farthest along in the journey toward value-based business models have established partnerships with payers in which insurance carriers help pay for value improvement initiatives, such as the infrastructure costs related to establishment of PCMHs. Others have arranged partnerships with commercial carriers to experiment with bundled payment. Such partnerships may prove key to finding the funding and organizational momentum to proceed with these important initiatives.

OTHER STRATEGIES AND INITIATIVES

As noted on the AMC capabilities road map, there are many other initiatives that should be pursued in parallel to those activities of particular emphasis to AMCs. Some of these additional initiatives, which are more thoroughly described in the commonalities section of this report, include the following.

Continue investment in clinical information systems. Like other types of provider, AMCs need EHRs in both inpatient and outpatient settings to help transform care delivery. A unique consideration for AMCs is how to modify the EHR to capture data required for all components of its organization, including unique requirements related to teaching and research. As Peter Markell, CFO of Partners, points out, “Our version of the EHR will need extensive customization. For example, we will develop our own genomics add-on module.” Additionally, Partners is examining the research and teaching-related needs that will drive business requirements for data warehousing and analytics. Ultimately, a more streamlined approach to data collection and systems integration should help improve Partners’ cost structure.

Conduct a strategic assessment of staffing needs. Staffing needs for AMCs should be adjusted to take critical needs into account. For most AMCs, this will mean adding care coordinators, other physician extenders, and analytics staff. As with physicians, formal training and leadership will be required. Training and orientation will vary with the type

of staff added, and could include cultural orientation, such as team-based training, or more technical training, such as that required for analysts. Incentive structures will also be needed to create greater alignment. AMCs should take advantage of opportunities to use positions that become open due to attrition as strategically as possible.

RECOMMENDATIONS

In some respects, academic medical centers have the longest, most complex road map to transformation and sustainability of any of the cohorts analyzed in HFMA’s Value Project. The number of change initiatives that are required, and the degree to which these changes need to be coordinated with each other, can seem daunting. The distance between the least and most transformed and sustainable AMCs, especially in the areas of people and culture, is significant.

However, most academic medical centers have several major advantages. By their very nature, AMCs are integrated health systems, whether they are in a single governance structure or a more decentralized governance structure. They have well-established cultures of innovation. They have an image of excellence and trust, and they often have substantial asset bases and a position of leadership in their communities and states.

Specific recommendations for academic medical centers as they transition from fee-for-service to value-based payment include the following.

Align incentives across research, teaching, and care delivery functions of the AMC. An important early step in preparing for the emerging payment environment is to create further alignment across major operational components. Key steps in this process include educating leadership—including boards of directors—about changing payment dynamics and their potential implications, improving transparency about financial flows within the organization, and developing strategic plans with shared goals and initiatives.

Centralize governance. This is a huge, and hugely important, initiative for academic medical centers. It is imperative that a strong centralized leadership structure exists to make timely strategic decisions affecting the financial sustainability of the organization. Some AMCs are implementing funds flow models that strengthen central leadership by streamlining decision making and allow for centralized financial planning.

Develop primary care physician referral networks. A more immediate concern of some academic medical centers is shoring up primary care linkages to ensure that their referral base remains strong. Additionally, some AMC's without a solid primary care foundation are taking initial steps to expand primary care, with an eye longer term on population health management.

Reduce the organization's overall cost structure and improve care processes. Depending on its specific market environment, it may be increasingly difficult for an AMC to defend its higher contracting prices. Given that government and private payers are all under escalating pressure to contain health insurance costs, an AMC that aims for a relatively high price position will need specific financial and clinical data to substantiate that it is bringing greater value to the market and to specific purchasers. This might be established by demonstrating that better outcomes

on a higher-priced procedure result in a lower total cost of care to purchasers, or by demonstrating that a higher price purchases care of significantly superior quality. Even with the right data, however, an AMC should ensure that its customer segments are willing to pay higher prices to obtain superior quality.

For most AMC's, the path forward is likely to focus on cost containment, and aim for a price position in greater alignment with other providers in the market. Leading AMC's are pursuing opportunities to streamline care delivery while improving quality, utilizing techniques such as process engineering and instilling standards and protocols.

Ultimately, the nation's healthcare system as a whole will assist in transforming AMC's and will benefit from their transformation. Because they are a vital part of the overall healthcare system, it is important that AMC's make the transition from volume to value effectively.

ACADEMIC MEDICAL CENTER RESEARCH PARTICIPANTS

Participating Organization	No. of Faculty	No. of Staffed Beds	Market Served	Payer Mix*	Geography	Delivery Models
New York-Presbyterian Hospital	6,144	2,262	Urban, Highly Competitive	33% Medicare 28% Medicaid 37% Managed Care/Commercial 2% Other	New York, N.Y.	Specialty care; very limited primary care
Partners HealthCare	4,852	2,294	Urban/Suburban, Highly Competitive	33% Medicare 8% Medicaid 48% Managed Care/Commercial 11% Other	Boston, Mass.	Integrated primary and specialty care
Rush University Medical Center	260	676	Urban/Suburban, Highly Competitive	38% Medicare 22% Medicaid 35% Managed Care 1% Commercial 4% Self-Pay	Chicago, Ill.	Specialty care; very limited primary care
UAB Hospital	900	1,052	Urban/Suburban, Less Competitive	28% Medicare 22% Medicaid 38% Managed Care/Commercial 9% Self-Pay 3% Other	Birmingham, Ala.	Specialty care; very limited primary care
Vanderbilt University Medical Center	1,823	985	Urban/Suburban, Moderately Competitive	26% Medicare 18% Medicaid 47% Managed Care/Commercial 9% Other	Nashville, Tenn.	Specialty care; very limited primary care

Payer mix is based on inpatient discharges, including normal newborns.

ALIGNED INTEGRATED SYSTEMS

Aligned integrated systems with established building blocks of coordinated care delivery seem especially well positioned for a shift toward value-based payment. Their challenge is to demonstrate the value of integrated care delivery in a more transparent, value-driven environment.

An aligned integrated system has most of the following characteristics:

- Physicians play key leadership roles on board(s) and management.
- Organizational structure promotes coordination of care.
- Primary care physicians are economically integrated, and their practice sites provide geographic coverage.
- The system owns a health plan, offers single-signature contracting, or has a strategic relationship with a health plan.
- Financial incentives within the organization are aligned.
- Clinical and management information systems tie the elements of the system together.
- The system has the ability to shift financial resources among its various elements.

Seven organizations representing various regions of the country and types of markets participated in interviews for this report. In terms of size, the participants' physician base ranged from 280 physicians to more than 1,000 physicians. The number of primary care sites maintained by these organizations varied from seven to 70.

With the exception of Cleveland Clinic, all of the aligned integrated systems in the cohort have their own health plans. Billings Clinic's plan represents a small proportion of its revenue; the other organizations' health plans generate a substantial proportion of revenue and are viewed as extremely important in the transition to value-based payment.

Physicians play key leadership roles in all systems in this cohort. A leadership structure that pairs physician leaders with administrative partners is common. Additionally, all but Spectrum Health and Group Health Cooperative have physician CEOs. All participants in this cohort are engaging physician leaders in strategic discussions and decisions.

The two site visit organizations selected to represent this cohort were Billings Clinic in eastern Montana and

KEY RECOMMENDATIONS

Aligned integrated systems should consider the following action steps as they position themselves for value-based business models:

- Invest in capabilities to demonstrate the value of the integrated model.
- Continue to bend the cost curve.
- Play a leadership role in outcomes definition, measurement, and reporting.
- Pursue contracting arrangements and build capabilities to improve value.

Geisinger Health System in northeastern Pennsylvania. Key distinctions between the organizations include the following:

- Geisinger is a more mature integrated system, owns a health plan with more than 300,000 members, has 70 primary care sites, and has had a sophisticated EHR since the mid-1990s.
- Billings Clinic, about a quarter of the size of Geisinger, is a multispecialty clinic that merged with Deaconess Hospital in the mid-1990s and has since taken over management of the hospital.
- Billings Clinic recently gained control of a small Medicare Advantage plan.
- Both serve far-flung, largely rural service areas although the population densities in northeastern Pennsylvania are substantially higher than those in eastern Montana.
- Billings Clinic has one primary competitor in its market; Geisinger has multiple small competitors throughout its region.

CHALLENGES AND OPPORTUNITIES

Aligned integrated systems have a number of unique opportunities in the emerging value-based payment environment—as well as unique challenges.

Opportunities. Aligned integrated systems typically have strong primary care networks. An opportunity exists to leverage primary care even further to help contain or lower costs, engage patients, and drive improved clinical outcomes. As reported in the Value Project's *Defining and Delivering Value* report, customers are interested in

health outcomes more so than process measures of quality. Given their significant investment in IT and the breadth of services they offer, aligned integrated systems are well positioned to lead other organizations on the value journey in the area of outcomes definition, measurement, and reporting, which could favorably differentiate them from other types of healthcare providers. Aligned integrated systems also have opportunities to partner in creative ways with other provider organizations, payers, and employers.

Challenges. Aligned integrated systems face some challenges that are distinct from the other types of providers examined in this report. For example, it may be difficult for them to align network providers to their systems and approaches to clinical practice, particularly if their health plans represent a small proportion of revenue to the network provider. To the extent an aligned integrated system’s health plan competes with other plans, the efficiencies gained through care delivery reforms may produce unintended windfalls for competing plans that have not been willing to invest in value-based reform. Additionally, in a more transparent, value-driven environment, integrated systems that cross-subsidize across purchasers of their health plans (e.g., achieve

higher margin on some business lines, such as individual payers, that compensate for lower margins on others, such as small group accounts) may be required to revisit those approaches. And, such systems will increasingly be required to demonstrate the value of integration in terms of clinical and financial performance differentiation.

Differences among aligned integrated systems.

Aligned integrated systems are at different stages of readiness to undertake population risk management and associated payment models. For example, Geisinger, with its 70 primary care sites and long experience with its health plan, is better positioned for population health management. In contrast, Billings Clinic is only beginning to gain experience with running a health plan and lacks the marketplace, clinical process improvement data, and other building blocks needed to move as quickly toward developing competencies for population management and population-based risk. Additionally, integrated systems are at different places with respect to offering a coordinated continuum of care. Such marketplace and organizational characteristics will influence a particular integrated system’s readiness for population risk management and associated payment models.

UNIQUE CHALLENGES AND OPPORTUNITIES FOR ALIGNED INTEGRATED SYSTEMS

Challenges	Opportunities
<ul style="list-style-type: none"> • Keeping cost structure competitive and relatively low • Convincing health plans, employers and individuals of the value of an integrated approach • Competition from single-specialty medical groups, ambulatory imaging and surgery centers, and limited-service hospitals • Complexity in managing an aligned integrated system • Customers—including health plans and TPAs—developing their own delivery systems/provider entities (e.g., PCMHs, employer-based clinics) • Improved efficiencies in aligned integrated systems creating unintended windfalls for other health plans • Portability of care delivery models to less-integrated potential provider partners • Payment and reports based on process or satisfaction measures can put other nonaligned integrated system providers on a level playing field with such systems • Differentiating the aligned integrated system and improving its brand 	<ul style="list-style-type: none"> • With strong primary care physician base, enhanced ability to transition to population health management models that can drive cost reduction through reduced utilization related to better care management • Improved cost effectiveness (which can lead to higher market share or lower health plan pricing for owned health plan) • Formation of strategic partnerships with nonintegrated systems • Ability to capitalize on savings generated through value-based payment • Potential to take advantage of comprehensive clinical information systems (e.g., develop and report on outcomes measures, improved bidding on contracts) • Unique opportunities presented by owned health plans (e.g., payment innovations, data mining, strong patient loyalty) to improve delivery of health care • Potential to broadly disseminate the word on advantages of integrated care; offer consulting services

THE ROAD AHEAD: STRATEGIES AND INITIATIVES

The overarching strategic challenge for aligned integrated systems is to remain ahead of other types of providers on the journey from a volume- to value-based payment environment. These systems strive to demonstrate the value of their integrated care delivery models by providing exceptional clinical and financial performance. As the payment environment becomes more value-based, aligned integrated system leaders should strive to:

- Sharpen strategic plans and initiatives to reduce cross-subsidization among payers and demonstrate the value of integrated models
- Continue to bend the cost curve
- Strengthen the care continuum and coordination of care across the continuum

- Play a leadership role in outcomes definition, measurement, and reporting
- Experiment with value-based payment methodologies
- Experiment with approaches to improving patient engagement and accountability, especially in the management of chronic conditions
- Pursue strategic partnerships with employers and payers

Key elements of the road map for aligned integrated systems are distinct from the common road map presented at the beginning of this report. Important areas of emphasis for aligned integrated systems are indicated in bold on the cohort road map.

Sharpen strategic plans. Honing strategic plans requires capabilities such as clinical information systems, financial reporting and costing, performance reporting, and analytics

ALIGNED INTEGRATED SYSTEM ROAD MAP TO VALUE

LOWER ←

ORGANIZATIONAL CAPABILITIES

People/Culture

Governance	Review Governance	Adjust Board Composition
Strategy and Structure	Review Strategy by Segment	
Management	Develop Common Plans and Goals	
Physicians	Educate	Assess Performance
Staffing and Skills	Assess Needs	Plan Attritions
Communication and Culture	Deliver Value Message	Educate

Business Intelligence

Clinical Information Systems	Implement EHR, All Settings	Establish Alerts
Financial Reporting & Costing	Directional, Limited	Precise, All Settings
Performance Reporting	Core, Process Measures	Strategic Measures
Analytics and Warehouses	Review Data Governance	Integrate Clinical, Financial Data

Performance Improvement

Process Engineering	Identify Methodology(ies)	Establish Cross-Functional Forum
Evidence-based Medicine	Patient Safety	Readmissions and Hospital-Acquired Conditions
Care Team Linkages	Leverage Primary Care	Right-Size Specialty
Stakeholder Engagement	Create Transparency	Educate Patients

Contract & Risk Management

Financial Planning	Rolling Calendar	Update Cash Flow Planning
Financial Modeling	Maintain Short-Term View	
Risk Modeling	Analyze Profit/Loss	Estimate Financial Exposure
Contracting	Negotiate Prices	Partner with Quality

and warehouses. There are a number of key issues that aligned integrated systems should consider when revisiting their strategic plans.

First, for those aligned integrated systems with health plans, to what degree does the organization cross-subsidize among customers? Some organizations may be achieving a higher margin on strongly underwritten business lines, such as individual customers, and lower margins on other business lines, such as small group commercial accounts. The combination of financial performance across business lines generates an overall bottomline margin to the health plan, while the financial performance per business line can vary substantially.

In an environment of heightened transparency, extensive cross-subsidization of this type may not be tenable to customers. As a result, aligned integrated systems should

review their strategies by customer segment. The approaches to assessing stakeholder needs described in the common road map may be useful to aligned integrated systems in evaluating issues related to subsidization.

Second, aligned integrated systems should consider how to demonstrate superior value over competitors. For example, if the organization has a health plan, what is the price differential sought between that plan and competitors, by customer segment? As a delivery system, does the organization have the necessary longitudinal data and analytics to demonstrate to the marketplace its competitiveness on the basis of total cost of care to the purchaser?

Third, aligned integrated systems should consider what is required to demonstrate the value of integration to the market. Aligned integrated systems are positioning to better showcase their ability to deliver population-based

Degree of Care Transformation & Financial Sustainability				HIGHER
STRATEGIES & INITIATIVES				
Educate Leadership		Augment Governance		
Bend Cost Curve		Demonstrate Evidence of Lower Total Cost		
Align Incentives		Manage to Measurement		
Align Compensation		Develop Leaders	Lead Strategies and Initiatives	
Add Staff Strategically	Educate	Align Incentives	Enhance Leadership	
Engage Stakeholders		Experiment with Payment, Care Delivery		Take Risks
Establish Disease Registries				Develop Data Exchanges
Longitudinal		Complete Per-Member, Per-Month Costing		
Outcomes		Population Based		
Develop Analytics		Expand Databases	Support Real-Time Decisions	
Initiate Efforts	Utilize Data	Expand Cross-Department	Expand Cross-Continuum	
Standards, Protocols	High-Risk Care	Chronic Conditions	Wellness	
Partner Strategically		Expand the Scope of Services		Manage Care by Setting
Share Decision Making	Engage the Community		Establish Patient Accountability	
Update Capital Budgeting and Capital Access Planning			Quantify and Allocate Initiatives	
			Conduct Multifactorial Scenario Planning	
Utilize Predictive Modeling			Develop Risk Mitigation Strategy	
Experiment with Value-Based Payment (VBP)	Partner with Payers		Prepare for Second-Generation VBP	

care at a lower total price while providing superior clinical quality. For example, Geisinger Health System recently reported the success of its ProvenHealth Navigator PCMH model in producing savings of 4.3 to 7.1 percent in total cost of care for Geisinger Medicare Advantage health plan members. Although Geisinger has not yet reached a break-even ROI on the model, savings trends suggest that this break-even point will be achieved as more members get longer exposure to the model (Maeng, Daniel D., et al., “Reducing Long-Term Cost by Transforming Primary Care: Evidence from Geisingers’ Medical Home Model,” *American Journal of Managed Care*, March 2012).

Becky Kelly, director of payer relations at Billings Clinic, noted that in the absence of complete and timely data that can illustrate the health system’s ability to contain utilization and total cost of care to the purchaser, it is difficult to tell the organization’s “value story.” According to Kelly, the market does not recognize the difference in care models between Billings Clinic and its competitor. The demonstration of superior value requires precise, longitudinal clinical and cost data that can be analyzed by payer, employer, population, and patient basis, and Billings has made a priority of obtaining this data through investment in improved clinical and financial information systems.

Continue to bend the cost curve. Another critical aspect of strategic planning for aligned integrated systems is containing healthcare costs. “The American healthcare system is wasteful. At least 30 percent—and as much as 45 percent—of healthcare dollars is spent on inappropriate and unnecessary care,” says Glenn Steele, MD, CEO of Geisinger. “Integrated systems like Geisinger need to take the lead in showing how to make a big dent in this problem.”

Both Geisinger and Billings Clinic are working on initiatives that will continue to reduce inappropriate and unnecessary care and help contain healthcare costs. Areas of focus include care coordination, process improvement, chronic disease management, further leveraging of primary care through the addition of physician extenders, and general waste reduction.

Develop care delivery process engineering models.

Geisinger has been a national leader in end-to-end process engineering with its ProvenCare® model for cardiac vascular surgery. Albert Bothe, MD, executive vice president and chief medical officer for Geisinger, noted that gaining agreement from cardiovascular surgeons on what the model should look like was not easy. “Our six cardiovascular surgeons had eight different ways of doing cardiac vascular surgery,” Bothe said. “Thanks to the commitment of the chief of cardiac surgery, an agreement on standard processes for cardiac vascular surgery was reached; the process took six months. Now, there are 41 elements that need to be completed every time.” Geisinger developed a scorecard to gauge the progress of its cardiovascular physicians in following the agreed-upon processes. “At the end of the pilot, we had a 55 percent compliance score. Four months later, we reached more than 95 percent compliance,” Bothe says.

ProvenCare® continues to roll out new initiatives. Cataract surgery, cardiac catheterizations, and hip replacement surgery all have been incorporated into the ProvenCare® model; common care processes for low-back pain, epilepsy, and brain tumors are currently being examined.

Process engineering is not only important for cost containment, but also for quality improvement. System leaders leverage their investments in clinical and financial systems to find opportunities for streamlining of care delivery. Earl Steinberg, executive vice president, innovation and dissemination for Geisinger, defines Geisinger’s “secret sauce” as what the system has done in workflow management to increase the likelihood that particular clinical practices are performed consistently.

Some of the ingredients, such as culture and leadership, are not easily exportable. On the other hand, Steinberg noted, “We have a lot of experience with a clinical information system and analytics, which helps us use resources more effectively. These skills are exportable, as are effective care management techniques such as embedded case managers in primary care practices.”

Given the advanced capabilities that aligned integrated systems have demonstrated in utilizing data to frame performance improvement opportunities, these systems

may be better poised to expand such efforts to include cross-functional and cross-location initiatives. Some of the representatives from aligned integrated systems who were interviewed for this report acknowledged that, within their organizations, opportunities exist to better integrate across clinical departments, such as improving coordination between behavioral health and other components of the delivery model.

Focus on coordinating care of patients with chronic disease. Geisinger has 40 nurse case managers in primary care offices. As is true of other organizations that use embedded care coordinators, the focus is on patients with chronic disease where the potential savings are the greatest. Evidence-based approaches are being developed in rheumatology, nephrology, and other areas, and care protocols are being developed for use in primary care physician offices.

Billings Clinic is moving toward development of chronic diseases registries with the goal of improving its management of these populations and thus reducing costs. Adding PCMHs to its primary care practices is part of its approach.

Find opportunities for waste reduction. Since 2009, Billings Clinic has enhanced its focus on reducing expenses and waste, particularly related to supplies and contracting costs. The use of Lean Six Sigma tools has enabled Billings Clinic to achieve \$16 million in savings since 2009. Expected savings for 2012 are about \$8 million.

Billings Clinic organizes its Lean efforts—which are captured in the system’s strategic plan as “operational excellence initiatives”—around the core buckets of supplies, revenue cycle, patient throughput, patient access, and productivity, asking departments within its 19 “value streams” (e.g., radiology, laboratory, cardiology) to identify and define projects to help the organization achieve its operational excellence goals. With cost containment initiatives related to supply costs and revenue cycle well underway, the organization is now turning its attention to productivity initiatives. Billings Clinic has established a “no layoff” policy to encourage front-line staff to participate in performance improvement projects without worrying that they will perform themselves out of their jobs. It believes that it can carefully manage employee attrition to ensure that employees whose roles are affected by performance improvement projects will be able to find similar positions elsewhere in the organization.

In an interview with HFMA’s Value Project, Geisinger Health System’s chief innovation officer, Jonathan Darer identified four major themes for addressing excess cost and waste in the healthcare system:

- Improve advanced serious illness and end-of-life care.
- Reduce variation in the use of high-cost therapies (e.g., pharmacy and high-cost medications) and high-cost diagnostics (e.g., high-end imaging).
- Engage patients more fully.
- Reduce the potential for preventable harm through clinical decision support.

The bottom line: Containing healthcare costs requires multi-faceted approaches, and there is not a “silver bullet” path to savings.

Strengthen the care continuum. This strategy is of particular importance to aligned integrated systems intending to move more quickly toward population risk management. There are several dimensions to strengthening coordination of care across the continuum, including the following:

- Expanding the scope of services
- Improving alignment with network providers
- Partnering strategically with other providers

These strategies are related to physician and care team linkage capabilities on the road map.

Expanding the scope of services may be necessary for organizations positioning themselves to deliver population health management. Integrated systems may have to enter fields that are unfamiliar or not as attractive financially. For example, Billings Clinic does not offer rehabilitation and OB/Gyn services because these services are provided by another community hospital. If its goal is to deliver population health management, Billings Clinic may need to determine how to manage coordinated care for these services through such options as strategic partnerships or contracting.

Many integrated systems are comprised of employed and contracted physicians. Contracting is used to fill geographic or service gaps or, in some cases, to broaden market appeal. Performance on quality and cost may vary between the integrated and contracted components of the delivery system. As aligned integrated systems strive to ensure consistent performance in all geographies in which they operate, gain market share, increase their scale

and stretch their geographic boundaries, it is important that they experiment with ways to align providers and coordinate care across the delivery system. This work requires capabilities related to performance assessment, compensation alignment, and strategic partnering.

Group Health Cooperative is determining what standard measures and metrics to require for all of its network providers. The organization also is reviewing what core capabilities the health system can offer its network providers. “We have experience in managing populations and risk; how do we best bring that set of capabilities to our network?” says Scott Boyd, Group Health Cooperative’s vice president of finance.

Some aligned integrated systems have achieved this type of alignment through scale and influence. Geisinger Health Plan contracts with nearly 3,000 independent physicians, 25,000 specialists, and 112 community hospitals in its region. Just under half of the health plan’s revenues are paid to outside providers. Duane Davis, MD, CEO of Geisinger’s insurance operations, said the health plan “gives us an influence over providers in our three regions.” Billings Clinic has achieved significant influence in its region by combining ownership of some facilities (full or partial ownership of three hospitals, four rural physician clinics, and a 90-bed long-term care facility) with management of others (eight critical access hospitals in its service area).

Geisinger also has integrated network physicians into its PCMH model. Tom Graf, MD, who heads population health initiatives for the health system, says Geisinger modeled two medical homes in 2006 and rolled them out within six months; all of the health system’s PCMHs were completed by the end of 2010. “This is a key building block for all our other programs,” he says. A stated advantage of this approach is “the ability to reduce readmissions and comprehensively manage patients across the continuum.”

Geisinger also has opened its customized EHR to network providers as another way of strengthening ties, according to Lynn Miller, executive vice president, clinical operations.

Other participants are working toward greater alignment with network providers by augmenting their contractual terms. One participant studied by HFMA’s Value Project requires all network providers to have an EHR or risk contract termination. Dean Health utilizes the “Dean

Health Contract,” which aligns network providers to its quality, satisfaction, and financial goals.

Aligned integrated systems are also formulating strategic partnerships with other providers. One participant, Group Health Cooperative, recently announced an innovative partnership with Providence Health Care in Spokane, Wash. Seattle-based Group Health Cooperative and Providence, a 32-hospital system, have formed a joint venture to offer a single delivery network in Spokane available to any payers or employers interested in contracting with it; this is the first time that Group Health has made its physicians and clinics available to commercial subscribers of other health plans. The initiative combines Group Health’s 119 physicians and other professionals, accessible from 16 locations, with the 276 physicians and professionals in Providence Medical Group. Collectively, these organizations will provide the largest provider network in the region. This presents significant opportunities for longitudinal care coordination that serves a large population as well as population-based risk contracting.

Play a leadership role in achieving value-enhanced outcomes. An opportunity for aligned integrated systems to stay ahead of their competitors and distinguish themselves favorably with payers lies in their ability to use clinical, financial, and satisfaction data to report on quality in terms of functional outcomes.

There are different ways in which an integrated system could pursue this opportunity. For example, organizations with a health plan could pilot an approach with an engaged employer of sizeable membership to improve outcomes where data have indicated areas for improvement. Conducting focus groups with a subset of employers or patients also might be helpful in defining a starting point for functional outcomes measurement. Entities with a research arm, such as Geisinger, might consider focusing on the area of outcomes definition and measurement.

Experiment with value-based payment methodologies. Aligned integrated systems participating in HFMA Value Project research appear to be selective in how they are experimenting with value-based payment. A key distinction among aligned integrated systems is that some own significantly sized health plans, while others

do not. Ownership of a health plan affords systems some leeway to experiment with population-based risk payment arrangements.

Other integrated systems, such as Cleveland Clinic, are pursuing opportunities to experiment with value-based payment arrangements with purchasers. For example, Cleveland Clinic has established a payment arrangement with Lowe's, a self-insured employer. Under this arrangement, Cleveland Clinic is paid a fixed amount per patient for certain types of tertiary services. Cleveland Clinic, Geisinger, and Scott & White are three of six health systems around the country that are participating in a Walmart "Centers of Excellence" program. The program will provide heart, spine, and transplant surgeries at no out-of-pocket cost to Walmart associates under bundled pricing arrangements that Walmart has negotiated with the systems.

Billings Clinic offers another example. The health system's large, sparsely populated service area presents particular challenges for Billings Clinic as it considers opportunities for population management. Because most of the clinic's patients coming to Billings from the secondary or tertiary service area are referrals to Billings Clinic's specialists, these patients return to their communities for primary care. Billings Clinic's relatively low proportion of primary care physicians to specialists—20 percent to 80 percent—reflects eastern Montana demographics and referral patterns.

Because population-based value payments are likely to be established in the future, Billings Clinic is in the early stages of developing bundled payment for certain orthopedic procedures. The clinic intends to pursue a bundled payment with CMS's Innovation Center. "We won't make money on it," says Nick Wolter, MD, Billings Clinic's CEO. "We are undertaking this initiative to learn more about what bundled payment requires."

Experiment with approaches to more fully engage patients.

Aligned integrated systems are often well positioned to experiment with ways to improve patient engagement and accountability. Engaging patients is related to other value-based strategies, such as containing healthcare costs and outcomes reporting. Experimentation with patient participation relates to stakeholder engagement, analytical and data capabilities, and process engineering.

Geisinger is a leading example of an organization that is pushing the envelope on such experiments: Its ProvenCare® pathways detail process steps and accountabilities not only for clinicians, but also for patients. Geisinger also aligned its health plan design to encourage patients to engage in the ProvenCare® pathways by offering lower patient charges for participation.

Organizations interested in experimenting with ways to engage patients should develop data warehouses and analytics capabilities to better assess the effectiveness of different approaches. For example, analyses of socioeconomic and demographic information could help an organization determine the effectiveness of different patient engagement strategies for distinct subsets of patients. Process improvement capabilities are necessary to map and implement the process steps involved in the new approaches.

Pursue strategic partnerships with payers. Due to their size and influence, some aligned integrated systems may have unique opportunities to partner with commercial payers on payment experiments and obtaining funding for value-related infrastructure development. Billings Clinic is an example: The health system is in the second year of a three-year arrangement with Blue Cross that is focused on the establishment of PCMHs. Billings Clinic is one of two providers in the state that are working with Blue Cross on PCMHs. Per the terms of this arrangement, next year, Billings Clinic will be actively building the structures and processes required in a PCMH model, including adding care navigators. Blue Cross is paying a per-member, per-month rate for all attributed patients in a PCMH, on top of its regular discounted fee-for-service rates. Billings Clinic intends for all of its primary care to be delivered in a PCMH model, and is working through that transition now.

Partnering with payers on payment experiments or infrastructure funding may be a strategy that is more available to aligned integrated systems *without* sizeable health plans, such as Billings Clinic. Some integrated systems with health plans do not contract their delivery operations to competing plans (until recently, this was the case with Group Health Cooperative). And, in some markets, the competing carriers may not be interested in partnering with the delivery system of a competing plan.

A more viable option for aligned integrated systems with health plans, as well as those without, may be contracting with self-insured employers as a means of gaining experience with population risk management. When Cleveland Clinic negotiated its unique arrangement with Lowe's, the home improvement company, Lowe's customized its benefit design to financially encourage its employees to use this care pathway (for instance, by providing a specialized travel benefit for employees who traveled to Cleveland Clinic for care). Other systems may want to consider contracting with self-funded employers in similar arrangements, or to provide across-the-board services for local employers to gain experience with population risk management.

Geisinger Health System is taking a cutting-edge approach to partnering with employers. The organization is interested in learning how the innovations that have been successful at Geisinger can be "scaled and generalized" for other organizations. Geisinger's Duane Davis, CEO of the health system's insurance operations, noted that the organization has begun a third-party administrator service, working with a West Virginia health system in managing the health system's self-insured population. "Self-insured populations are an obvious place to start," Davis says. "They provide both a business reason and a population to work on."

Pursuing opportunities to partner with payers (e.g., health plans and employers) relates to the contracting capability in the aligned integrated systems road map.

OTHER STRATEGIES AND INITIATIVES

There are numerous additional initiatives that the aligned integrated systems studied by HFMA's Value Project are evaluating in their transition from volume to value. Suggested action steps include the following.

Encourage physician leadership and decision making.

Successful aligned integrated systems have strong physician leadership involved in strategic decisions and care delivery transformation. Mark Rumans, MD, physician-in-chief for Billings Clinic, noted that although structures such as paired leadership models can be managerially complex, having physician leadership in place can make execution happen more quickly once decisions are made. "It can take a lot of time to process a decision," Rumans says.

"We have to be thoughtful; our actions impact the community. But, once we decide to do something, we can move quickly toward implementation."

At aligned integrated systems, cultivating physician leadership is an ongoing priority. For example, physician leadership development is of continuing emphasis at Billings Clinic. In addition to the formal leadership accountabilities described above, development opportunities include serving on committees or leading initiatives. Also, there is a formal training component to physician leadership development involving courses such as emotional intelligence and effective coaching.

Continue to invest in business intelligence. Although both Geisinger and Billings Clinic have had sophisticated clinical information systems for years, there are continuing opportunities to combine clinical and financial information to improve overall decision making within the organizations.

Geisinger's business intelligence capabilities are well respected by hospitals and health systems across the country. The organization has developed and integrated numerous customized applications into its EHR, which also houses reminders and a patient portal. Geisinger has a substantial data warehouse that is populated with financial information from its mainframe-based decision support system, clinical information from its EHR, and claims data from its health plan. There are an estimated 200 users of the warehouse. The system also operates Keystone Health Information Exchange; 34 Pennsylvania organizations are involved.

Additionally, Geisinger has access to the data needed to understand the variable and fixed costs for each service it provides, and has the ability to aggregate financial data for an episode of care. With the data available, Geisinger can produce analyses of cost per product and cost per contract, patient analyses, and dashboards. The health system's financial and clinical support department can calculate estimated net revenue for proposed contracts, which is helpful in contract negotiations.

Even with these advanced capabilities, there is room for Geisinger to bolster its business intelligence. Opportunities include finding better measures of outcomes (not just quality processes) and using business intelligence to better position the system for population health management. The latter ideally involves economic and demographic data as

well as epidemiological information on the specific market area and population targeted for management.

Billings Clinic is investing in a new system to improve its business intelligence capabilities. The health system anticipates that it will achieve improved functionality in 18 months, with an initial emphasis on clinical data and analytics. Nick Wolter, CEO of Billings Clinic, indicated that improved business intelligence capabilities will help Billings Clinic further develop its integrated model.

Additionally, Wolter envisions that improved business intelligence capabilities will enable the organization to further develop its chronic disease registries and population management capabilities. Stemming from its participation

in the Physician Group Practice Demonstration, information for Billings Clinic’s diabetic patients is maintained in a registry overseen by two registered nurses. Patients with congestive heart failure are also included in such a registry; patients call in their vital signs daily, and when the need for follow-up care is indicated, nurses arrange for patients to be seen so they can receive treatment that might help them avoid hospitalization. Wolter estimates that inpatient admissions from these two groups have been reduced by 35 percent, or \$3 million per year. “We’re going to do some good things, and it’ll cost us some revenue. But, if we’re seen as providing higher value, we’ll make up for it in increased volume,” he says.

ALIGNED INTEGRATED SYSTEM RESEARCH PARTICIPANTS

Participating Organization	No. of Physicians	Mix PCP/ Specialist	No. of Primary Care Sites	Market Served	Payer Mix*	Geography
Billings Clinic	280	20% / 80%	7	Urban/Rural	39% Medicare 17% Medicaid 30% Commercial 8% Self-Pay 6% Other	Eastern Montana & Northeast Wyoming
Cleveland Clinic	600	10% / 90%	50	Urban/Suburban	Not Reported	Northeast Ohio, South Florida, Nevada
Dean Clinic	500	45% / 55%	60	Suburban/Rural	30% Medicare + Medicaid 50% Dean Health Plan 20% Other	Southern Wisconsin
Geisinger Health System	1,000	30% / 70%	70	Urban/Rural	28% Medicare 15% Medicaid 27% Commercial 27% Geisinger Plans (including 12% Medicare Advantage)	Northeastern Pennsylvania
Group Health Cooperative	1,067	55% / 45%	25	Urban/Suburban	Not Reported	Washington, Northern Idaho
Scott & White	900	33% / 67%	30	Urban/Rural	37% Medicare 22% Medicaid 37% Managed Care/ Commercial 4% Other	Central Texas
Spectrum Health System	585	27% / 73%	48	Urban/Suburban	44% Medicare + Medicaid 56% Commercial	West Michigan

* Payer mix is based on inpatient discharges including normal newborns. Revenues to integrated systems’ own health plans are included in the payer mix estimates above.

RECOMMENDATIONS

As they prepare for value-based business models of care and care delivery, hospitals and health systems in the other four cohorts can learn from aligned integrated systems. These systems are advanced in aligning financial incentives. They have significant experience with sophisticated EHRs and in analyzing data from these information systems. Their skills in clinical care coordination put them among leading hospitals and health systems in the country in this area, and their focus on innovations in outpatient care (particularly for patients with chronic disease) holds promise for further reducing costs. Additionally, aligned integrated systems demonstrate that physician leadership not only works, but is a key to success.

The challenge for aligned integrated systems is to stay ahead of competitors as they take steps to better coordinate care and amass scale. Recommendations for aligned integrated systems include the following.

Invest in capabilities to demonstrate the value of the integrated model. It may take a long time to achieve market recognition for integrated care, particularly in markets dominated by strong single-specialty medical groups, specialty hospitals, and physician-owned ambulatory imaging and surgery centers. Investing in clinical and financial data and the ability to analyze such data longitudinally and at the payer, employer, population, and patient level is critical to demonstrating that aligned integrated systems deliver better quality at a lower total price. Additionally, such capabilities are critical for organizations interested in population health management and associated financial risk.

Continue to bend the cost curve. As reported in *Defining and Delivering Value*, employers and governmental payers face increasing pressure to contain expenditures on health care, and the demands on healthcare providers to better contain costs are escalating. Aligned integrated systems are well positioned to lead the charge in curtailing the annual rate of increase in health expenses. Key capabilities for bending the cost curve include business intelligence, process engineering (including opportunities to improve care coordination across functions within the existing

integrated delivery network), leveraging of primary care, focusing on chronic disease management, and experimenting with ways to improve patient engagement. Additionally, aligned integrated systems with health plans that are cross-subsidizing substantially among payers should evaluate the sustainability of such practices and develop cost containment plans accordingly.

Lead on outcomes measurement and reporting. The dimension of quality that payers and patients are most interested in is outcomes, including those that report on return of patient functionality. Many aligned integrated systems are well positioned to lead in outcomes definition, measurement and reporting, given their control of many elements of the care continuum, prior investments in business intelligence, and cultural orientation toward measurement and improvement. Integrated systems should consider strategic partnerships with employers or other payers to undertake this work, which could further distinguish the value of integration.

Pursue contracting arrangements and build capabilities to improve value. Organizations intending to move toward population risk management need to define, assess, and fill in the care continuum through services or strategic partnerships with purchasers or other providers. Partnerships with payers, including self-insured employers, can provide opportunities to experiment with population-based payment models.

Organizations not ready to accept population-based risk should take steps toward improving their capabilities to manage care at the population level. Aligned integrated systems can pursue bundled payments as a way to experiment with improved care coordination across settings, for example, or can add care coordinators and develop disease registries to augment care for patients with chronic conditions.

Aligned integrated systems are learning organizations; they are generally not satisfied with the status quo and have a strong cultural orientation toward continuous improvement. This pursuit of excellence will prove crucial to the continued success of these systems in a value-based environment.

MULTIHOSPITAL SYSTEMS

Most multihospital systems have been designed to take advantage of economies of scale. How will they reorient their organizations to optimize their advantages under value-based reimbursement? For example, how will they reprioritize what services to centralize and what to customize to local conditions? And, how will they further engage physician leaders in their efforts to improve value?

For purposes of this discussion, a multihospital system is defined as a health system with more than one hospital. Many multihospital systems include a mix of urban, suburban, and tertiary care hospitals and safety-net facilities. Some multihospital systems operate in more than one state.

As part of HFMA's Value Project research, 11 multihospital systems ranging in size from a three-hospital to a 39-hospital system were studied. These systems serve a mix of markets. The multihospital systems' payer mixes range from 37 percent to up to 70 percent combined Medicare and Medicaid. Of the 11 organizations studied, three operate within a single state and eight are multistate organizations. Many are in markets dominated by one or two health plans.

Two multihospital systems were selected for site visits: BJC HealthCare and Nebraska Methodist Health System.

BJC is a 12-hospital system, the dominant player in the St. Louis market, and the largest employer in the St. Louis community. BJC includes an academic medical center and research operations as well as skilled nursing facilities and behavioral health.

Nebraska Methodist has three hospitals in a competitive and rapidly consolidating Omaha market. BJC's annual revenues are approximately six times those of Nebraska Methodist.

The St. Louis market has not moved significantly toward value-based payment. In Omaha, the dominant carriers, including Blue Cross Blue Shield of Nebraska and Wellmark (Blue Cross Blue Shield of Iowa), are pursuing value-based payment mechanisms. Nebraska Methodist is working with payers to create value-based reimbursement pilots.

CHALLENGES AND OPPORTUNITIES

Multihospital systems acknowledge that they have significant opportunities to achieve cost savings from systemwide economies of scale.

KEY RECOMMENDATIONS

Multihospital systems should consider the following action steps as they position themselves for value-based business models:

- Determine the appropriate balance between centralized leadership and decision making and decentralized experimentation and control.
- Fill out or manage a broader continuum of care.
- Develop and educate physician leaders to help define strategies and drive care delivery, affordability, and other improvement efforts.
- Make integrated, updated clinical and financial analytics available to key decision makers throughout the system and to customers.
- Experiment with payment mechanisms as a means to gain knowledge, develop capabilities, and drive change.
- Continue to add scale, selecting the most advantageous partnerships through a variety of affiliation models.

Scale economies and other opportunities. These include IT system economies, supply and other purchasing economies, and revenue cycle and other "processing economies." Larger systems—such as Dignity Health and Catholic Health East—have found that the larger they get, the larger the savings opportunities available. Some indicate that the IT savings alone from joining a large multihospital system justify the move. Large multihospital systems also often have more favorable terms for accessing capital markets.

Systems that are clustered around a region—including BJC, Advocate, Fairview, and Nebraska Methodist—also benefit from "regional economies." These can include aggregating larger patient volumes for expensive equipment and programs, locations and facilities that are appealing to health plans, and the cost-effective use of a marketing budget.

Challenges. Although multihospital systems have been aggregated to take advantage of economies, they usually begin by dealing with disparate information systems and data structures across locations and facilities. Advocate Health Care continues to face challenges in reconciling disparate electronic health records. "We have one EHR

in inpatient settings and a different EHR in physicians' offices," says Dominic Nakis, CFO for Advocate. "Our IT department is building an interface between them."

Many multihospital systems operate with different physician models within the same health system; some hospitals may rely on employed physician groups, while others may rely on private practice physicians. Some medical groups may be relatively far along in developing care pathways and approaches to population management, while others are not.

The relatively decentralized physician leadership in multihospital system structures can make it more challenging to progress with clinical improvement and other strategic initiatives. Several leaders at one multihospital system commented that the lack of a physician chief operating officer at the system level slowed change in care delivery.

Many multihospital systems acknowledge they are disadvantaged with respect to having the building blocks required to develop integrated care strategies. The decentralized approach to leadership in many multihospital systems can make it more difficult to develop the team-based culture necessary to coordinate care across departments and a broader continuum. Different EHRs with disparate data definitions and structures make it harder to connect systems for effective care coordination. Weaker centralized leadership also can make it more challenging to instill common care protocols and other tenets of evidence-based practice.

Differences in governance and management between multihospital systems. Some multihospital systems make most key governance decisions at a centralized level, whereas

others emphasize local, market-specific decisions. Similarly, management processes may be more or less centralized.

When it was first established in 1992, BJC was primarily decentralized, with hospital CEOs making a high percentage of the key decisions.

Initially, the only IT system in common across the BJC facilities was e-mail. BJC has multiple versions of EHRs throughout the system. "Right away, we decided that to force standardization would be culturally unacceptable," says David Weiss, senior vice president and chief information officer. Instead, BJC built warehouses and a query process using data consolidated from the several systems. Today, system leaders are debating the organization's path forward on EHR and other systemwide IT-related strategies. CFO Kevin Roberts describes an evolving approach to centralization at BJC. While emphasizing the autonomy of the individual components of the system, BJC also is working to centralize more services.

Many other multihospital systems were early investors in systems to centralize both clinical and financial information. As a CIO from another multihospital system noted, "With common systems came common processes, from clinical protocols to the revenue cycle. And with common processes come less clinical variation, more functionality, and lower costs."

Many multihospital systems also vary substantially in terms of size and complexity (with some covering multiple states or requiring a regional level of governance in between the system and the individual hospitals). Also, some multihospital systems are dominant players within their market areas, whereas others operate in highly competitive markets.

UNIQUE CHALLENGES AND OPPORTUNITIES FOR MULTIHOSPITAL SYSTEMS

Challenges	Opportunities
<ul style="list-style-type: none"> Optimizing the system's combination of centralized and decentralized governance Relatively decentralized physician leadership Integrating physician and nonphysician management and leadership approaches Varying degrees of financial alignment with physicians Working with nonstandardized approaches to clinical and financial information systems Working toward a common culture among widespread locations 	<ul style="list-style-type: none"> Leveraging economies of scale to optimize investments and achieve cost reduction Sustaining and leveraging favorable terms for access capital Utilizing joint learning opportunities/multiple "labs" for experimentation Forming strategic partnerships Taking advantage of favorable payer relationships Managing the multihospital system's diversified portfolio of activities

THE ROAD AHEAD: STRATEGIES AND INITIATIVES

Under a value-based payment structure, multihospital system leaders expect to continue to have it both ways—to accumulate scale *and* to differentiate their businesses at the local level. Multihospital system leaders strive to deliver consistent, high quality and cost-competitive care across all components of their systems. As one BJC leader commented, “We consider our diversification to be a real strategic advantage. For example, as issues are tackled at the local level, best practices can be shared across the system.” This leader noted that diversification of operations can help a multihospital system cushion shocks in payment, volume, or revenue changes that might affect one component of the system, but not others.

Under value-based payment, multihospital systems expect to:

- Determine the appropriate balance between centralized leadership and decision making and decentralized experimentation and control
- Develop and elevate physician leaders to help develop strategies and drive care delivery, affordability, and other significant improvement efforts
- Experiment with payment mechanisms as a means to gain knowledge, develop capabilities, and drive change
- Fill out or manage a broader continuum of care
- Improve cost structure by streamlining and integrating information systems and data structures

Like other providers, multihospital systems should coordinate a number of initiatives to position themselves for the future. These changes require capabilities that span people and culture, business intelligence, performance improvement, and contract and risk management.

Many of the changes required are similar to those described in the common road map. However, some initiatives that multihospital systems should tackle are unique or of particular emphasis to this type of organization and are highlighted in bold on the multihospital system road map.

Determine the appropriate balance between centralized leadership and decision making and decentralized experimentation and control. This initiative requires capabilities in the areas of governance, strategy and structure, management, and communications and culture.

As multihospital system leaders revisualize their systems, they are making a subtle change in emphasis, from viewing the system as a group of hospitals and other businesses toward a care management system, with a collection of business units pursuing a common set of services.

Leaders in multihospital systems are focusing on articulating consistent systemwide messages, strategies, and cultures around both quality and cost improvement. “We are trying to take hundreds of millions of dollars out of the system. But with crossfunctional teams of front-line caregivers, that is not the lead message from a change management perspective,” says Fred Hargett, Novant’s CFO. Instead, leaders at Novant have refined the message so that it focuses on optimizing the patient experience, including delivering efficient care.

Multihospital system leaders are also reassessing centralized versus decentralized and standardized versus customized functions. In general, the direction multihospital systems are taking is toward more centralization. For some multihospital systems, the goal is “for every patient that visits any service, anywhere in the system, to receive the same evidence-based care.” On one hand, the move to integrated systemwide patient information and evidence-based medicine provides a major impetus to standardization, BJC leaders say. On the other hand, leaders question: “Do we really want the same level of process and cost overhead at our downtown academic centers as we do at our small rural facilities?” The answer for many multihospital systems is an area-by-area reevaluation of what should be standardized.

Organizations are using systemwide planning efforts to create a focus on cost containment and care delivery transformation. At Novant, every director and above has aligned incentives to contain costs; at Baptist Health South Florida, incentive alignment is geared toward performance on quality. BJC uses an even stronger approach to incentive alignment. At the executive level, including senior leaders at the hospitals, 15 percent of compensation is considered variable and driven by performance on financial *and* quality initiatives. System employees’ incentives are a composite of targets related to quality and financial performance on high-impact initiatives.

At Fairview, employed physician incentives are at the population level, such as per-member, per-month metrics.

Develop and elevate physician leaders. Numerous physician-related initiatives are being undertaken as multihospital systems anticipate population health management. Meanwhile, many multihospital systems acknowledge that they are “behind the curve” in the critical task of developing and then fully utilizing physician leaders.

Integrate the actions of physician organizations across the system. Many multihospital systems are integrating physicians by creating a governance and management structure that encompasses all physicians that practice within the health system. These umbrella organizations range from informal leadership groups to affiliated corporations and ACO-like organizations. Integrated physician groups can pursue common approaches to disease management and care protocols, and may also achieve economies of scale in purchasing and improved access to capital.

Elevate physician leaders within the senior level management process. Leading multihospital systems are taking specific steps to develop strong physician leadership to ensure that physicians are involved in strategies ranging from care delivery to affordability and other key areas. More than 100 physicians participate regularly in the management activities of Advocate Health Care. Further, leaders from Advocate Physician Partners and Advocate Health Care meet regularly to chart the course of the overall enterprise. A key part of this activity is promotion of physicians within the organization to higher ranks of senior leadership.

Align physician financial incentives to organizational goals. Some multihospital systems are pursuing strategies to improve the financial alignment between physicians and hospitals. Advocate Physician Partners, a joint venture between physicians and Advocate Health Care, structures its physician incentive plan around a set of measures in

MULTIHOSPITAL SYSTEM ROAD MAP TO VALUE		
LOWER ←		
ORGANIZATIONAL CAPABILITIES		
People/Culture		
Governance	Educate Leadership	Revisualize the System
Strategy and Structure	Bend the Cost Curve	Adjust Centralized/Decentralized Functions
Management	Align Business Unit Incentives	
Physicians	Educate	Develop Leaders
Staffing and Skills	Assess Needs	Plan Attritions
Communication and Culture	Articulate the Value Message	Educate
Business Intelligence		
Clinical Information Systems	Develop EHR + Data Architecture	Implement EHR Systemwide
Financial Reporting and Costing	Connecting Systems, Data	Directional, Limited
Performance Reporting	Core, Process Measures	Strategic Measures
Analytics and Warehouses	Review Data Governance	Integrate Clinical, Financial Data
Performance Improvement		
Process Engineering	Prioritize Targets	Spotlight Process-Based Scorecarding
Evidence-based Medicine	Patient Safety	Readmissions and Hospital-Acquired Conditions
Care Team Linkages	Evaluate Primary Care Sufficiency	Expand Care Teams
Stakeholder Engagement	Create Transparency	Educate Patients
Contract & Risk Management		
Financial Planning	Review Capital Allocation Strategy	Integrate Business Unit Budgeting
Financial Modeling	Maintain Short Term View of Performance	
Risk Modeling	Analyze Profit/Loss	Estimating Financial Exposure
Contracting	Negotiate Prices	Partner with Quality

such areas as medical and technological infrastructure, clinical effectiveness, efficiency, patient safety, and patient experience. The measures, based on national best practices, research findings, and other recognized benchmarks, also align with Advocate Health Care’s strategic objectives. Physicians are awarded points based on their achievement of the measurements, and physician bonus payments are based on the number of points earned.

Nebraska Methodist has developed a similar point system for sharing the benefits of a new bundled payment pilot and other planned value-based payment initiatives. Points are assigned for elements of preprocedure primary care, the operation itself, and post-care activities, structured in a way that shares accountability across physicians (an anesthesiologist, for example, may receive points for reminding a surgeon to complete a certain task). The points are monitored to ensure compliance, added

up, divided by the shared savings amount, and allocated. The system is also developing a module within its business intelligence application to enable physicians to keep track of their points.

Experiment with payment mechanisms. Experimenting with payment relates to cultural, business intelligence, and contracting capabilities on the road map.

Many multihospital systems recognize they have a unique market position (e.g., geographic coverage, market positioning, scale), and this gives them an opportunity to experiment with value-based reimbursement contracts. Multihospital systems also report these contracting arrangements can lead to other, secondary gains for the system.

More specifically, some multihospital systems may be positioned sufficiently to pursue population-based risk arrangements. Such organizations are more likely to have control or access to clinical and financial longitudinal

Degree of Care Transformation & Financial Sustainability				HIGHER
STRATEGIES & INITIATIVES				
Integrate Business Unit Perspectives			Augment Governance	
Develop Systemwide Strategic Plan			Develop Networkwide Plan	
Redesign Scorecards			Monitor/Adjust Performance	
Elevate/ Integrate/Coordinate Physicians	Assess Performance	Align Incentives	Lead Strategies and Initiatives	
Add Strategically	Educate	Align Incentives	Enhance Leadership	
Engage Stakeholders			Experiment with Payment, Care Delivery	
Establish Alerts		Establish Disease Registries		Develop Data Exchanges
Precise, All Settings		Longitudinal	Complete Per Member, Per Month Costing	
Outcomes			Population Based	
Develop Analytics		Expand Databases	Support Real-Time Decisions	
Reduce Variation		Focus Cross-Department	Focus Cross-Continuum	
Standards, Protocols		High-Risk Care	Chronic Conditions	Wellness
Right-Size Specialty		Manage Care Network		Manage Care by Setting
Share Decision Making			Establish Patient Accountability	
Develop Network-Level Budgeting and Reporting				Quantify Initiatives
				Conduct Multifactorial Scenario Planning
Utilize Predictive Modeling			Develop Risk Mitigation Strategy	
Experiment with Value-Based Payment (VBP)		Partner with Payers		Prepare for Second-Generation VBP

data across a continuum of care considered sufficient for population risk management purposes, and perhaps some experience managing care by setting. Multihospital systems with stronger primary care foundations, the ability to analyze data at the payer, population, and patient level, and the capability to establish a strategic partnership with a payer (e.g., health plan or self-insured employer) also are better suited to move more quickly to population health management.

Readiness for population risk management is an important consideration as organizations determine what types of payment experiments are best for their organizations. Embarking on this type of arrangement in a way that does not pose undue financial risk to the multihospital system could be an excellent way to prove out capabilities to be successful with this type of payment model.

Conduct contracting experiments with a subset of the system.

“Experimenting with selected hospital and physician groups within the system is a way of putting one foot in the water,” one multihospital system CFO says. Also, one multihospital system is negotiating with a major commercial carrier to provide bundled specialty services in a value-based payment arrangement.

Experiment with pay for performance to drive readiness.

Multihospital systems appear to be relying heavily on experimentation with payment models as a tactic to drive change. Baptist Health South Florida is seeking unique payment arrangements. For example, it has contracted with a Caribbean island to provide inpatient care to its citizens for a fixed amount. In this shared savings/loss arrangement, Baptist Health is placing case managers on the island to find opportunities to continue outpatient services and avoid inpatient care when appropriate.

Advocate Health Care has established a shared savings arrangement with Blue Cross Blue Shield of Illinois, and is acting on early experience by adding care coordinators and an actuarial analyst to bolster its performance in this payment model.

Fairview Health and OSF HealthCare are both Pioneer ACO participants. According to its CFO, Daniel Fromm, Fairview’s participation as a Pioneer ACO was a deliberate move to extend the system’s population management capabilities to their Medicare population.

Experiment with narrow network products. Nebraska Methodist Health System negotiated a unique arrangement with Blue Cross Blue Shield of Nebraska. The multihospital system will be part of a narrow panel network product that mirrors the “bronze” plan the carrier will offer in an insurance exchange.

Use contracting experiments to add still more scale.

Multihospital systems are in an excellent position to add partners. Many multihospital systems recognize that they are in a position to choose their future partners from among several options. Some of these arrangements are strategic linkages as opposed to mergers, such as ACOs that span more than one health system. For example, Nebraska Methodist Health System has entered into an ACO with an academic medical center that competes with it in the Omaha market.

Fill out or manage a broader continuum of care. This is a key area of capability development for many multihospital systems. With the move toward population-based management, a host of services need to be coordinated, from primary care to inpatient care, rehabilitation, home care, wellness care, and hospice services.

Evaluate sufficiency of primary care. Given its significant role in effective population care management, many multihospital systems are measuring primary care access and purposefully expanding it. Actions such as creating PCMHs, adding physician extenders, and creating patient and caregiver portals are underway. Some organizations also are working to reduce “leakage” (i.e., decreasing the number of referrals that leave the system for specialists elsewhere).

Identify the continuum. Multihospital systems are making a series of make/build/buy/partner decisions to provide the full continuum of care and service across their service area. Multihospital systems that cover a large geographic area are buying services in one community and contracting in another.

Integrate the care continuum. This raises potentially new issues. For example, developing a consistent, evidence-based approach to home care may require multiple affiliates, some of which cross state lines. Managing a broad

care network consistently across diverse geographies and market areas creates complexities that are somewhat unique to this cohort.

Improve cost structure. Improving cost structure is an important area of emphasis as multihospital systems strive to improve value in a more transparent market environment. BJC is taking a number of steps to improve cost structure. It has established several systemwide cost-related initiatives in which all of its facilities are required to participate. These include volume performance index analysis, accomplishing annual improvements in labor costs, holding unit cost increases to two percent or less annually, and accomplishing significant savings in supply costs. BJC leaders visited Memorial Hermann in Houston to understand that system's success in supply cost management. Additionally, BJC's cost-containment road map includes reductions in readmissions, specific quality improvement initiatives, and appropriate use of ancillary services in inpatient settings.

Multihospital systems have a particular opportunity to improve efficiencies by standardizing or otherwise connecting information systems and data. Baptist Health South Florida leaders spoke about the lead time in gathering reimbursement data across its multiple locations, a challenging process given the differing financial systems that exist and the lack of connectivity among them. At CHRISTUS Health, CFO Randy Safady noted that different data definitions across hospitals and use of different data storage locations have slowed the organization's efforts to build data marts. "Our initial emphasis is on data clean up, establishing uniform definitions, and then centralizing warehousing," he says.

Multihospital systems with disparate EHRs and data structures are developing centralized approaches to data governance, prioritizing efforts to develop common EHRs and data architecture, or otherwise finding sustainable ways to connect organizationally. Such efforts involve capabilities such as strategic planning, clinical information systems, financial reporting and costing, and analytics and warehouses.

An additional, important opportunity for multihospital systems to contain cost is to focus on utilization variation. Daniel Fromm, CFO of Fairview Health, noted, "We

fully understand the imperative to bend the cost curve. If we don't do something, the results are predictable. We have to focus on utilization patterns." In its ACO, Nebraska Methodist Health System is participating on multidisciplinary committees that are identifying initiatives to contain cost and improve quality, focusing on high volume, high cost, and/or high variability services. The intent is to establish common protocols and best practices. Dignity Health has leveraged process engineering—specifically, the Lean approach—to reduce variation, and is investing further in case management capabilities to focus on high risk care. Baptist Health South Florida is investing in systems and processes related to medication administration. Advocate Health, which is experimenting with a shared savings arrangement, is concentrating on improving capabilities related to the management of high-risk care and chronic conditions.

Efforts to standardize care delivery approaches across locations will be helpful to a multihospital system not only in its efforts to improve quality and contain cost, but also to deliver a more consistent level of performance across its locations. Minimizing variation—and variability in performance—across the system will be important in a more transparent, value-driven market environment.

OTHER STRATEGIES AND INITIATIVES

Multihospital systems, as well as other forms of health delivery systems, need to coordinate a significant number of parallel change processes if they are to fare well under value-based payments. Strategies that will help multihospital systems include the following.

Invest in staffing and skills. As the payment environment transitions, multihospital systems, like other cohorts, are most likely going to require staff with specialized skills that are not familiar to their organizations. For example, Advocate has invested in actuarial staff and care coordinators as it gains experience in a shared savings arrangement. A commercial carrier sends Advocate complete longitudinal patient data for the patients attributed to Advocate in the shared savings arrangement, which the actuary analyzes and discusses with staff in care delivery, finance, and other departments to formulate improved approaches to care management.

MULTIHOSPITAL SYSTEM RESEARCH PARTICIPANTS

Participating Organization	No. of Hospitals	No. of Staffed Beds	Market Served	Payer Mix*	Geography
Advocate Health Care	9	3,025	Urban/Suburban	38% Medicare 15% Medicaid 39% Managed Care 7% Self-Pay 1% other	Chicago area
Baptist Health South Florida	6	1,504	Urban/Suburban	25% Medicare 12% Medicaid 55% Commercial 8% Other	Miami area
BJC HealthCare	12	3,242	Urban/Suburban	60% Medicare + Medicaid 33% Commercial 7% Other	St. Louis, Mo., area and eastern Illinois
Bon Secours Health System	14	2,570	Urban/Suburban	65% Medicare + Medicaid 30% Commercial 5% Self-Pay	KY, MD, NY, SC, VA
Catholic Health East	23	6,262	Urban/Rural	48% Medicare 19% Medicaid 28% Commercial 5% Self-Pay	DE, FL, GA, ME, MA, NJ, NY, NC, PA, CT, AL
CHRISTUS Health	24	4,479	Urban/Rural	50% Medicare 10-20% Medicaid 30% Commercial, Self-Pay	AR, LA, NM, TX
Dignity Health	39	8,559	Urban/Rural	42% Medicare 21% Medi-Cal/Medicaid 28% Commercial 9% Self-Pay/Other	16 states
Fairview Health Services	7	1,637		25% Medicare 15% Medicaid 45% Commercial 5% Self-Pay	Minneapolis-St. Paul, Minn., area
Nebraska Methodist Health System	3	550	Urban/Rural	40% Medicare 10% Medicaid 47% Commercial 3% Self-Pay	Omaha, Neb., and southwest Iowa
Novant Health	13	2,725	Urban/Suburban	45% Medicare 15% Medicaid 35% Commercial 5% Self-Pay	NC, SC, VA
OSF HealthCare	8	1,260	Urban/Suburban/Rural	44% Medicare 15% Medicaid 35% Managed Care/ Commercial 6% Self-Pay	IL, MI

* Payer mix is based on inpatient discharges including normal newborns.

Continue to invest in clinical information systems. At Novant, “Information technology is the biggest area of investment related to payment environment,” CFO Fred Hargett says. Novant is holding off on upgrading its costing capabilities, Hargett noted; “We can only do so much at one time.” Advocate is similarly placing its highest investment priority on standardizing and mining clinical information.

At Bon Secours, the system’s CFO, Melinda Hancock, sees opportunities to better mine the organization’s EHR to identify opportunities for savings and quality improvement, such as reductions in variation. “I would rank this ahead of coding, data marts, or costing systems,” she says.

Upgrade costing and financial reporting. Multihospital systems resemble other cohorts in terms of the steps they are taking to improve the granularity and breadth of costing data. Fairview Health, for example, determined that its inpatient costing data were sufficient and instead decided to prioritize costing capabilities at the practice level to determine profitability by physician. Fairview is focusing on processes, assumption sets, and allocation models to get this information set up right.

Advocate Health Care has decided to invest in a new cost accounting and budget system, which should help the organization improve efficiencies. Unlike Fairview, Advocate is implementing its cost accounting system in the hospital, to focus on inpatient and outpatient services rather than physician practices. The new system integrates cost accounting and budgeting, so budgeting processes should become more standardized and electronic.

As noted in the Value Project’s *Defining and Delivering Value* report, payers are increasingly requiring evidence of providers’ ability to contain costs. Multihospital systems, like other types of providers, should aim to deliver financial information that can show, per payer (e.g., health plan or employer), the total cost of care over time for that population, down to a per-member, per-month basis.

Manage care by setting. Advocate has invested in software that allows the system to assess how patient care is being managed end-to-end, to find opportunities to deliver care across venues in more cost effective ways, and to identify higher cost situations that can be managed by case managers.

Fairview Health also is gaining experience in managing patient care by setting. The system is looking at metrics like per-member, per-month cost for prescriptions, zeroing in on total cost of care as well as specific claims, and seeking opportunities to manage patients well in lower cost settings. Although the analytical function is housed in contracting, both financial and clinical staff are working with claims, clinical, and financial data.

Engage the patient. Multihospital systems appear to be following a path to patient engagement consistent with other cohorts. However, multihospital systems may have advantages and disadvantages in developing these capabilities. An advantage is the opportunity to experiment with different approaches in different locations, and share best practices. A disadvantage is that different locations may serve very different patient populations with characteristics that make it difficult to translate best practices from one location to another.

Develop network-level budgeting and reporting. Multihospital systems are working toward the development of network level budgeting and reporting capabilities. They are developing financial plans for the broader network (including non-owned continuum businesses) as well as the system.

RECOMMENDATIONS

Multihospital systems have significant advantages as they evolve and transform into effective population health managers. However, numerous changes are required. Based on this research, the highly effective, sustainable multihospital systems of the future should consider the following action steps.

Determine the appropriate balance between centralized and decentralized elements of the system. Multihospital systems aim to maintain the ability to customize for local conditions and needs, but centralize key quality, business intelligence, and finance functions.

Develop healthcare systems and continuums. Leading multihospital systems are shifting from a culture of disparate hospitals and other services toward a care management system, with a collection of operations aligned toward common goals. As multihospital system leaders plan

strategically for the future, including determining what payment experiments to undertake, they will need to define the care continuum required for success. An important next step is to determine what options exist for addressing gaps in the care continuum. Multihospital system leaders are often not looking to acquire all the necessary pieces in the continuum; instead, they are seeking out strategic partnerships and focusing on effective management of care across the continuum.

Elevate, train, and integrate physician leaders into effective governing structures, with aligned incentives.

Multihospital systems should aim to involve physicians in strategic leadership positions not only related to care delivery, but also other critical areas such as organizational affordability, capital investment planning, and more.

Make integrated, updated clinical and financial analytics available to key decision makers throughout the system and to customers.

This is a significant undertaking particularly in multi-hospital systems with disparate EHRs, cost accounting systems, and data definitions, as well as those with systems gaps. To prepare for the emerging payment environment, multihospital systems

are determining how to standardize and collect longitudinal clinical and financial data. These data are critical not only for identifying opportunities to reduce variation and improve quality and cost structure, but also for demonstrating to customers the system's ability to deliver high quality, efficient care at a defined population level.

Experiment with payment mechanisms to learn how to succeed in managing care for a defined population without damaging cash flows and (often dominant) market positions.

Multihospital systems are uniquely positioned to experiment across locations and disseminate best practices. Further, they are typically large and influential organizations. They can leverage their scale to form unique partnerships with payers, employers, and other providers as a way to further experiment with payment methods and position for improved market share.

Continue to add scale, selecting the most advantageous partnerships through a variety of affiliation models.

As described throughout this section, opportunities may exist for a multihospital system to add scale through enhanced IT economies, improved purchasing arrangements, and partnerships with other provider organizations.

RURAL HOSPITALS

Rural hospitals are distinct from other types of providers because they are dominant providers in somewhat isolated markets. What advantages do rural hospitals have as the nation moves toward value-based business models in health care? What are the most important strategies and initiatives for rural hospitals as they position for success in an era of payment reform?

For the purposes of this research, rural hospitals are defined as inpatient and outpatient facilities in a service area with fewer than 50,000 residents. Rural hospitals include critical access hospitals (25 beds or less) and larger, sole community providers.

As part of HFMA's Value Project research, six rural hospitals were studied. The organizations are geographically diverse, and their payment mixes vary. Some receive full cost funding from Medicare. Among the cohort participants, the proportion of Medicare plus Medicaid revenue ranged from 59 to 80 percent. As sole community providers, many of these organizations receive cost-based reimbursement from Medicare. They tend to be more concerned about possible reductions in Medicare rates than value-based payment mechanisms employed by commercial carriers and others.

Two rural hospitals were the subject of site visits: Franklin Memorial Hospital in Farmington, Maine, and Andalusia Regional Hospital in southern Alabama. There are three key distinctions between these hospitals:

- *Physician employment.* Franklin Memorial employs 38 physicians, who comprise nearly all of its medical staff. Andalusia employs one primary care physician and one specialist.
- *Ownership.* Andalusia is owned by a for-profit system, LifePoint Hospitals. Franklin Memorial is a not-for-profit hospital that is owned, in effect, by the community.
- *Cost position.* Andalusia is able to make money from Medicare, its best payer. Franklin Memorial is experiencing strong marketplace pressures to reduce its cost structure.

CHALLENGES AND OPPORTUNITIES

Rural hospitals have several advantages over other healthcare organizations as they prepare for value-based business models of care.

KEY RECOMMENDATIONS

Rural hospitals should consider the following action steps as they position to deliver and demonstrate improved value:

- Position the organization to achieve greater scale.
- Develop financial models and plans that account for reduced revenues, including loss of critical access or sole provider funding.
- Determine the appropriate balance of primary and specialty care services to meet community needs.
- Invest in business intelligence.
- Leverage resources to strengthen community ties.

Rural hospitals are typically the dominant provider in a market area, with strong community loyalty and well-defined service areas. These attributes can help rural hospitals in negotiations with providers in larger market areas, which are likely to be interested in securing rural hospitals as a source of referrals.

One unique feature of some rural hospitals is that they offer nontraditional medical services to help meet their communities' needs. For example, Franklin Memorial provides both dentistry and mental health services. "If a behavioral issue flares up with a patient, we need the capability to provide mental health services," says Jerry Cayer, executive vice president at Franklin Memorial. "These services are integral to our ability to meet the healthcare needs of the community we serve." If these services were not provided locally, patients' needs might go unmet, or patients might have to drive long distances to larger metropolitan areas for treatment, resulting in a lack of coordinated care for the community's residents. By offering nontraditional medical services of this nature, rural hospitals can help to fill some of the gaps in the continuum of care, which could be helpful as they consider opportunities to improve the health of the populations they serve.

As smaller facilities, largely with local governance, rural hospitals generally have the ability to make informed decisions more quickly than larger systems. This characteristic is likely to be important in light of the dynamic, emerging payment environment.

But rural hospitals also face a number of unique challenges in the move toward improved value. Of all the cohorts, rural providers typically have the least amount of scale, which limits their access to affordable capital. Limited scale also contributes to difficulties in establishing comprehensive population management capabilities. In the absence of offering a continuum of care, for example, it is more challenging for a rural facility to provide all of the necessary components of total health management, from wellness to post-acute services.

Potentially significant reductions in Medicare and Medicaid funding threaten the livelihood of rural facilities. Many rural facilities benefit from critical access or sole community provider payments—Medicare reimbursement at “reasonable cost.” Organizations interviewed by HFMA’s Value Project cited the loss of these reimbursement programs as a key concern, and also expressed concern about the potential erosion of state Medicaid programs.

Key market and organization-specific differences among rural hospitals include the following.

Ownership. Many rural systems are not-for-profit and owned by the community. Some are owned by larger systems, and others have close relationships with regional hospitals.

Physician employment. Employment of physicians varies among rural hospitals. Some are, in effect, small integrated systems, while others operate with a base of independent practitioners.

Service areas. The service areas of rural hospitals vary considerably, from those serving predominantly agricultural areas to those serving small communities heavily dependent on one or two major employers. Income levels of rural households often are below state and national averages.

THE ROAD AHEAD: STRATEGIES AND INITIATIVES

Rural hospital leaders recognize that the emerging payment environment will have a significant impact on their organizations. These leaders are beginning to position for value-based payment by focusing in several key areas. Rural hospital leaders strive to:

- Position their organizations to achieve greater scale, which will improve access to capital and enable the development of capabilities required to better care for the local patient population
- Reduce readmissions to enhance quality of care and avoid financial losses under CMS’s new payment structure
- Broaden quality measurement to enhance performance on dimensions of quality beyond patient satisfaction

UNIQUE CHALLENGES AND OPPORTUNITIES FOR RURAL HOSPITALS

Challenges	Opportunities
<ul style="list-style-type: none"> • Lack of scale economies • Loss of reimbursement advantage for critical access hospitals or sole-community provider status • More limited ability to attract and retain physicians and clinical support staff • Limited access to capital at competitive rates • Need for careful consideration of financial investments • Competition from integrated and multihospital systems • Size (Not large enough to organize an ACO) • Because of infrequency of certain surgical procedures, difficulty in matching quality standards of larger hospitals/health systems or publish accurate data, which may affect payment • Risk of exclusion from insurance plan network (e.g., lab services) • Lack of reimbursement for telehealth 	<ul style="list-style-type: none"> • Take advantage of dominant position in rural market. • Build strategic partnerships or alliances, or seek virtual integration (e.g., position rural facility to offer expanded services). • Strengthen community connections. • Seek ways to benefit from the organization’s size (smaller = more nimble). • Enhance patient experience. • Look for ways to benefit from well defined service areas, which present opportunities for innovative approaches to patient engagement and population health management. • Strengthen financial viability of employed primary care physicians. • Build on strong local governance.

- Invest in business intelligence
- Find and retain physicians and clinicians
- Develop financial models and plans that account for potential reduced revenues, including loss of critical access and sole provider funding
- Leverage boards and local assets to strengthen community ties

Rural hospitals, like other types of providers, should coordinate a number of initiatives to position for success under value-based payment. These initiatives span the four value-driving capabilities of people and culture, business intelligence, performance improvement, and contract and risk management.

Many of the initiatives that rural hospitals interviewed by HFMA's Value Project are undertaking to prepare for value-based business models are recommended across cohorts, but some are specific to this cohort.

Achieving greater scale. Compared with hospitals and health systems in the other four cohorts, one of the major problems facing many rural hospitals is small volumes: They treat fewer patients and perform fewer surgical and imaging procedures. Their size also is a barrier to financing: They tend to be viewed as riskier credits.

Rural hospitals primarily use three strategies to improve scale:

- Ensuring the right mix of specialists in the community
- Increasing their primary care base
- Networking with larger systems

These strategies can help improve coordination of care, enable the development of foundational population care capabilities such as chronic disease management, and better position rural hospitals for value-based payment.

Right-size specialty services. Rural facilities are reevaluating the need for specialty services in their communities as part of their organization's strategic planning efforts. Franklin Memorial, for example, underwent a strategic planning process through which it recommitted to offering some specialty services. Wayne Bennett, the hospital's CFO, says competitive dynamics, including the emergence of value-based payment, have made it imperative that the hospital deliver these specialty services efficiently and effectively. As a result, Franklin Memorial has engaged

in an intensive effort to bend its cost curve by assessing overhead costs associated with quality management, case management, utilization review, and documentation staff as well as taking another look at vendor contracts and the use of supplies. "We are trying to figure out how to streamline and reengineer our delivery of specialty services," Bennett says. "I think there's a lot of opportunity to improve value in this area."

In addition to determining what level of specialty services is realistic and appropriate for community needs, rural hospitals also are assessing how best to deliver these services. Some organizations have opted to provide certain specialty services through telehealth partnerships. For example, Copper Queen Community Hospital has established telehealth arrangements for cardiology services and strokes and is working on a burn program.

For services provided by specialists in the community, some organizations have established suites where visiting specialists (who usually come from regional tertiary care facilities or larger multispecialty clinics) can see patients when they are in town, making it easier for these specialists to conduct pre- and post-operative patient visits. Franklin Memorial has dozens of physicians—mostly specialists from outside areas—who have admitting privileges. Andalusia has 52 physicians on its courtesy staff, and a number of specialists—representing cardiology, urology, pulmonology, neurology, nephrology, oncology, and ophthalmology—hold periodic clinics at the hospital in a strategic partnership with a neighboring system.

Increase the organization's primary care base. Adding one or two primary care physicians to a rural hospital can significantly affect care delivery, mainly because of their importance in managing patients in a value-based payment environment and the power they hold in coordinating care with specialists. Attracting and using physician extenders also can help rural hospitals bolster their primary care base. Crete Area Medical Center, a 24-bed critical access hospital in Nebraska, has taken the additional step of organizing its four physicians and three midlevel providers into patient-centered medical homes. This strategy will help the facility more effectively address underlying population care issues such as chronic disease management. As Bryce Betke, Crete's CFO, noted, "We are doing this to position for the future."

Network with larger health systems. Rural hospitals may have an opportunity to network with larger, neighboring health systems, many of which are likely to be interested in generating more referrals from rural areas. These types of strategic partnerships could better position the rural facility to gain access to specialists within the community, leverage capabilities of the system, and participate in a broader continuum of care.

For example, Crete Area Medical Center aligned with a larger health system in 2001, leveraging the health system’s expertise in Lean process improvement, PCMHs, and quality performance measurement, including readmissions, infections, medical errors, and harmful events, says CFO Bryce Betke.

Franklin Memorial in Maine has three larger systems nearby. A subcommittee of board members is charged with determining whether Franklin Memorial should align with any of these systems, and, if so, which one. A potential

advantage to Franklin Memorial of this type of alignment is augmenting the availability of specialists from the larger systems in Franklin Memorial’s community.

Networking with a larger health system provides the rural facility with the opportunity to participate in a broader continuum of care. For example, the network could complement the primary and long-term care provided by the rural facility with secondary and tertiary services. This type of affiliation could provide access to longitudinal patient data that enables total health management across the care continuum. It might also present opportunities to participate in population risk-based payment arrangements.

Reduce readmissions. Given CMS’s Hospital Readmissions Reduction Program, reducing readmissions is a matter of financial survival for rural hospitals. Because of their relatively small volume of patients, one or two bad cases

RURAL HOSPITAL ROAD MAP TO VALUE

LOWER ←

ORGANIZATIONAL CAPABILITIES

People/Culture

Governance	Review Governance	Adjust Board Composition
Strategy and Structure	Review Strategy by Segment	
Management	Align Executive Leadership	Develop Common Plans and Goals
Physicians	Educate	Assess Performance
Staffing and Skills	Assess Needs	Plan Attritions
Communication and Culture	Deliver Value Message	Educate

Business Intelligence

Clinical Information Systems	Implement EHR, All Settings	Establish Alerts
Financial Reporting & Costing	Directional, Limited	Precise, All Settings
Performance Reporting	Core, Process Measures	Strategic Measures
Analytics and Warehouses	Review Data Governance	Integrate Clinical, Financial Data

Performance Improvement

Process Engineering	Identify Methodology(ies)	Establish Cross-Functional Forum
Evidence-based Medicine	Patient Safety	Readmissions and Hospital-Acquired Conditions
Care Team Linkages	Measure Primary Care Access	Expand Primary Care
Stakeholder Engagement	Create Transparency	Educate Patients

Contract & Risk Management

Financial Planning	Rolling Calendar	Update Cash Flow Planning
Financial Modeling	Maintain Short-Term View	
Risk Modeling	Analyze Profit/Loss	Estimate Financial Exposure
Contracting	Negotiate Prices	Partner with Quality

in a rural hospital might ruin an otherwise excellent track record in reducing readmissions.

Rural providers are strengthening skills related to measurement, process improvement, and care coordination to reduce readmissions. “We are very aware of our 30-day readmissions,” says Paula Caraway, director of quality at Andalusia. “Our readmission rate had been above average and is now below average. We now conduct post-discharge callbacks with congestive heart failure patients, who have significant rates of noncompliance with post-discharge instructions.” In addition, Andalusia has established relationships with several nursing homes that provide post-acute care. Crete Area Medical Center also has initiated post-discharge phone calls to patients to try to mitigate readmissions. Copper Queen Community Hospital has established a readmissions committee charged with monitoring and reducing readmission rates, and has also established post-discharge follow-up protocols.

Measure quality beyond patient satisfaction. Rural hospitals may have traditionally emphasized patient satisfaction as a predominant indicator of quality. Today, leaders are acknowledging the importance of high performance on other dimensions of quality. Michael Swan, vice president of quality at Franklin Memorial Hospital, said that rural hospitals’ “local touch” is an important but inadequate measure of quality. “There still have to be hard measures of processes and eventually, clinical outcomes.” Expanding the definition of “quality” beyond patient satisfaction to processes of care and outcomes requires underlying business intelligence capabilities including integrated clinical and financial data, as well as analytics.

Invest in business intelligence. Both Andalusia Regional Hospital and Franklin Memorial Hospital have made ongoing investments in inpatient clinical information systems. Franklin Memorial has had a clinical information system in

Degree of Care Transformation & Financial Sustainability				HIGHER
STRATEGIES & INITIATIVES				
Educate Leadership			Augment Governance	
Assess Mergers and Alliances			Bend Cost Curve	
Align Incentives			Manage to Measurement	
Align Compensation	Develop Leaders		Lead Strategies and Initiatives	
Add Staff Strategically	Educate	Align Incentives	Enhance Leadership	
Engage Stakeholders	Experiment with Payment, Care Delivery		Take Risks	
Establish Disease Registries			Develop Data Exchanges	
Longitudinal			Complete Per Member, Per Month Costing	
Outcomes			Population Based	
Develop Analytics			Support Real-Time Decisions	
Initiate Efforts	Utilize Data	Expand Cross-Department	Expand Cross-Continuum	
Standards, Protocols	High-Risk Care	Chronic Conditions	Wellness	
Right-Size Specialty Services		Partner Strategically		Manage Care by Setting
Share Decision Making	Engage the Community		Establish Patient Accountability	
Update Capital Budgeting and Capital Access Planning			Quantify and Allocate Initiatives	
			Conduct Multifactorial Scenario Planning	
Utilize Predictive Modeling			Develop Risk Mitigation Strategy	
Experiment with Value-Based Payment (VBP)	Partner with Payers		Prepare for Second-Generation VBP	

place for 17 years, and has added almost 50 interfaces to keep the system up to date. Andalusia has taken advantage of grant funding available from the state's largest commercial carrier to acquire a system that mines patient data on infection rates and positive cultures and triggers alerts on possible hospital-acquired infections.

In ambulatory settings, Andalusia and Franklin Memorial are proceeding at different rates. Franklin Memorial, which employs nearly all of its physicians, has all of the physicians on EHRs. Andalusia, with a predominantly independent medical staff, has approximately half of its physicians on an EHR. The hospital is converting to a new clinical information system over the coming year and hopes that many of the physicians not currently on EHRs will implement them after the hospital's new system is in place.

As payment methodologies increasingly require providers to capture costs across a continuum of care, rural hospitals will also need to invest in cost accounting capabilities. Both Franklin Memorial and Andalusia are making additional investments in cost accounting in consideration of emerging payment policies.

Ultimately, the investments that rural hospitals are making in their underlying clinical and cost accounting systems should enable integration of clinical and financial data to inform organizational decision making. Attracting skilled analysts who can cross-walk clinical and financial information may be a particular challenge for rural providers: In a Value Project survey of HFMA members, only 38 percent of respondents from rural hospitals were confident that they could find a sufficient number of appropriately trained data analysts within the next three years, as opposed to 73 percent of respondents from urban organizations. Information officers at hospitals interviewed for this report are focused on growing their own talent, identifying or hiring staff with promising skills that can be cultivated to meet future analytics needs.

Find and retain physicians and clinicians. This is often a serious challenge for rural providers. Both of the organizations that were the subject of site visits offer physicians the opportunity for salaried employment.

At Franklin Memorial, offering salaries to physicians has proven effective in attracting a physician base. "The hospital got into employing physicians by accident. As

practices started to go under, we had no choice but to employ key physicians," says Jay Naliboff, MD, director of medical practices for Franklin Community Health Network. "This leaves us with a big hurdle: How do you make the practices financially viable? ACOs, with better payment for primary care, would help."

For Andalusia and its predominantly independent medical community, medical practice independence and the attractiveness of the community as a place to live and raise children are especially important. However, CFO Shirley Smith notes that it is sometimes necessary to offer a salary guarantee, and this is a financial liability for the hospital.

Develop long-range financial plans. The potential loss of special treatment—specifically, reimbursement for reasonable costs by Medicare—is of significant concern to many rural providers. Both Franklin Memorial and Crete Area Medical Center leaders indicated that the loss of this funding source represents millions in lost revenue dollars.

If critical access and sole provider funding sources were removed from the federal budget, it is likely that the arrangements would be phased out over several years. Rural hospitals are beginning to undertake multifactorial scenario planning and augment their longer-range financial plans in consideration of the possibility that these funding sources go away. Franklin Memorial, for example, has begun to quantify this impact. Crete Area Medical Center has taken the next step of discussing immediate, intermediate, and long-range steps that the organization could take if it lost its funding.

Leverage boards and community assets. It is imperative that rural hospitals compose boards of local community leaders capable of understanding the complexities of the emerging payment environment and of making tough decisions in light of this new future.

Both Andalusia and Franklin Memorial have been strategic in the ways in which they have composed the membership of their boards. The CFO of a national flooring company's local plant (1,400 employees) is the chairman of the board of Andalusia Regional Hospital. The board chair of Franklin Memorial and two additional board members are associated with a local paper mill (800 employees). Board members and the companies they are associated with

are vitally interested in the quality of care provided by the hospitals and physicians in each community and the future economic viability of the rural facilities they are serving.

Rural hospitals should provide board members with a thorough education about the potential implications of reduced revenue and shifting payment methodologies. Both Andalusia and Franklin Memorial have strong governing boards that are well-versed on value-based payment and its implications for their hospitals. Franklin Memorial's leaders have spent a significant amount of time educating hospital board members about the emerging payment environment, competitive dynamics, and internal performance drivers. Wayne Bennett, the hospital's CFO, described board members as providing "strong board leadership at the appropriate level of governance. They are proactive, not reactive."

At many rural hospitals, becoming better positioned to respond to changes in payment and care delivery, particularly on the cost side, remains a major challenge for governing boards, management teams, and physician leaders.

For example, the board of Franklin Memorial was recently surprised by a financial downturn that was attributed to reductions in average length of stay and emergency department visits, which were the result of quality improvement efforts focused on reducing readmissions. This example illustrates the complexity of understanding and navigating the steps required to be successful under value-based payment while ensuring ongoing financial viability. Ongoing education of board members and hospital leaders, as well as superior financial planning, is vital to a successful journey toward improved value.

Rural hospitals have a competitive advantage in their ability to engage the communities they serve more broadly and to foster loyalty to their facilities. Most rural organizations are viewed as valuable community assets and have unique opportunities to leverage their strong community ties as they develop capabilities to improve the health of the local patient population.

Franklin Memorial has a particularly rich history of community engagement. In the late 1960s and early 1970s, a group of physicians associated with Franklin Memorial formed Rural Health Associates, an early HMO focused on disease prevention and community health. Ultimately,

Rural Health Associates had to disband because the model needed more members to sustain the financial risks involved. Bennett noted that having a larger system partner will help Franklin Memorial as it reconsiders a population health management strategy today. Meanwhile, Franklin Memorial is beginning to develop population health capabilities such as PCMHs and chronic disease registries.

OTHER STRATEGIES AND INITIATIVES

For rural hospitals to be successful under value-based business models, there are a number of additional initiatives, as described in the common road map, that should be undertaken to support the strategies above. Two are highlighted below.

Foster a more nimble culture. The ability to make informed decisions fairly quickly was cited as a competitive advantage by nearly every board member, executive, and physician interviewed in this cohort. The relatively small number of individuals involved in the decision-making process in rural hospitals, and their strong and unified commitment to doing what is best for both the community and organization, is typically viewed as a significant advantage. For example, Franklin Memorial was able to quickly consolidate two physician practices in a new building in Livermore Falls, about half an hour south of Farmington. "It's an effective model," says Jerry Cayer, executive vice president for Franklin Memorial. "We got rid of two buildings and kept our costs down. Plus, this protects our market to the south."

Rural hospitals are aiming to create cultures that embrace change. Bennett of Franklin Memorial shared that hospital leaders are emphasizing the importance of being nimble regardless of the future: "The message is, we need to be prepared for change." Crete Area Medical Center has made an effort over the last several years to engage its workforce in process improvement. Leaders are on message that "we are not cutting jobs" through process improvement efforts. Further, employees contribute to idea logs that are considered by management. Employees' performance evaluations consider the degree to which they generate ideas and participate in performance improvement. Crete's Betke noted that the hospital's employee survey indicates 99 percent engagement.

Invest in process improvement. Jim Heilsberg, Whitman Hospital and Medical Center’s CFO, described that facility’s investments in rapid process improvement as an effort to “see care delivery through a new lens. We are beginning to measure what we do, and looking for opportunities to reduce inefficiencies. We are beginning to change the mindset of how we deliver value, by changing systems of care.” Many of the hospitals interviewed for this report are focusing on chronic conditions for their care delivery reform efforts, investing in chronic disease registries to drive quality improvement in a manner that positions the organization for a population health management role.

Other rural hospitals are similarly leveraging process engineering as a means to improve financial and clinical performance. Diane Moore, CFO of Copper Queen Community Hospital, commented that process

improvement efforts are helping the hospital staff to function better as a team, and noted that process improvement efforts in 2011 resulted in \$800,000 in savings. Crete Area Medical Center uses Lean methodology to drive process improvement. Bryce Betke, Crete’s CFO, noted, “We are tackling process engineering to work smarter, not harder.”

RECOMMENDATIONS

Like the other provider cohorts, rural hospitals face the challenge of undertaking many strategies and initiatives simultaneously to prepare for emerging payment models. Rural hospitals have unique advantages to leverage, including relatively nimble decision-making processes and strong community affiliations. Recommendations for the rural cohort include the following.

RURAL HOSPITAL RESEARCH PARTICIPANTS

Participating Organization	No. of Beds	No. of Employed Physicians	Critical Access Hospital?	Payer Mix*	Geography
Andalusia Regional Hospital	88	2	No	58% Medicare 18% Medicaid 19% Managed Care/Commercial 5% Self-Pay	Andalusia, Ala.
Copper Queen Community Hospital	14	13	Yes	27% Medicare 32% Medicaid 35% Commercial	Bisbee, Ariz.
Crete Area Medical Center	24	9	Yes	43% Medicare 27% Medicaid 26% Managed Care/Commercial 4% Self-Pay	Crete, Neb.
Franklin Memorial Hospital	43	38	No	60% Medicare 20% Medicaid 18% Managed Care/Commercial 2% Self-Pay	Central Maine
New Ulm Medical Center	35	39	Yes	44% Medicare 17% Medicaid 38% Commercial 1% Self-Pay	New Ulm, Minn.
Whitman Hospital and Medical Center	25	0	Yes	75% Medicare/Medicaid 20% Commercial 5% Self-Pay	Colfax, Wash.

*Payer mix is based on inpatient discharges including normal newborns.

Position the organization to achieve greater scale. Rural hospitals would be well-served to improve scale to better position for coordinated care delivery and enhanced population care management from preventive care and wellness to end-of-life care. Strategies include expanding primary care and strategic partnerships with other providers, including aligning with a larger, neighboring system.

Plan for a future of reduced revenue. Today, many hospitals rely on critical access and sole provider funding and would suffer financially if that type of payment arrangement was discontinued. Given the risk associated with such change, and the extreme financial pressures that payers and employers are under, rural hospitals should conduct multiyear, multifaceted scenario planning that informs near-term, intermediate, and longer-term strategies to remain financially viable in an environment of extremely constrained revenue.

Determine the appropriate balance of primary and specialty care services to meet community needs. Primary care, including a focus on chronic disease management, should be a priority for rural providers and will help position their organization for a role in population health management. The prevalence of chronic diseases within the community should also help determine specialty care needs, such as cardiology, neurology, pulmonology, nephrology, podiatry, and ophthalmology. Factors including the size of the population served, its demographics, and the distance to larger facilities should help determine the

need for additional specialty services such as obstetrics or behavioral health. These factors will also aid decisions on whether specialty needs require a full-time physician on staff or can instead be met with visiting specialists, telehealth arrangements, or physician extenders.

Invest in business intelligence. The research suggests that rural hospitals lag other cohorts in their investment in business intelligence. Some facilities lack EHRs in outpatient settings, for example, and many are deficient in their costing capabilities. However, in light of emerging payment models, business intelligence is a sound investment. Like other types of providers, rural hospitals will need actionable information to cost effectively manage the health of a population and to identify areas of opportunity for improved quality at a reduced cost.

Leverage resources to strengthen community ties. One of a rural hospital's greatest assets is the loyalty of the local community. Leaders of rural facilities should be savvy in building boards with strong area business leaders with the acumen and fortitude to make tough decisions in a dynamic environment. Hospital leaders should seek opportunities to leverage board members' ties to the community, and exploit other points of local leverage to shore up a community's loyalty. More solid footing within the community can bolster opportunities for population health management, including creative, personal approaches to care delivery, from wellness to chronic disease management.

STAND-ALONE HOSPITALS

Many stand-alone hospitals face challenges in achieving sufficient scale to undertake certain kinds of value-based payment, such as shared savings arrangements or capitation. How can stand-alone hospitals preserve their independent status while gaining scale? What are critical areas of focus for stand-alone hospitals seeking to stand out favorably in comparison with larger, more integrated competitors?

The stand-alone hospital cohort includes freestanding hospitals in market areas with 50,000 or more residents. These hospitals typically desire to be independent and community-directed, making healthcare choices that best serve their communities. They often face continuing pressures to merge with other hospitals or with multihospital or integrated systems.

As part of HFMA's Value Project research, six stand-alone hospitals ranging in size from 68 to 290 staffed beds were studied. The organizations are geographically dispersed, and their payer mixes include both governmental and commercial payers. Winona Health, Longmont United, and Holy Spirit Health System report being in markets with several top competing commercial carriers; Enloe Medical Center and Elmhurst Memorial are in Blue Cross Blue Shield-dominated markets.

Physician employment levels vary among the organizations studied: Winona Health in Minnesota and Holy Spirit Health System in Pennsylvania, the subjects of site visits by Value Project researchers, employ most of their physicians, while Longmont United Hospital, Longmont, Colo., and Platte Valley Medical Center, Brighton, Colo., have a mostly independent medical staff.

Some of the participants in this cohort operate as small systems. Holy Spirit Health System and Winona Health, for example, each operate a hospital as well as multiple clinic locations staffed by employed physicians. Other participants in the cohort, such as Longmont United Hospital and Platte Valley Medical Center, concentrate on hospital operations with independent medical offices in their service areas.

There are key differences between the two organizations that were the subject of site visits. Holy Spirit is larger, with a 290-staffed bed hospital, 10 primary care locations (including two women's health centers), and annual

KEY RECOMMENDATIONS

Stand-alone hospitals should consider the following action steps as they position themselves for value-based business models:

- Aggressively manage cost structures, with an emphasis on initiatives that also improve patient experience.
- Pursue opportunities to improve scale.
- Leverage community ties, including those of board members.
- Invest purposefully in cost accounting systems and business intelligence.
- Foster a culture that embraces change.
- Experiment with payment methodologies.

revenues of \$272 million. Winona Health has a 68-bed hospital with five clinic locations and annual revenues of \$114 million. Holy Spirit operates in the highly competitive Harrisburg market, where other hospital competitors are aggressively pursuing market share. In contrast, Winona Health is the only hospital in the community of Winona, Minn., and enjoys a fairly symbiotic relationship with two large neighboring systems, Mayo Clinic in Rochester, Minn., and Gundersen Lutheran Health System in LaCrosse, Wis.

Although both organizations are concentrating on ways to improve value, Winona Health has oriented itself around Lean management philosophies and process improvement approaches. For example, Winona has utilized Lean to create an inverted leadership model enabling physicians and frontline staff to drive performance improvement activities. The health system also incorporates Lean approaches in strategic planning.

CHALLENGES AND OPPORTUNITIES

The path that stand-alone hospitals take as they transition to a value-based payment environment is framed by a number of challenges and opportunities that are unique to this group.

Opportunities. Stand-alone hospitals have several opportunities to pursue in this transition.

Compared with most other types of organizations, stand-alone hospitals benefit from patients who have a strong sense of loyalty toward community hospitals that meet their

health needs and those of family, friends, and neighbors. Stand-alone hospitals have a significant opportunity to build on ties with patients in ways that bolster residents' loyalty to the facility even further, potentially enabling experiments in patient engagement.

Similarly, stand-alone hospitals may have stronger local business ties than an aligned integrated system or multihospital system serving a larger geographic area. These business relationships can be leveraged into strategic partnerships that improve the hospital's competitiveness, supporting value-based payment experimentation and total health management.

Additionally, as smaller, more nimble organizations, stand-alone hospitals are well-positioned to foster adaptable cultures. Organizational agility will be required to drive the process, care delivery partnerships, and payment experiments necessary to position stand-alone hospitals for the future.

Challenges. A significant challenge that stand-alone hospitals face is their relative lack of scale. This can impact an organization in several ways. Lack of scale may make coordination of the patient experience across the continuum more difficult. It can make it more challenging for stand-alone hospitals to access competitive capital. It also can make it tough for them to compete against larger, more visible systems.

In some markets, lack of leverage makes it difficult for the stand-alone hospital to engage payers in partnerships;

often, stand-alones accept the prices health plans offer them rather than attempting to set market prices. A stand-alone hospital likely lacks the scale to become an ACO and undertake population health management. Limited scale may make it more difficult for these organizations to attract top talent. And, lack of scale presents challenges when working with some vendor solutions, such as EHRs, which are typically sized for larger organizations, such as aligned integrated systems.

Stand-alone hospital participants share the challenge of getting physicians to think in terms of standardized, proven approaches, rather than autonomously.

Stand-alone facilities that are working with independent physicians may face greater challenges in cultivating physician leaders. Many of these facilities lack a formalized approach to physician leadership development. All acknowledge the important role physicians play in identifying, driving, and maintaining clinical performance improvements.

The capabilities road map for this cohort, located below, is designed to address the key challenges facing this cohort as well as to help stand-alone hospitals determine how to act on the unique opportunities available to them.

THE ROAD AHEAD: STRATEGIES AND INITIATIVES

Stand-alone hospitals participating in this research acknowledge that the emerging payment environment will profoundly affect their organizations. Stand-alone hospital leaders are pursuing several overarching strategies

UNIQUE CHALLENGES AND OPPORTUNITIES FOR STAND-ALONE HOSPITALS

Challenges	Opportunities
<ul style="list-style-type: none"> • Lack of market share and geographic coverage • Lack of scale • Limited access to competitive capital • Tougher to maintain or achieve excellent bond ratings • Growth of competing aligned integrated systems and multihospital systems • Difficulty aligning/integrating physicians • Lack of payer leverage • Difficulty getting IT vendors to scale down to size of stand-alone hospital • More likely to be a price "taker" than a price "setter" • Unlikely to have sufficient scale to form an ACO on its own; would likely be a contracted component in a larger ACO 	<ul style="list-style-type: none"> • Local, community-oriented governance • Strong community connections • Size (smaller = more nimble) • Strategic partnerships or alliances or virtual integration (e.g., leverage expertise, improve competitiveness) • Demonstration of superior performance on quality and cost

to position themselves for success in an era of payment reform. Strategies of stand-alone hospitals interviewed by HFMA's Value Project include the following:

- Achieve greater scale.
- Deliver superior financial and clinical performance.
- Cultivate an organizational culture that embraces change and risk-taking.
- Leverage boards and community assets.

Like other providers, stand-alone hospitals should coordinate a number of initiatives to position themselves for the future. These initiatives span the four value-driving organizational capabilities that healthcare providers should cultivate to adapt to a value-based business model:

- People and culture
- Business intelligence
- Performance improvement
- Contract and risk management

Many of the changes required are consistent with those described in the common road map. However, some initiatives that stand-alone hospitals should tackle are unique to these organizations or are of particular emphasis. These are highlighted in bold on the stand-alone hospital road map.

Achieve greater scale. As previously described, lack of scale creates several challenges for stand-alone facilities. There are several paths stand-alone hospitals can take to increase scale. In the road map, these initiatives relate to the strategy and structure, care team linkages, contracting, and clinical information systems capabilities.

One strategy for achieving scale is through strategic partnerships with other community provider organizations. Longmont United Hospital offers two examples of strategic partnerships with other providers:

- The hospital formed a limited liability company with all orthopedic surgeons in the area through a comanagement agreement. The entity aims to improve the quality and efficiency of orthopedic care delivery while also positioning the providers for bundled payment. (For more discussion of co-management agreements, see HFMA's "Achieving Physician Integration with the Comanagement Model" at www.hfma.org/Templates/InteriorMaster.aspx?id=20619.)

- Longmont participates in the Boulder Valley Care Network (BVCN), a provider consortium that includes Boulder Community Hospital and Avista Hospital and their related medical staffs. BVCN is providing population management services for the Boulder Valley School District. Together with the school district, BVCN has designed incentives for savings to be distributed among the providers.

With the school district, BVCN is conducting an analysis of chronic disease in the district's population. Each month, the medical directors from each of the participating provider entities review claims summaries in their efforts to better manage costs. Although the facilities are not electronically connected, they also intend to tap into the Colorado Regional Health Information Organization to share clinical data. Such approaches are anticipated to improve patients' end-to-end care experiences.

Longmont United Hospital is using its participation in BVCN as a way of gaining experience in aligning with other organizations to experiment with population-based payment. In the future, BVCN could become an ACO. Rather than being a "contractor" in a larger system's ACO, Longmont United has a seat at the table through its participation in BVCN. Additionally, BVCN will participate in CMS's bundled payment initiative; participating provider organizations are collaborating with CMS and each other to determine the specific focus of the initiative.

Some stand-alone hospitals may lack the scale to achieve a unique partnership with a payer. There are facilities that have been able to establish such relationships, which afford the opportunity to share infrastructure costs, experiment with payment, and strengthen community relationships.

Holy Spirit Health System, for example, operates in the competitive Harrisburg, Pa., market where payers have an interest in balancing power among the competing hospitals and systems. The system has negotiated several deals with payers:

- Holy Spirit Health System is piloting two patient-centered medical homes (PCMHs) in partnership with Highmark Blue Cross. Holy Spirit received funding from Highmark to hire a PCMH development nurse and a transitions development nurse. In addition, Highmark pays a per-patient visit fee, with more money available to sites that obtain PCMH certification.

- The system negotiated a shared savings program tied to savings relative to regional cost trends with Capital Blue Cross.

Local self-funded employer payers may represent a great opportunity for the stand-alone cohort to experiment with population health management while reinforcing local employers’ commitment to sustaining the community hospital. For example, Boulder Valley Care Network is exploring additional self-funded arrangements. In fact, Longmont United Hospital, which is self-insured, is contracting with BVCN to provide population care to its own employees. Stand-alone hospitals may want to evaluate such opportunities in their markets.

Another avenue for improving scale is strategic leveraging of vendors. For example, stand-alone hospitals could partner with their EHR vendor for ongoing support. This approach could leverage the expertise of the vendor

while minimizing the need for the organization to invest in its own information technology staff. Additionally, some sort of partnership arrangement with an EHR vendor could help relatively smaller stand-alone hospital organizations command resources from the vendors, many of whom are stretched to meet the demands of larger organizations like aligned integrated or multihospital systems.

One research participant has moved in this direction. The hospital has outsourced its revenue cycle activities (e.g., coding, billing, and collections) and maintenance and enhancements for its EHR to the health record vendor. A form of “virtual integration,” these agreements take advantage of the vendor’s technical expertise in both revenue cycle and electronic health records. The agreements contain performance standards with incentives and penalties.

Some stand-alone hospitals have the opportunity to participate in regional health information exchanges

STAND-ALONE HOSPITAL ROAD MAP TO VALUE		
LOWER ←		
ORGANIZATIONAL CAPABILITIES		
People/Culture		
Governance	Review Governance	Adjust Board Composition
Strategy and Structure	Review Strategy by Segment	
Management	Align Executive Leadership	Develop Common Plans, Goals
Physicians	Educate	Assess Performance
Staffing and Skills	Assess Needs	Plan Attritions
Communication and Culture	Deliver Value Message	Educate
Business Intelligence		
Clinical Information Systems	Implement EHR, All Settings	Leverage Vendor Expertise
Financial Reporting & Costing	Directional, Limited	
Performance Reporting	Core, Process Measures	Strategic Measures
Analytics and Warehouses	Review Data Governance	Integrate Clinical, Financial Data
Performance Improvement		
Process Engineering	Identify Methodology(ies)	Establish Cross-Functional Forum
Evidence-based Medicine	Patient Safety	Readmissions and Hospital-Acquired Conditions
Care Team Linkages	Measure Primary Care Access	Expand Primary Care
Stakeholder Engagement	Create Transparency	Educate Patients
Contract & Risk Management		
Financial Planning	Rolling Calendar	Update Cash Flow Planning
Financial Modeling	Maintain Short-Term View	
Risk Modeling	Analyze Profit/Loss	Estimate Financial Exposure
Contracting	Negotiate Prices	Partner with Quality

(HIEs). HIEs can be another tool to expand the scale of the stand-alone facility. For example, Winona Health is deeply engaged with other Minnesota providers to develop an 11-county HIE in southeastern Minnesota.

Finally, some stand-alone hospitals may consider the possibility of merging or affiliating with a larger system as a means to achieve broader scale. Several cohort participants acknowledged that, depending on market conditions, the pressure can be high to consider these types of arrangements. It is important for stand-alone hospitals to develop the skills to evaluate such opportunities. Boards and executives are assessing these potential arrangements in the context of their strategic plans, objectively evaluating this path relative to other potential courses of action, and in some cases establishing organizational performance “trigger points” to determine when such strategic discussions should be undertaken.

Deliver superior financial and clinical performance.

Building and maintaining a solid track record on performance is critical for organizations that aim to preserve their independent status, become successful under value-based business models, and deliver financially sustainable results. Stand-alone hospitals should strive for top-quartile performance, honing their skills in strategic planning, management, communication, process engineering, and care team linkages capabilities, among others.

Stand-alone hospitals are taking a variety of approaches to benchmarking their financial performance to competitors. Platte Valley Medical Center uses peer group per-adjusted-patient-day cost information from the state hospital association. At Holy Spirit Health System, CFO Manuel Evans accesses a “host of public databases” to find ratio comparisons. He is also exploring the possibility of

Degree of Care Transformation & Financial Sustainability				HIGHER
STRATEGIES & INITIATIVES				
Educate and Leverage Leadership			Augment Governance	
Assess Mergers and Alliances			Optimize Cost Structure	
Align Incentives			Manage to Measurement	
Align Compensation	Develop Leaders		Lead Strategies and Initiatives	
Add Staff Strategically	Educate	Align Incentives	Enhance Leadership	
Engage Stakeholders	Experiment with Payment, Care Delivery			Take Risks
Establish Alerts	Establish Disease Registries		Develop Data Exchanges	
Precise, All Settings				Longitudinal
Outcomes			Population Based	
Develop Analytics	Expand Databases		Support Real-Time Decisions	
Initiate Efforts	Utilize Data	Expand Cross-Department	Expand Cross-Continuum	
Standards, Protocols	High-Risk Care	Chronic Conditions	Wellness	
Right-Size Specialty	Partner Strategically			Manage Care by Setting
Share Decision Making	Engage the Community			Establish Patient Accountability
Update Capital Budgeting and Capital Access Planning			Quantify and Allocate Initiatives	
			Conduct Multifactorial Scenario Planning	
Utilize Predictive Modeling			Develop Risk Mitigation Strategy	
Experiment with Value-Based Payment (VBP)	Partner with Payers		Prepare for Second-Generation VBP	

obtaining total cost of care comparatives from commercial carriers. Winona Health is discussing how to calculate total cost of care indicators on commercial business. “We don’t have it yet,” Mike Allen, Winona’s CFO noted, “but we think total cost is where we need to go.”

Achieve an optimal cost structure. Given the imperative for stand-alone hospitals to deliver a superior price position, these hospitals typically focus on developing and adhering to multi-year, aggressive cost-cutting plans. Longmont United Hospital has a long history of focusing on cost containment. Past efforts have involved putting case managers in the emergency department to more appropriately triage the route patients should take for care. According to Neil Bertrand, Longmont United Hospital’s CFO, while this initiative reduces annual revenue, it also reduces cost to customers. “It is the right way to deliver

care,” he says. Longmont is considering cost containment opportunities related to vendor management, service lines, processes of care, and refinancing of debt.

Leverage primary care capabilities. Providers in this cohort, as in others, need a strong primary care base to support referrals and address population health management. At Winona Health, the top strategic concern is access to primary care, and the organization is pursuing creative options to expansion, including adding physician extenders. Expansion of primary care also is a top priority at Holy Spirit Health System. “We need both more physicians and more locations to position us for population health management and value-based payment,” says medical director Peter Cardinal. Strategies include further acquisition of primary care practices, establishment of PCMHs, and hiring additional care managers.

STAND-ALONE HOSPITAL COHORT PARTICIPANTS

Participating Organization	No. of Staffed Beds	No. of Employed Physicians	Market Served	Payer Mix*	Geography
Elmhurst Memorial Hospital	259	120 (affiliated under a foundation model)	Suburban	55% Medicare 10% Medicaid 30% Managed Care/Commercial 5% Self-Pay	Elmhurst, Ill.
Enloe Medical Center	265	Corporate practice of medicine prohibition	Urban/Rural	49% Medicare 21% Medicaid 27% Managed Care/Commercial 3% Self-Pay	Chico, Calif.
Holy Spirit Health System	290	80	Suburban	53% Medicare 14% Medical Assistance 28% Managed Care/Commercial 5% Self-Pay	Harrisburg, Pa.
Longmont United Hospital	156	54	Suburban	46% Medicare 11% Medicaid 33% Managed Care/Commercial 10% Self-Pay	Boulder County, Colo.
Platte Valley Medical Center	70	6	Suburban/Rural	32% Medicare 21% Medicaid 37% Managed Care/Commercial 10% Self-Pay	West Adams County, Colo.
Winona Health	68	50	Small City	45% Medicare 10% Medicaid 40% Managed Care/Commercial 5% Self-Pay	Winona, Minn.

*Payer mix is based on inpatient discharges including normal newborns.

Look more closely at how ambulatory services are developed.

Winona Health is a leader in applying process engineering methodology to reduce variation and improve the patient experience not only in the hospital, but also, increasingly, in ambulatory and administrative settings. For example, the organization significantly reduced patient wait time in family practice through process reengineering and created a new patient checkout process to schedule next appointments for patients with chronic disease or otherwise in need of follow-up at checkout. Also, the department now asks for immediate feedback from patients on their level of satisfaction with their visit. These new processes are drivers of improved patient satisfaction.

Winona's CFO, Mike Allen, noted that the organization does not limit its process engineering efforts to care delivery. "We need 1,100 people—everyone, administrative and clinical—focused on quality improvement every day. We are finding opportunities not only in clinical but also in business functions."

Holy Spirit Health System, which aims to achieve a lower-than-average price position in its market, also is concentrating on efforts to reduce clinical variation. "There are tremendous variations in care in this community. We don't want that here at Holy Spirit," says Richard Schreiber, chief medical informatics officer.

Involve patients and caregivers directly in process engineering efforts. This approach can be helpful in communicating the commitment the hospitals have to serving the community, while conveying to front-line staff the facility's strong patient-centricity. Winona Health periodically involves patients in Lean projects and, according to Linda Wadewitz, director of continuous process improvement, "We want to become more public in the community about our Lean work, especially promoting how we involve patients in improving the care experience."

Translate value-focused strategic plans into organization-wide goals and tactical plans that are communicated broadly and align organizational efforts. Winona Health is already moving down this path. Its key strategic goals are organized around the Triple Aim, emphasizing patient satisfaction, quality and cost indicators, and community health. To assess quality, Winona Health examines metrics such as those related to adverse events and those used by various quality ranking associations. Cost metrics include productivity

(revenue per FTE) and more traditional metrics such as net revenue, operating margin, and days cash on hand. The goal is to achieve top-decile performance on these metrics. Community health metrics, including total cost of care, are under discussion.

Employ a value message focused on improving the patient experience. This is the focus at Holy Spirit Health System, which has developed a relationship-based care initiative in which waves of multidisciplinary employee teams participate in patient-centered training. Winona Health, too, focuses its staff on patient-centered care, helping them to distinguish value-added from non-value-added steps in care delivery.

Cultivate a nimble culture. Stand-alone hospitals will need to develop cultures that can drive them to a superior and sustained level of performance. For stand-alone hospitals in highly competitive markets that are moving quickly toward more transparency and value-based payment, this need is particularly acute.

Winona Health leaders consider process improvement to be a core competency vital to the future success of the organization and have taken many steps to cultivate an environment where staff and physicians embrace change. Some of these steps include creating career paths related to performance improvement project leadership, establishing communication norms for staff and leaders, and issuing a board-approved policy that staff affected by job eliminations resulting from performance improvement projects will have the opportunity to find employment elsewhere in the organization.

Like other cohorts, stand-alone hospitals are experimenting with payment methodologies as a way of creating change and learning. Some of these payment experiments have been mentioned previously. Additionally, Elmhurst Memorial Hospital is readying for value-based payment by contracting with an actuarial firm to assist in analyzing claims data related to population risk-based contracting.

Experiment with care delivery models. As noted, Holy Spirit Health System is establishing PCMHs and is learning how to manage chronic disease and work in care teams. Winona Health is adding physician extenders to primary care, requiring the organization to "share" patients in ways that providers had not previously. Longmont United Hospital's

participation in the BVCN also is an example of care delivery experimentation. Winona Health intends to use its own self-funded population as a means to experiment with new approaches to engaging patients.

Increase the risk tolerance and comfort with change within stand-alone hospitals. The ability to take calculated risk is critical in this cohort, which lacks the financial reserves of larger organizations. Experimentation with payment methodologies should help organizations develop cultures that are more comfortable with taking some risks. As Neil Bertrand, CFO of Longmont United Hospital, noted, “Our path forward on value-based payment is through experimentation. We want to see what works.” Multiscenario financial modeling and improved risk models are designed to help stand-alone hospitals better estimate the financial risk to the organization.

Leverage boards and community assets. This strategy requires capabilities related to governance as well as stakeholder engagement.

Like both of the site visit organizations, stand-alone hospitals are seeking to build board membership strategically with community business leaders who have strong financial and strategic thinking skills and an appetite and commitment to learn about health care. Board members who are community opinion leaders—individuals who can help strengthen ties between the hospital and the broader business community—can be particularly effective. As organizations develop strategies that deliver value to each customer segment, they need boards with the capability to understand complex information and the willingness to make tough decisions.

Like the other cohorts, stand-alone hospitals are educating their boards extensively about the upcoming changes in the healthcare payment environment. For example, the board at Enloe Medical Center in Chico, Calif., has heard numerous presentations on market dynamics. According to its CFO, Myron Machula, “Our board is thinking through questions about our sustainability in the changing healthcare environment.”

As the payment environment shifts, it is important that board leaders are willing to make difficult decisions on behalf of the hospital that are potentially different

from those made in the past. Bottom line: The board has a responsibility to see the future and to help organizations be successful in it.

Board members’ relationships within the community are being leveraged by stand-alone hospitals across the nation. For example, board members may have relationships with local self-insured employers or other community providers. These kinds of organizations may represent strategic partners enabling opportunities to experiment with population-based risk.

Most stand-alone hospitals have close ties within their communities. Winona Health’s participation in “Live Well Winona,” a partnership with other leading local businesses that aims to improve community health, is an example. A byproduct of this effort is repositioning Winona Health as a wellness provider, rather than sickness provider. Participation in this program will help Winona Health as it begins to tackle population health management. Additionally, it is likely to provide opportunities for experimenting with ways to engage patients effectively in their overall care. The nimbleness and strong community ties that stand-alone hospitals enjoy provide opportunities to think beyond the hospital’s walls in providing total health services.

OTHER STRATEGIES AND INITIATIVES

As illustrated on the value road map for stand-alone hospitals, there are numerous other initiatives that stand-alone hospitals should simultaneously pursue to better position themselves for a value-based payment environment. These include the following enablers of the strategies related to people and culture, business intelligence, performance improvement, and contract and risk management.

Strengthen physician ties. Stand-alone hospitals generally have three options available: co-management agreements with physicians, employment of physicians, and community coalitions. Among the research participants, Holy Spirit Health System entered into a successful comanagement agreement with an orthopedics clinic. Winona Health decided to employ its physicians. Longmont United Hospital is pursuing a community coalition path.

Even in the most integrated of these three options, physician engagement and alignment remains challenging. At Winona Health, which employs physicians on a salaried basis, physicians are aligned to performance improvement in a few key ways. Individual physicians are accountable for maintaining or improving patient satisfaction within their department. Further, they are paid for their direct time spent on Lean projects.

But physicians are not always on board with an organization's approach to care delivery improvement. One leader noted, "It takes quite a leap of faith for some physicians to believe in this team-based approach." Longmont United Hospital lacks a physician-led forum to identify and discuss care delivery improvement ideas. Holy Spirit Health System, which employs some of its physicians, has experienced a lack of physician enthusiasm in establishing PCMHs. "It is difficult to change the culture of physician autonomy and get them to think more about being part of a system," says Cardinal, medical director for Holy Spirit Health System. "We're trying to emphasize communications, quality, accountability, and aligned financial incentives."

Given the importance of physician engagement and leadership to clinical care transformation, it is important that stand-alone hospitals tackle all of the capabilities related to physicians in the common road map. This work will require patience, experimentation, good data to frame improvement opportunities objectively and clearly, investment in physician leadership (such as national educational forums and programs), and strong administrative partnerships.

Strategic investment in systems capabilities. In general, stand-alone hospitals could benefit from following the common road map. However, it is worth noting that stand-alone hospitals may not have adequate capital available to invest in cost accounting systems, heightening the need for careful planning about what costing data are required to feed decision support systems. Among the participants in this cohort, some are considering alternatives to investment in detailed cost accounting in all aspects of their operations. Holy Spirit Health System, for example, lacks costing data for professional services. Longmont United

Hospital invests in cost accounting capabilities sporadically, depending on business needs. The view of leaders in that organization is that if new payment methodologies require more granular data, they will evaluate their options and decide how to proceed. Based on these examples, the key for stand-alones on tight budgets appears to be to objectively determine what kinds and depth of costing data will be required to deliver on their strategic plans, including experimentation with payment and care delivery, and to plan accordingly.

With respect to investment in data warehouses and analytical capabilities, capital may again be a limiting factor, and organizations may need to consider alternative ways to develop the ability to convert data into actionable information for decision making. At Winona Health, for example, data are housed separately in the billing system, the EHR, patient satisfaction surveys, and financial reports. Winona is adding a new position responsible for information management. This person will assume responsibility for providing data analytics necessary for population management, pulling together clinical and other kinds of data from these disparate systems, and also will be tapped for data analytics required for Lean projects. This is a full-time position that will report to the CFO.

RECOMMENDATIONS

Stand-alone hospitals face particular challenges and opportunities as they transition from volume to value. To be successful in this emerging environment, it is important that stand-alone facilities achieve greater scale economies than they have today as well as demonstrate and maintain superior performance on both quality and cost. HFMA recommends that stand-alone hospitals take the following action steps.

Aggressively manage cost structures, with an emphasis on initiatives that also improve patient experience.

Leading providers in this cohort continue to explore opportunities for cost containment in contracts and vendor relationships and, increasingly, emphasize care delivery improvements as central to both improving cost structure and the patient experience. Stand-alone hospitals are utilizing process improvement techniques to reduce

clinical variation. They are shoring up access to primary care and leveraging it by investing in physician extenders and other team-based approaches. These efforts are enabled by increasingly accurate and longitudinal clinical and financial data analysis.

As organizations gain traction on cost structure management, it is important that these improvements translate to value to the customer. Stand-alone hospitals will need the capabilities to demonstrate that, on a total cost basis (e.g., for an episode of care, or for population care management), they are delivering superior financial as well as clinical results.

Pursue opportunities to improve scale. Central to improving scale is developing strategic partnerships. Some stand-alone hospitals should consider cultivating innovative partnerships with other provider organizations as a means not only to improving scale, but also to experiment with payment arrangements and position for population health management. Longmont United Hospital's participation in the BVCN is an example.

Being proactive in arranging these kinds of partnerships improves a stand-alone hospital's chances of being "at the table" in designing an ACO versus being on the receiving end of decisions or shut out entirely. Partnerships with payers can improve scale by enabling important care delivery infrastructure development, or experimentation with payment. Affiliations with local self-funded employers can similarly provide opportunities to gain experience with payment models while strengthening community ties. Additionally, stand-alone hospitals would be well served to take a disciplined approach when considering options to add scale through merger or affiliation with a larger entity.

Leverage community ties, including those of board members. Stand-alone hospitals have the opportunity to compose their boards strategically and leverage board members' relationships with other community leaders, including businesses, to shore up support and utilization of the hospital. Additionally, because they are

community-based, stand-alone hospitals have a greater opportunity than most other cohorts to experiment with creative ways within the community to engage patients in their health. Improved patient engagement is likely to be an important component of delivering higher quality care at a better price.

Invest purposefully in cost accounting systems and business intelligence. As noted, stand-alone hospitals should carefully consider how to deliver on their strategic plans—such as through payment experiments and approaches—as they allocate capital to invest in cost accounting and decision support systems. None of the stand-alone hospitals involved in this research had invested in systems that would allow ready access to longitudinal costing data. This could put them at a disadvantage relative to other providers that are moving forward with these kinds of business intelligence investments. Stand-alone hospitals should carefully consider what investments in costing capabilities and decision support are required for success under emerging payment models.

Foster a culture that embraces change. Stand-alone hospitals require a culture that can drive the organization to high levels of performance. Leaders should take advantage of their relatively smaller size and cultivate organizations that are patient-centric, engaged in performance improvement, and willing to take risks. Fostering physician engagement and leadership is central to developing this type of culture.

Experiment with payment methodologies. Purposeful experimentation helps to foster an organizational culture that is accustomed to change while providing the practical opportunity to learn what capabilities different payment methodologies require.

With these areas of focus, stand-alone hospitals should be well positioned to transform how they deliver care and participate in the care continuum while remaining financially sustainable, independent entities.

CONCLUSION

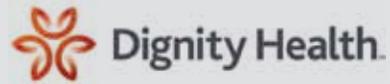
This report has emphasized the value journey of hospitals and health systems. But these organizations will not be able to complete the journey alone. All stakeholders—patients and employers, government and commercial payers, clinicians, legislators and other policy makers—will need to collaborate to reach the goal of a healthcare system in which all stakeholders are aligned around the common pursuit of value.

The road maps outlined in their report highlight many areas of potential collaboration between hospitals and health systems and other industry stakeholders. HFMA encourages readers of this report to share its findings and the road maps it presents with these stakeholders and work together with them to move forward on the value journey.

For additional information and resources from HFMA's Value Project, visit the project website at hfma.org/valueproject.

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**HFMA'S VALUE PROJECT: PHASE 2
THE VALUE JOURNEY
ORGANIZATIONAL ROAD MAPS FOR
VALUE-DRIVEN HEALTH CARE**

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