

## HFMA'S VALUE PROJECT

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# The Value Journey

Organizational Road Maps for Value-Driven Health Care

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STAND-ALONE  
HOSPITALS



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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		

# STAND-ALONE HOSPITALS

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

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](http://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 ←		
<b>ORGANIZATIONAL CAPABILITIES</b>		
<b>People/Culture</b>		
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
<b>Business Intelligence</b>		
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
<b>Performance Improvement</b>		
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
<b>Contract &amp; Risk Management</b>		
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
<b>STRATEGIES &amp; INITIATIVES</b>				
<b>Educate and Leverage Leadership</b>			Augment Governance	
<b>Assess Mergers and Alliances</b>			<b>Optimize Cost Structure</b>	
Align Incentives			<b>Manage to Measurement</b>	
Align Compensation	Develop Leaders		Lead Strategies and Initiatives	
Add Staff Strategically	Educate	Align Incentives	Enhance Leadership	
<b>Engage Stakeholders</b>	<b>Experiment with Payment, Care Delivery</b>			<b>Take Risks</b>
Establish Alerts	Establish Disease Registries		<b>Develop Data Exchanges</b>	
Precise, All Settings				Longitudinal
<b>Outcomes</b>			Population Based	
Develop Analytics	Expand Databases		Support Real-Time Decisions	
<b>Initiate Efforts</b>	<b>Utilize Data</b>	Expand Cross-Department	Expand Cross-Continuum	
Standards, Protocols	High-Risk Care	Chronic Conditions	Wellness	
Right-Size Specialty	<b>Partner Strategically</b>			Manage Care by Setting
Share Decision Making	<b>Engage the Community</b>			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	
<b>Experiment with Value-Based Payment (VBP)</b>		<b>Partner with Payers</b>	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.

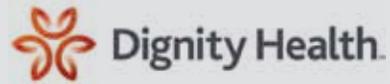
**Experiment with payment methodologies.** Purposeful experimentation helps to foster an organizational culture that is accustomed to change while providing the practical opportunity to learn what capabilities different payment methodologies require.

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.

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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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