An HFMA Value Project Report

The Healthcare Value Sourcebook

hfma
healthcare financial management association

ABOUT THE VALUE PROJECT

Of all the transformations reshaping American health care, none is more profound than the shift toward value. Quality and patient satisfaction are being factored into Medicare reimbursement, while private payers are pushing for performance and risk-based payment structures. At the same time, rising healthcare costs are creating more price sensitivity among healthcare purchasers, including government agencies, employers, and, of course, patients themselves, who are being asked to pay higher premiums, copayments, and deductibles for their care.

Hospitals have always cared about quality because they are fundamentally dedicated to patient well-being. But today's pressures make it financially imperative to develop collaborative approaches that combine strong clinical outcomes with effective cost containment.

HFMA's Value Project aims to help guide the transition from a volume-based to a value-based healthcare payment system.

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ABOUT THIS SECTION

With the support of leading hospitals and health systems, which serve as the project's steering committee and research sponsors, HFMA engaged in a series of interviews with finance and administrative leaders and their clinical partners at providers who are leading the transition to value, including:

Advocate Health Care
Baptist Health South Florida
Baylor Health Care System
Bellin Health
BJC HealthCare
Bon Secours Health System
Catholic Health East
Catholic Healthcare West
Cleveland Clinic
Geisinger Health System
HCA – Hospital Corporation of America
Intermountain Healthcare
Lee Memorial Health System
The Methodist Hospital System
New York-Presbyterian
Novant Health
Partners HealthCare
Rush University Medical Center
Scottsdale Healthcare
Sharp HealthCare
Spectrum Health
Texas Health Resources
UAB Medicine – UAB Hospital
Unity Health System

HFMA also interviewed a range of organizations representing the perspectives of patients, employers, commercial payers, and government agencies, including:

The Access Project
American College of Physician Executives
Blue Cross Blue Shield Association
Catalyst for Payment Reform
HFMA-UK
Institute for Healthcare Improvement

In addition, HFMA conducted two industry surveys, the first on the current state of value in health care and the second on future directions for value in health care. The results of these interviews and surveys form the basis of this section, which defines the concept of value in health care, describes the current state of value and the capabilities that are being developed by providers actively engaged in value-based initiatives, and identifies likely future directions of a value-based healthcare system.

SECTION 1

Value in Health Care: Current State and Future Directions

EXECUTIVE SUMMARY

Over the years, the mechanisms used to finance and measure healthcare delivery have obstructed the ability of patients and other purchasers of care to perceive value. A payment system in which a combination of employer contributions and government funding is the dominant payment source means that patients' out-of-pocket expenses typically bear little relationship to the total price of care. Price controls and cost-shifting have created different pricing structures for different purchasers of care. Quality metrics have focused on process-related measures that tell patients little about the functional outcomes they might expect from care.

The move toward value is starting to push these obstructions aside. Patients, employers, government agencies, and health plans increasingly want to know what they can expect to receive for what they pay for care. They are seeking out providers who will give them this information and follow through with cost-effective care. They are, in other words, expecting to get value.

How should providers respond to the demand for value? In interviews with leading provider organizations across the country and surveys of the field, HFMA identified four capabilities that organizations should develop to prepare for a value-based healthcare system. These include:

- **People and culture:** The ability to instill a culture of collaboration, creativity, and accountability
- **Business intelligence:** The ability to collect, analyze, and connect accurate quality and financial data to support organizational decision making
- **Performance improvement:** The ability to use data to reduce variability in clinical processes and improve the delivery, cost-effectiveness, and outcomes of care
- **Contract and risk management:** The ability to develop and manage effective care networks and predict and manage different forms of patient-related risk

"The Current State of Value in Health Care," the second chapter in this section, details essential skills within each of these four capabilities that healthcare organizations should begin to develop now. Organizations that are actively working to improve the value of care offer examples of how to develop and apply these skills. Advocate Physician Partners, for example, provides a non-employment model of physician engagement for the people and culture capability, while Spectrum Health describes how interdisciplinary teams of clinicians and finance staff can collaborate on creating metrics that provide actionable data for business intelligence. Rush University Medical Center shares its approach to identifying variability within clinical processes to drive performance improvement. And Sharp HealthCare describes an innovative risk management program that helps keep capitated patients in network and ensures the continuity of their care.

In the third chapter of this section, focus turns to "The Future State of Value in Health Care." This chapter outlines a series of assumptions that will push the healthcare system in two directions. The first is a trend toward greater provider integration, as accountability for care outcomes spreads across the care continuum. The second is a trend toward greater assumption of risk by providers, as the healthcare system seeks to reduce costs through better management of population health.

The trends toward increased provider integration and greater provider assumption of risk will not necessarily push all healthcare organizations in the same direction. Instead, a range of strategies will likely be available, combining different degrees of integration and risk. Based on models that are emerging today, this section highlights five possible future value strategies that healthcare organizations could pursue, detailing key capabilities, possible benefits, and potential challenges for each.

Throughout the research process, the healthcare organizations HFMA interviewed made reference to the "value journey." This section begins with where our healthcare system is today, follows promising paths that innovative healthcare organizations are pioneering, and describes possible new destinations for healthcare organizations in a value-based future.

CHAPTER 1

Defining Value

What is value in health care? In most industries, value resides at the intersection of a purchaser's perception of the quality of a good or service and the amount he or she is willing to pay for that good or service. If you had to pay $15 for a cheeseburger at a fast-food restaurant, you would probably not think that you got good value. But if you paid the same amount for a well-prepared filet mignon dinner, you would probably think you received value, just as you might in a $3 cheeseburger. Value, in other words, is a concept of relative worth. It is a function of quality over payment, and a product's value is increased by an improvement in quality, a reduction in the amount paid, or both.

The same definition should apply in health care, and for most commentators on the question of value in health care, it does.[1] However, measuring value in health care remains elusive for several reasons. First, *there is no clear, consensus definition* of what constitutes "quality" among providers, let alone purchasers, for whom a "quality" outcome will often vary according to such factors as expectations, age, and general health. Second, in many cases, *the full amount paid for health care is not apparent.* Payment for a full episode of care (for example, pre-acute, acute, and post-acute services related to a surgical procedure) is made to a fragmented collection of providers. Also, payment for care is often divided among multiple purchasers: the patient (primary purchaser); employers and/or state and federal programs, such as Medicaid and Medicare (secondary purchasers); and perhaps a health plan (serving as an intermediary between purchasers and providers). All of these purchasers have overlapping, but not identical, interests in the quality and price of the care provided. And third, under the current payment system, *providers typically are not compensated for producing value;* instead, they are economically rewarded for the volume of services they provide.

THE VALUE EQUATION RECONSIDERED FOR HEALTH CARE

$$\text{Value} = \frac{\text{Quality}^*}{\text{Payment}^\dagger}$$

* A composite of patient outcomes, safety, and experiences
† The cost to all purchasers of purchasing care

HFMA's Value Project is intended to help healthcare organizations create value for the multiple purchasers of health care. In this sourcebook, HFMA will do the following:

- Define the practices of providers who are leading the way toward a value-based healthcare system
- Describe the primary capabilities that healthcare organizations will need to develop in the areas of people and culture, business intelligence, performance improvement, and contract and risk management to improve the value of care provided
- Provide specific strategies, tactics, and tools that healthcare organizations can use to build, enhance, and communicate their value capabilities
- Identify the trends today that are defining the future state of value in health care and describe new care delivery models that could help healthcare organizations create value

[1] Harvard Business School professor Michael Porter, for example, defines value in health care as outcomes (the indicator of quality in Porter's formulation) relative to costs (the total amount paid for the full cycle of care). See Michael Porter, "What Is Value in Health Care?", *New England Journal of Medicine* (Dec. 23, 2010): 2477–2481.

TOWARD A PURCHASER-CENTERED VALUE EQUATION

Creating value in health care will require bringing payment and quality—the two factors of the value equation—to the fore and, as in other industries, defining them around the purchaser's needs.

PAYMENT

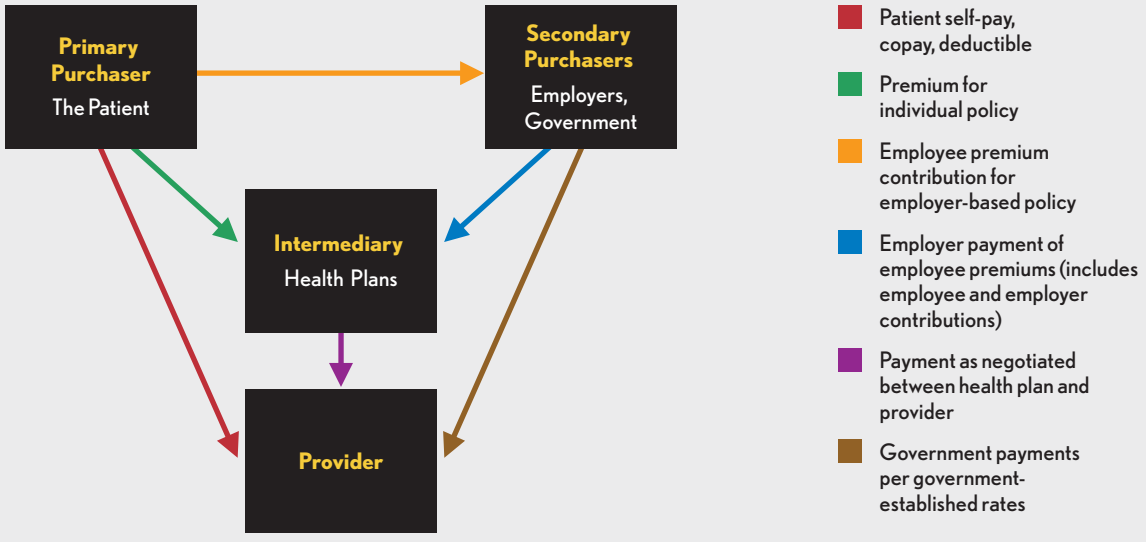
To avoid confusion, we use the term "payment" to describe the cost of purchasing services—the amount paid by the patient, employer, and government purchasers—and will use the term "cost" to describe the healthcare provider's cost of providing the service. In a purchaser-centered value equation, the provider's cost is relevant to the purchaser only to the extent it drives the amount of payment. The cost of providing care is, nonetheless, an important consideration for providers, who are tasked with maintaining financial viability while improving quality of care.

With respect to the value equation, the central problem with payment in the current state is that the purchaser who initiates a purchase of healthcare services—the patient—will often have little or no sense of the total price of the services purchased. The diagram below illustrates how payment streams flow within the current system.

The greatest patient sensitivity to payment for a particular service occurs, first, along the payment stream highlighted in red, which involves direct payment from the patient to the provider in the form of self-payment, copayments, or deductibles, and second, along the payment stream highlighted in green, which represents self-insured individuals who must pay their full premium. If, however, the patient has employer-based insurance or is a Medicare beneficiary with a low copay or deductible, sensitivity to the total payment for a service is significantly reduced. Although patients are in fact paying a significant amount for their care in the form of monthly premium contributions deducted from their paychecks or in taxes paid to fund state and federal programs, these payments are largely out of mind for patients who will instead focus on the "out-of-pocket" amount of a copay or deductible paid at the time of care.

An additional complication in health care's current state is that payment, from a purchaser perspective, is fragmented among different providers. Take a procedure such as a joint implant, which will require preliminary visits to an orthopedic specialist's office, a procedure (inpatient or outpatient) at a hospital, follow-up visits with

HEALTHCARE PAYMENT STREAMS



the orthopedic specialist, physical therapy sessions, and other related services. The services of the different providers in this scenario will be billed separately, even though all these services together define a single episode of care. Without a consolidated bill, it is difficult for the individual patient to fully understand the total amount paid for care.

On the other hand, employer and government purchasers of care and health plans have high sensitivity to the total amounts paid for health care, and are much more attuned to the total price of care. This has several implications for the value equation.

First, employers and health plans have an incentive to shift more of the payment burden to patients in the form of higher copays, deductibles, or premium contributions to make patients more price-sensitive. As noted earlier, an employee may not make a direct connection between a monthly premium contribution and payment for an episode of care, but as the percentage of employee copays and other direct care payments increases—in addition to premium payments—the employee should become increasingly sensitive to the overall price of care.

Second, purchasers of all types have an incentive to spend money on preventive programs or care coordination programs if such programs have the effect of reducing overall payments for health care (this is especially true for employers if savings can be seen in the near term). Employer-sponsored wellness programs have been around for some time, but the significant rise in such programs in recent years suggests that employers have reached a point where the rising costs of health care justify an investment in employee wellness.[2] Health plans and employers are still trying to quantify the ROI for such programs, but some studies have indicated positive results.[3]

Third, and perhaps most important, employer and government purchasers of care are heavily invested in finding the right balance to the value equation, and have significant influence over both health plans and providers. These purchasers have already begun influencing the payment system. The Centers for Medicare & Medicaid Services (CMS), for example, has announced its intention to use value-based purchasing "to transform Medicare from a passive payer of claims to an active purchaser of quality health care for its beneficiaries."[4] And both individual employers and employer coalitions are actively working with health plans and providers to move healthcare payment from an emphasis on volume to a focus on value.[5] In many instances, these value-based payment methods will push providers toward acceptance of more performance risk and toward greater collaboration—and integration—with other providers across the care continuum.

The trend in payment is thus to give the patient a better sense of the price of care, shift more healthcare dollars to preventive and primary care, and change the payment system in ways intended to improve quality, stabilize or lower prices, and promote the coordination of care among providers.

QUALITY

Identification of quality, the value equation's numerator, is ambiguous at best. The biggest problem, of course, is that there is no comprehensive, standard definition of quality for the healthcare industry. CMS has developed core measures that have been adopted by many other payers, but with respect to clinical treatment, these are largely focused on processes that may be indicators of, but are at least one step removed from, actual outcomes. The outcome metrics currently employed are fairly blunt indicators of quality, emphasizing either mortality or readmission rates within a certain period of time following a procedure or admission. Moreover, these outcome metrics emphasize adverse events, not the positive outcomes that purchasers expect from care.

Patient Concerns

In beginning to work through a definition of quality of care, one must start with the patient, the recipient of care. And for the patient, the quality of care depends on a combination of the factors highlighted in the exhibit on page 5.

Access to care—making care both available and affordable—is a baseline requirement that brings the patient within the process of care delivery. Once there, the patient

[2] *Employer Investments in Improving Employee Health*, a January 2011 report by the National Business Group on Health and Fidelity Investments, found that the ratio of the aggregate number of employee wellness programs to be implemented in 2011 compared with the aggregate number being discontinued was 8:1.

[3] See, for example, John Commins, "Wellness Programs Show Hard-dollar Savings," *Health Leaders Media* (Feb. 28, 2011).

[4] Centers for Medicare & Medicaid Services, "Hospital Inpatient Value-Based Purchasing Program Final Rule," *Federal Register*, vol. 76, no. 88 (May 6, 2011), p. 26490.

[5] See, for example, the agreement between home-improvement retailer Lowe's, Inc., and the Cleveland Clinic regarding heart surgeries for Lowe's employees and their dependents, described on p. 33 of this report.

has three primary concerns with the quality of care: safety, outcomes, and respect.

The first of these three concerns, safety, has always been part of the healthcare landscape but took on increased prominence in 1999, when the Institute of Medicine released its landmark *To Err Is Human: Building a Safer Health System* report. Many providers now have adopted process metrics and patient safety checklists in an ongoing effort to reduce preventable medical errors.[6] But even though safety is an essential component of the quality of care, it does not sufficiently define it. Safety is something patients assume when they enter a provider setting; it is equivalent to the "defect rate" in industrial manufacturing, but because it directly affects human lives, it has higher stakes. Just as no one expects to pay for a defective product, no one expects to pay for care that causes harm.

The industry has begun to take steps toward an outcome-based definition of quality. The current metrics on mortality and readmissions following inpatient admissions are early examples. But neither mortality nor preventable readmission is something that patients expect from care. Instead, they are interested in functional outcomes: How soon will I be able to walk or drive a car? When will I be able to return to work? It may take weeks or months of the patient's treatment to report such functional outcomes, meaning that accountability for quality of care must spread across the care continuum. Moreover, these outcomes will depend on such factors as the patient's age, general health, or comorbidities. Adding further complication, providers must have functional ways to define outcomes that are both measurable and manageable.

The last remaining concern—respect for the patient's needs—comprises several elements. Respect involves asking patients about their hopes and expectations for care, including open conversations about care alternatives and the attendant costs and benefits that will enable patients to make decisions about the level of care that is best for them. And it means respecting such fundamental patient needs as privacy, comfort, convenience of care, and security. Care delivery that respects the patient in these ways should lead to higher patient satisfaction. At the same time, a clear understanding of what the patient wants may help avoid costs for care that the patient would prefer not to receive.

Other Purchaser Concerns

Although the patient is at the center of the value equation's quality numerator, the concerns of employers, government agencies, and health plans will inevitably influence the definition of quality. Even though the concerns of patients and these other purchasers will overlap significantly, there may be some important differences system stakeholders will need to reconcile.

To the extent that health insurance benefits retain and attract talented employees, employers will want to ensure that the plan they offer satisfies employee expectations for access to care. Government programs will also care about access, especially for Medicare beneficiaries in the politically powerful age-65-and-older demographic. Employers and government purchasers may, however, be more willing than patients to consider tiered access programs, in which preventive, acute, and other medically necessary care is widely accessible and affordable but elective procedures are less so. Gaps between patient and purchaser expectations for access are already appearing, for example, in state Medicaid programs, where efforts to contain the impact of Medicaid payments on strapped state budgets are leading state legislatures to consider controls on access to certain high-cost services.[7]

[6] Note, however, that a recent study in *Health Affairs* indicates that several commonly used measures of patient safety miss many adverse events and that adverse event rates at many hospitals—even those that have focused on safety initiatives—remain high. David C. Classen et al., "'Global Trigger Tool' Shows that Adverse Events in Hospitals May Be Ten Times Greater than Previously Measured," *Health Affairs*, vol. 30, no. 4 (April 2011): 581-589.

[7] The Arizona state legislature, for example, eliminated certain organ transplant services from Medicaid eligibility in the state's FY11 budget, although those cuts were subsequently restored.

There will be little difference between patients and other purchasers with respect to patient safety concerns. In the area of outcomes, purchaser concerns are also likely to be closely aligned, although the concerns of employer purchasers will focus primarily on cost and workforce productivity. Employer and government purchasers are also likely to support engagement efforts that help patients make better informed choices about their care, especially where these efforts help patients avoid care that is unlikely to produce significant positive outcomes. For government purchasers, however, this is a potentially sensitive area, as demonstrated by the political debates over voluntary end-of-life counseling when shaping implementation of the Affordable Care Act.

The key to quality, then, will involve the creation of meaningful, measurable standards that address patient concerns for care, while balancing the related concerns of other purchasers. This will not be an easy process, and it will require the ongoing collaboration of providers, patients, government agencies, employers, and health plans.

Hospitals and health systems may well want to initiate the process of developing meaningful quality and cost of care metrics instead of waiting to have such metrics imposed on them through government regulation or employer or health plan demands. First, as accountability for care begins to reach beyond the hospital walls, the long-term outcomes of care will have increasingly significant financial implications. Providers who are attuned to metrics indicative of a procedure's or treatment's success will be much more confident in their ability to predict long-term financial outcomes. Second, providers who are able to speak clearly and convincingly to patients and other purchasers of care with meaningful data related to quality outcomes and the price of care will be better positioned to compete for purchasers' healthcare dollars. And third, provider-defined metrics that are linked to measurable quality and cost improvements could play a significant role in shaping industry standards.[8]

[8] For example, six health systems (Cleveland Clinic, Dartmouth-Hitchcock, Denver Health, Geisinger Health System, Intermountain Healthcare, and Mayo Clinic) recently announced a collaboration with the Dartmouth Institute to gather data and share information on outcomes, quality, and costs for a range of common conditions and treatments.

CHAPTER 2

The Current State of Value in Health Care

A recognition that the current healthcare system is unsustainable is driving the turn to value. The Congressional Budget Office projects that government spending on Medicare, Medicaid, and other federal healthcare-related programs subject to mandatory spending will more than double from a combined $870 billion in 2011 to $1.8 trillion in 2021, growing from a combined 5.8 percent to 7.4 percent of GDP over the same period.[9] From 1999 to 2010, premiums for employer-sponsored health insurance grew a cumulative 138 percent, compared with cumulative wage growth of 42 percent over the same period.[10] But there is little evidence that increased spending is being matched with increases in the quality of care.[11]

As noted earlier in this report, there are many problems with the system today. Payment is fragmented among the various purchasers of care, making it difficult for patients to make informed choices based on the actual price of care. Quality data, from the patient's perspective, is often not meaningful and is incomplete, with little information available to compare expected functional outcomes among providers. But the main culprit for the current system's ills is the fee-for-service payment system, which rewards volume over value and does nothing to promote the coordination of care among providers. The first step in correcting the system is a transition from volume-based to value-based methods of payment, and that transition is already under way.

PAYMENT TRENDS

In late 2008, CMS stopped reimbursing healthcare providers for "never events"—serious adverse events that should never occur or are reasonably preventable through adherence to evidence-based guidelines. Since then, CMS has continued to signal its intention to become "a prudent purchaser of health care services, paying not just for quantity of services but also for quality,"[12] and several provisions in the Affordable Care Act support this intention. Beginning in October 2012, CMS's value-based purchasing program has provided incentives to hospitals that exceed certain quality measures relating to clinical care processes and patient experience, while hospitals that fall short on these measures compared with their peers receive reduced payments. The Affordable Care Act also provided for the creation of accountable care organizations (ACOs) that participate in shared savings programs for the management of Medicare beneficiary populations. In addition, it established a national bundled payment pilot program for 10 conditions, in which hospitals, physicians, and other members of the provider "team" receive a global payment for an episode of care.

On the private side, the not-for-profit PROMETHEUS Payment® program worked with coalitions of providers and payers (both health plans and employer coalitions) to test a bundled payment system based on "evidence-informed case rates" for selected chronic conditions and

[9] Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2011 to 2021* (January 2011)

[10] Kaiser Family Foundation, *Employer Health Insurance Costs and Worker Compensation* (February 2011) at http://www.kff.org/insurance/snapshot/Employer-Health-Insurance-Costs-and-Worker-Compensation.cfm

[11] See, for example, Laura Yasaitis et al., "Hospital Quality and Intensity of Spending: Is There an Association?", *Health Affairs*, vol. 24, no. 4 (July 2009): 566-572.

[12] CMS, "Fiscal Year 2009 Quality Measure Reporting for 2010 Payment Update" (Sept. 3, 2010)

inpatient and outpatient procedures. Similarly, experiments such as Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract, which combines global health-adjusted payments per patient with performance incentives for high-quality care, seek to promote provider accountability for managing the quality and cost of patient care.[13]

VALUE-DRIVING CAPABILITIES

Providers are also preparing for a shift from volume-based to value-based care. Research for the Value Project has included surveys of the industry on the current state of value in health care and interviews with providers that are actively working to make a transition to value. This research has identified four key areas of emphasis in which providers are working to build their capabilities.

- **People and culture:** The ability to instill a culture of collaboration, creativity, and accountability
- **Business intelligence:** The ability to collect, analyze, and connect accurate quality and financial data to support organizational decision making
- **Performance improvement:** The ability to use data to reduce variability in clinical processes and improve the delivery, cost-effectiveness, and outcomes of care
- **Contract and risk management:** The ability to develop and manage effective care networks and predict and manage different forms of patient-related risk

In the discussion that follows, highlights from the provider interviews and results from the current state survey are combined to illustrate the state of the industry today in relation to these four capabilities and the essential skills that will be needed to further advance value transformation.

[13] See Michael E. Chernew et al., "Private-Payer Innovation in Massachusetts: The 'Alternative Quality Contract,'" *Health Affairs*, v. 30, no. 1 (January 2011): 51-61.

PEOPLE AND CULTURE

The pursuit of value in health care will require new levels of interdisciplinary collaboration, new levels of accountability for results, a new focus on driving process improvement throughout provider organizations, and an ability to communicate the value of a provider's care to the community it serves. At a foundational level, providers should have the skills to perform the following:

- Define the role of value in the organization's strategic mission and communicate value to both internal and external stakeholders
- Create engaged, integrated, multidisciplinary teams able to plan and implement process change
- Identify and effectively respond to patients' concerns or issues that might affect their experience or safety

STATE OF THE INDUSTRY TODAY

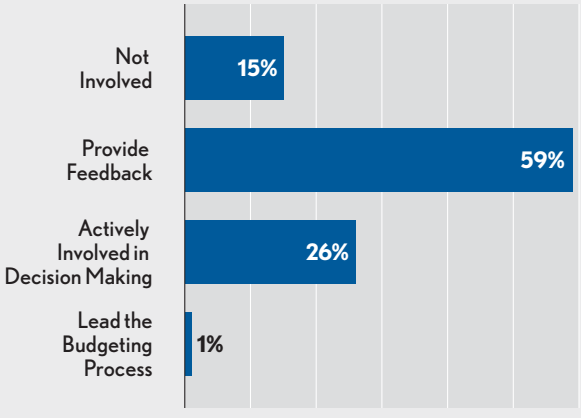
The creation of value requires the participation of clinicians as well as finance and administrative staff. Each needs to pay attention to and respect the concerns of the other. Clinicians, in other words, must be conscious of the cost implications of the choices they make, while finance and administrative professionals must realize that quality outcomes are at least as important as cost efficiencies and reductions.

HFMA's industry survey on the current state of value indicates that organizations are engaging physicians in key decision-making processes affecting costs, although most do not currently engage physicians as full partners in management. Using involvement of physicians in key budgeting and resource allocation decisions as an indicator of physician engagement at the management level, HFMA found that physician leaders had no involvement at only 15 percent of the respondent organizations. At 59 percent of the organizations, physicians provide feedback on budget and resource allocation decisions, and at 27 percent, physicians lead or are actively involved in decision making—a good sign that physicians have been well integrated into management decisions.

On the finance and administrative side, HFMA's survey on the current state of value indicates that CFOs spend the majority of their time in more traditional roles, emphasizing cost reduction, efficiency improvement, and volume and revenue growth. But a substantial portion of a CFO's time today is also dedicated to initiatives related to clinical quality improvement and patient satisfaction. HFMA found that a median 40 percent of a CFO's time spent on improvement initiatives is dedicated to clinical quality improvement and patient satisfaction.

PHYSICIAN ENGAGEMENT

How are physician leaders typically involved in the department budgeting/resource allocation process?*

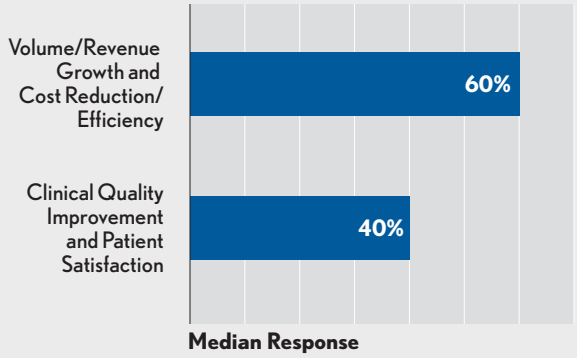


*Total exceeds 100% due to rounding.

Source: HFMA Value Project Survey, January 2011.

CFO TIME ALLOCATIONS

Consider the amount of time you spend on improvement initiatives. How would you estimate that your time is allocated?



Source: HFMA Value Project Survey, January 2011.

While these results indicate that CFOs are typically devoting less time to quality and patient satisfaction than to volume or revenue growth and cost-effectiveness initiatives, the amount of time that CFOs already devote to quality improvement and patient satisfaction shows promise. "I'm encouraged by these results. It's a good start in the direction that CFOs will need to go," says Peter DeAngelis, Jr., FHFMA, CPA, COO of Catholic Health East in Newtown Square, Pa., and an HFMA Value Advisory Council member.

ESSENTIAL PEOPLE AND CULTURE SKILLS

A prerequisite to developing value-based people and culture is the full commitment of the organization's executive leadership and board to guiding the organization through the changes that a value-based system will require. Building on this foundation requires two essential skills: First is the ability to clearly and concisely articulate to internal and external stakeholders the role that value plays in the organization's strategy. Next is the ability to promote multidisciplinary collaboration while defining the specific roles that key clinicians—physicians and nurses—and finance and administrative professionals play in the creation of value. As such, providers should consider the following experiences of peers in communicating their value message and how these organizations' methods for including both clinical and financial representatives facilitates process improvement and safer, more patient-centered care.

Communicating the Value Message

A first step in communicating an organization's value message is distilling that message down to a clear, concise statement that communicates the organization's need for value in a compelling way. Novant Health, based in Winston-Salem, N.C., looked at the value equation through the perspective of its patients and realized that affordability of care was a significant concern. It also looked at payment trends and determined that the direction is toward Medicare levels of reimbursement. It combined these perspectives into a simple statement for staff: The system's goal would be "affordability at Medicare levels."

Many organizations also communicate the importance of value internally by linking compensation structures to quality and culture. Nonfinancial incentives can also play a significant role in communicating the value message internally. Spectrum Health in Grand Rapids, Mich., hosts an annual Synergy Awards program. Teams from within the health system compete for the awards within such categories as sustainability, innovation, and care improvement, and their entries are scored against a grid that aligns with key organizational goals. Miami-based Baptist Health South Florida has taken a similar approach, hosting an annual Performance Improvement Showcase event to award entities that have been recognized for top performance improvement efforts within the system. Abstracts of the work the entities are doing are collected and distributed throughout the system to facilitate knowledge sharing.

Advocate Physician Partners, a joint venture between physicians and Advocate Health Care, based in Oak Brook, Ill., addresses both internal and external stakeholders with its annual Value Report. The report highlights the organization's clinical integration efforts and quantifies these efforts in terms of patient lives affected and saved, as well as economic impacts and cost savings.

As an example, Advocate Physician Partners' 2011 Value Report highlights the organization's Asthma Outcomes initiative. The report identifies a tool it uses to objectively assess asthma control levels, describes a study that establishes the national average control rate, outlines the components of an asthma action plan that all the members of Advocate Physician Partners are asked to implement, and highlights the organization's achievement of an 88 percent control rate for patients with asthma (38 percentage points above the national control). Drawing on statistics on the economic and medical impact of asthma, the Value Report quantifies the effect of the Asthma Outcomes initiative in terms of days saved from reduced absenteeism (58 days), lost productivity (436 days), and amounts saved in direct and indirect medical costs ($13 million). The 2011 Value Report describes similar outcomes and impacts for a generic prescribing initiative, a diabetes care initiative, a postpartum depression screening initiative, and a childhood immunization initiative.

The Value Reports published by Advocate Physician Partners accomplish several communication goals: recognition and affirmation of the work of the organization's clinicians; promotion of value to patients, employers, government entities, and health plans; and emphasis on leadership's commitment to creating and improving value.

Engaging Clinicians in Value

A clear finding from the Value Project interviews is that value cannot be created without the engagement and leadership of clinicians: both physicians, who drive most of the decisions affecting quality and cost of care, and nurses, who are on the frontline of the patient experience and are often best situated to identify and respond to issues affecting the patient and care delivery.

Physicians. Many healthcare organizations are considering an employment model to increase physician alignment and engagement with organizational goals. But an employment model is not feasible or desirable in all markets. The Advocate Physician Partners joint venture with Advocate Health Care, which in 2011 included approximately 3,800 physicians, 2,900 of whom are independent, represents an innovative approach to physician engagement outside the employment model. The joint venture was set up with a shared governance model, with two classes of directors—one from the system side and one from the physician side—represented on the board. Through the joint venture's Clinical Integration program, Advocate Physician Partners and 10 Advocate Health Care hospitals employ structured and ongoing collaboration to improve the quality and efficiency of health care.

A key feature of the program is its pay-for-performance incentive system. Advocate Physician Partners researches metrics and establishes performance targets for each of the program's clinical initiatives, based on national best practices, research findings, and other recognized benchmarks.[14] Physician performance on each of these metrics is monitored throughout the year and reported to physicians quarterly. An incentive plan links the performance of hospital administrators and physicians as a means to increase levels of collaboration and coordination of care. Also, the incentive plan is structured to reward both the individual physician and the physician's peer group, helping to develop a shared culture of excellence and accountability. Physicians are awarded points based on their achievement of quality metrics, and physician bonus payments are based on the number of points earned.

Because physicians are involved in all phases of development and decision making for the performance metrics, physician buy-in with the metrics is high. Nonfinancial incentives—including recognition of high-scoring physicians and competition between medical groups—have also increased physician engagement.

The specific details of Advocate's model yield several general lessons for physician engagement at any organization. First, physicians must be represented at a decision-making level across all levels of the organization—from governance down to the unit level. Second, metrics generated with the participation of physicians will ensure the greatest physician buy-in. And third, giving physicians a stake in the outcomes of process improvement initiatives matters, whether that stake takes the form of a financial or nonfinancial incentive.

Nurses. Arizona-based Scottsdale Health System has a strong shared governance program with its nursing staff. If department metrics are not where they should be, then the system will provide nursing staff with the support needed. At the same time, nursing staff understand that they will be accountable for improving the metrics. One example of this shared sense of accountability and commitment can be seen when system leadership identified an increase in pressure ulcer rates at one of the facilities. Two nurses traced it to a defect in mattresses affecting 600 patient beds that were then replaced at no charge by the vendor. Since the discovery, the pressure ulcer rate has decreased to zero in the intensive care unit.

The presence of nursing experience and expertise on process improvement initiatives—again, starting at the top and going down to the unit level—is a common factor among most of the providers interviewed for the Value Project. Peter Markell, CPA, CFO of Partners HealthCare in Boston, Mass., notes that many hospitals have adopted Lean methodologies, derived from Toyota's production practices. "Under the Toyota model, you let people on the floor make decisions," he says. "Nurses are the people on the floor."

Engaging Finance and Administrative Staff in Value

Engaged clinicians are essential to value creation, but so are engaged finance and administrative professionals. "The CFO needs to be glued at the hip with the quality officer," says David Bernard, vice president of finance, The Methodist Hospital System, Houston, Texas. "Revenue depends on quality."

[14] A selection of the metrics used for Advocate Physician Partners' initiatives is available in Advocate's Value Report at www.advocatehealth.com/valuereport.

Many of the CFOs interviewed for the Value Project note that engagement with quality requires a change in mind-set for the finance executive. "Not putting an initial focus on cost was something that required a leap of faith on my part, but I'm now a believer in this approach," says Kathy Arbuckle, CPA, CFO of Marriottsville, Md.-based Bon Secours Health System. Clinicians are engaged by quality and service improvements for the patient; any resulting cost reductions become a natural outcome as variability in clinical processes is reduced and inefficiencies in care delivery are identified and removed.

Bon Secours has also developed a "dyad" model of leadership—combining finance and administrative staff with physicians and nurses—for its Clinical Transformation program. The model extends from the system's senior leadership team down to teams at local hospitals that together "walk the line" by following patients through the care process to identify safety and waste issues. The team then works together to resolve the issues of care delivery and unnecessary cost identified.

Bringing finance and administrative professionals together with clinicians in an ongoing collaborative process supports process improvement and a patient-centered focus. When commenting on the ingredients for organizational success, Joseph Fifer, FHFMA, CPA, then vice president of finance for Spectrum Health's hospital group, points to the importance of a strong working relationship among the executive team—including finance and administrative officers, the chief medical officer, and the chief nursing officer. "Sincere, mutual respect for each others' disciplines is an absolute necessity," says Fifer. "You have to manage with knowledge of what's going on at the bedside, as well as what's going on at the bottom line. For finance executives, this means getting out of the office to round with the chief nursing officer or sit in on physician meetings. These activities matter; you have to want to know about them. Once that culture of mutual respect has been established at the top, it cascades down throughout the organization."

BUSINESS INTELLIGENCE

For providers to deliver value in health care, they must have accurate, actionable data on the two elements driving the value equation: quality of the care delivered and cost of providing care (the basis for the price that purchasers should be asked to pay for care). They must also be able to link quality and financial metrics to quantify the value of care provided. To build this business intelligence, organizations must have skills to perform several functions:

- Accurately and consistently report data on appropriate metrics developed in collaboration with clinicians
- Drive information sharing throughout the organization by linking department-level dashboards and individual measures to strategic goals and executive dashboards
- Report quality results against core measures

STATE OF THE INDUSTRY TODAY

HFMA's survey on the current state of value indicates that many providers, while recognizing the significance of the link between quality improvement and cost-reduction efforts, are just starting to measure the impact of poor quality and waste on their organizations, and similarly, are just beginning to move beyond traditional methods of cost accounting.

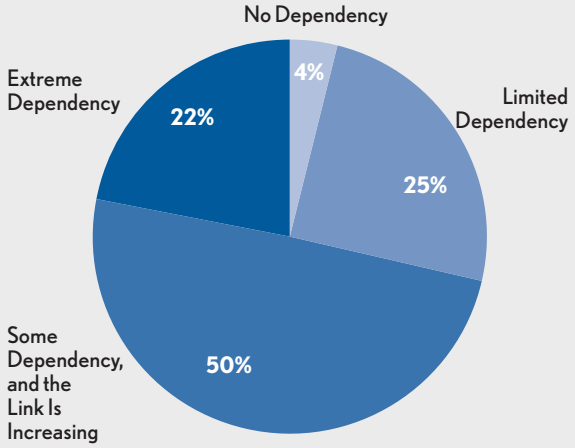
As noted in the exhibit at lower left, fewer than one-third of respondents believe there is no or limited dependency between quality improvement and cost-reduction efforts. One-half of respondents believe there is some dependency, and the link is increasing. Almost one-quarter believe there is extreme mutual dependency.

While more than half of respondents have begun measuring the costs of adverse events and the margin impact of readmissions, only 20 percent of respondents report that they actively manage to these measures (i.e., use the data to drive actions that reduce costs or improve margin). What's more, half of respondents have begun measuring or managing to the cost of waste in care processes, such as duplicative or unnecessary tests or procedures.

The majority of respondents use traditional costing methods, with 69 percent reporting use of ratio of cost-to-charges. In contrast, only 30 percent report use of activity-based costing, which provides a more accurate

LINKING QUALITY AND COST

What level of dependency do you associate between quality improvement and cost-reduction efforts?*



*Total exceeds 100% due to rounding.

Source: HFMA Value Project Survey, January 2011.

MEASUREMENT AND USE OF BUSINESS INTELLIGENCE

To what extent does your organization measure and utilize business intelligence related to value in the following areas?

	Not	Measure	Manage
Costs of Adverse Events	43%	37%	20%
Margin Impact of Readmissions	38%	42%	20%
Cost of Waste in Care Processes (i.e. duplicative/ unnecessary tests or procedures	50%	29%	21%

Not We do not measure.
Measure We have measured the impact, but do not manage to the metrics.
Manage We manage to these measures (e.g. data drives actions to reduce costs or improve margin).

Source: HFMA Value Project Survey, January 2011.

assignment of both direct and indirect costs to hospital procedures and services. This differential narrows, however, for larger facilities (500 beds or more). Fifty-eight percent of larger facility respondents use ratio of cost-to-charges, but 50 percent of these respondents also use activity-based costing (note that respondents to this survey question were asked to select all costing methods used in their organization). Moreover, 79 percent of larger facility respondents report use of a specialized cost accounting system, as compared with 39 percent of the overall respondents.

ESSENTIAL BUSINESS INTELLIGENCE SKILLS

The need for better business intelligence is both recognized and real. Many of the providers interviewed for the Value Project readily acknowledge the inadequacies of their current systems, but they are working to enhance their skills with using data and to develop the systems that will lay the foundation to succeed under value-based payment.

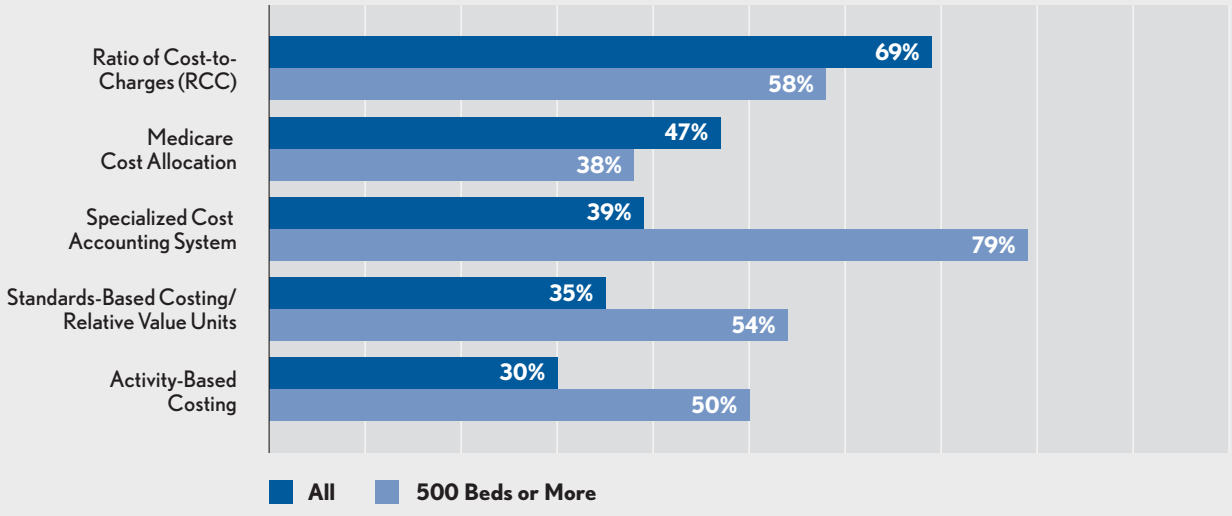
Ensuring Accuracy and Consistency of Data

A small group of providers—including Intermountain Healthcare, Geisinger Health System, and the Cleveland Clinic—represent the vanguard of business intelligence in health care. Intermountain, for example, has already spent decades customizing its business intelligence system to its changing needs. Its first system, introduced in 1960, used automation to improve decisions by, for example, screening for possible interactions during drug entry or recommending antibiotics and associated dosage schedule based on the patient's medical history. The latest iteration of its business intelligence system—the Enterprise Clinical Information System, currently in implementation stage—is a system-wide electronic medical record that offers real-time patient views aggregating patient data from all system visits, provides access to best-practice clinical workflow protocols, and uses clinical information to develop granular and longitudinal costing estimates for patient care.

Few organizations, of course, have the expertise or resources to develop their own custom business intelligence systems, but many of the providers interviewed for the Value Project are building business intelligence capabilities—especially in the area of quality improvement—using available software and tools. Bellin Health in Green Bay, Wis., uses a commercially available software program to identify statistically significant variations in care delivery that offer significant opportunities for improvement. Baylor Health Care System in Dallas, Texas, uses the Institute for Healthcare Improvement's Global Trigger Tool to monitor and characterize the nature of adverse events within system facilities. Hospital teams review the data regularly to direct quality initiatives based on patterns of events and preventability.

COSTING METHODS

What methods are in use to allocate indirect and overhead costs to departments, procedures, or activities?



Source: HFMA Value Project Survey, January 2011.

In comparison with investments in business intelligence for quality, investments in business intelligence on the finance side have lagged behind. As a result, tying cost implications to performance on quality metrics often requires a good deal of time-consuming, manual work. Providers also struggle to quantify precisely the financial impact of quality initiatives, although many of the Value Project interviewees note that the effects of quality initiatives on metrics such as length of stay and other indirect macro indicators provide some demonstration when initiatives are working to reduce costs.

A key point is that less than perfect data should not stop a provider from pursuing value. "We need direction, not perfection, from the data," says Phyllis Lantos, FHFMA, CFO of New York-Presbyterian Healthcare System. "As an industry, we have so far to go. Data use is a tool, not the answer, in improving value."

A second point is that, although data use may be less than perfect, it needs to be used with the greatest consistency possible. This consideration is especially important when working with physicians, who are data-driven and quick to question the credibility of the information they are asked to work with in improving the value of patient care. Spectrum Health wanted to use clinical improvement projects to improve outcomes for high-volume surgical procedures and medical conditions, but it realized clinicians had little faith in existing metrics and little consensus on the proper metrics. It formed collaborative teams of clinicians and finance staff to develop actionable data for these procedures and conditions. The teams identified mutually agreed-upon metrics and defined how the metrics would be calculated, collaboratively determined the proper source of the data, and established a formal vetting process for the data. As a result of these efforts, Spectrum has been able to actively drive down complication and mortality rates for its high-volume conditions and procedures, positioning itself to take advantage of $23 million in pay-for-performance incentives under contracts with two managed care providers.

Sharing Information Across the Organization

For business intelligence to be actionable and effective, organizations must ensure that the right information is getting to the right users. At the same time, users need to be able to understand the significance of the information they are receiving within the broader context of organizational strategic goals.

Several of the organizations interviewed for the Value Project have focused their balanced scorecards on a core set of organizational goals. Sharp HealthCare's leadership, for example, felt it had reached a point where too many metrics and targets were being measured and decided to bring focus to the organization by defining the "Sharp Experience" around six pillars: quality, service, people, finance, growth, and community.[15] All of the organization's strategic initiatives are aligned under these six pillars, and management decisions are communicated to all employees so they understand why the initiatives are in place and how the initiative metrics drive toward the broader system goals.

Bellin Health Systems balances its system-wide scorecard across the fundamental categories of effectiveness, efficiency, engaging others, growth, and teamwork. A cross-functional, interdisciplinary leadership team works with "brand" and unit leaders to translate the system-wide scorecard measures into metrics that cascade down to the individual goals of front-line staff (Bellin's brands are organizational structures that combine all of the services needed for treatment of a condition or procedure). For example, the system goal of engaging others has a "likelihood of recommending" measure. This is traced at the brand level by the "likelihood of recommending" score from the Bellin Psychiatric Center's inpatient survey result, at the unit level by the "likelihood of recommending" score for the Bellin Psychiatric Center's adult unit, and at the individual therapist's or psychiatrist's level by scores on individual patient satisfaction surveys.

The alignment of system-wide goals with department-level and individual metrics helps keep the entire organization on track. Staff understand how the information they are gathering and reporting relates to the organization's overall direction, while management and executive teams can readily see whether the organization is exceeding, meeting, or underperforming on its goals.

Reporting Quality Results Against Core Measures

Changes in Medicare payment—particularly CMS's new value-based purchasing program—mean that most healthcare organizations will be paying attention to

[15] The Sharp Experience pillars resemble the Studer Group's five pillars of service, quality, financial, people, and growth (see www.studergroup.com), but add a sixth pillar for community.

their ability to report on CMS core measures and HCAHPS patient experience of care measures, if they have not already been doing so. Payment under value-based purchasing will be tied to both achievement, which measures a hospital's performance as compared with other hospitals' performance, and improvement, which measures a hospital's improvement on its baseline performance score. For hospital business intelligence systems to be effective under value-based systems, they will need to automate reporting against these core measures in a way that allows users to easily monitor and track progress across the organization, compare performance with internal benchmarks and national averages, and respond to issues as they arise.

Partners HealthCare in Massachusetts has developed a dashboard that tracks internal performance against Massachusetts-area health system averages, national hospital averages, and other selected competitors. The dashboard tracks performance on such metrics as CMS core measures, Leapfrog Group patient safety measures, HCAHPS patient satisfaction survey measures, and HEDIS ambulatory care measures. The dashboard shows green if Partners is performing in the top 10th percentile of its comparison group, yellow if below the top 10th percentile but still above the group average, and red if below the group average.

The Partners dashboard serves several purposes: It demonstrates the organization's commitment to quality above and beyond what is required, it keeps staff focused and engaged in quality improvement, and, through comparisons with specific competitors, it promotes the staff's own competitive drive to be the best.

Business intelligence will likely require the most capital investment of the four value-driving capabilities described in this section, as healthcare organizations build IT systems and acquire software that enable them to track and link performance outcomes and cost data. However, business intelligence also may be the most important of the four capabilities, as it facilitates linking clinicians and staff throughout the organization, produces the data that can verify the outcomes and financial implications of performance improvement efforts, and enables the creation of patient information repositories that will become increasingly important as providers contemplate the assumption of risk.

PERFORMANCE IMPROVEMENT

Performance improvement capabilities comprise the skills needed to reduce variability in clinical processes and improve delivery and outcomes of care. To effectively improve performance, providers will need skills to be able to conduct the following:

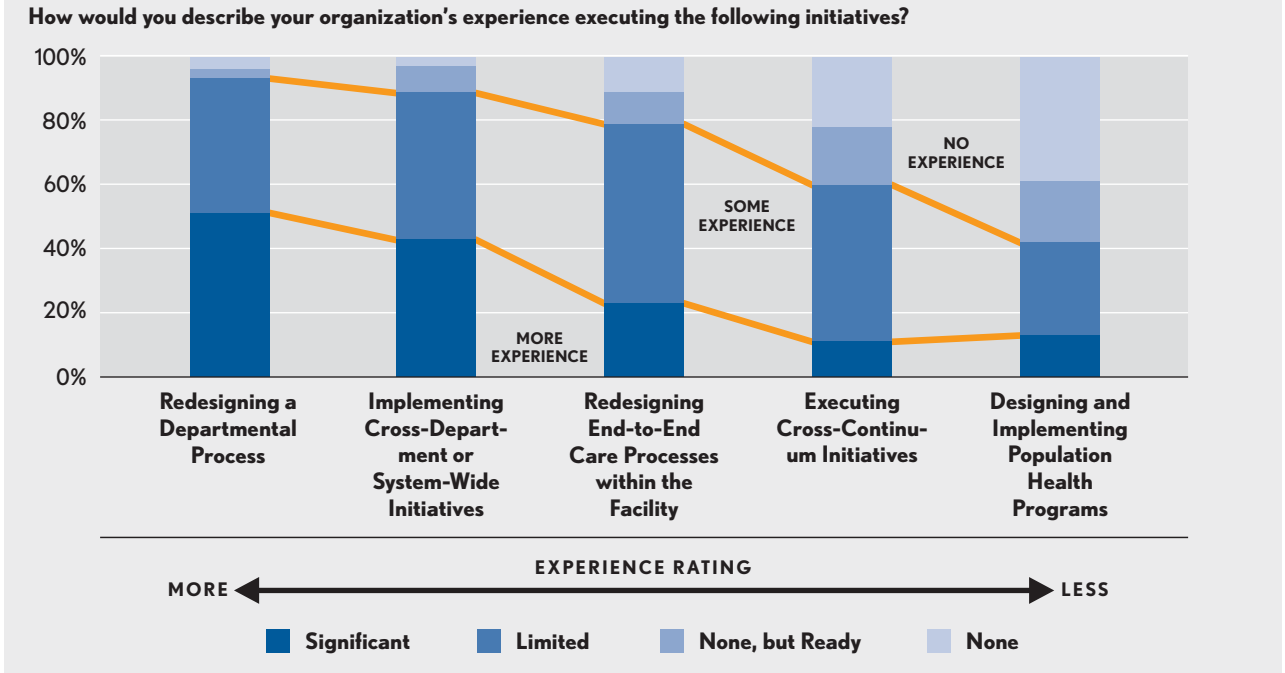
- Identify and prioritize improvement opportunities
- Develop well-defined processes to ensure that clinical redesign projects achieve their defined goals
- Identify and create consensus around evidence-based practices (from both internal and external sources)

STATE OF THE INDUSTRY TODAY

The results of HFMA's current state survey indicate that more than 90 percent of respondents have at least some experience redesigning clinical processes within a department—with over 50 percent reporting significant experience. Just under 90 percent report significant (43 percent) or some (46 percent) experience implementing cross-department or system-wide initiatives. Experience levels drop off significantly, however, for care redesign that moves beyond a facility's walls to a cross-continuum initiative. Just 11 percent of organizations report significant experience with such initiatives, while 48 percent have some experience. Similarly, only 13 percent of respondents report significant experience with designing and implementing population health programs, with providers reporting some experience in this area at 29 percent.

This difference between experience levels for in-facility and cross-continuum initiatives is not surprising. The earliest CMS quality initiatives have focused on patient safety metrics and avoidance of "never events" within the immediate control of a facility. But new initiatives are moving accountability for care beyond a hospital's walls. A penalty for readmission of a patient within 30 days of a procedure may relate back to the care provided within the hospital, for example, but it may also be the product of post-acute care or a patient's failure to adhere to a care protocol. As accountability for the longitudinal care outcomes of patients increases, so too will the need for patient engagement and coordination of care across the continuum.

EXPERIENCE WITH PERFORMANCE IMPROVEMENT ACROSS THE CONTINUUM



Source: HFMA Value Project Current State Survey, January 2011.

ESSENTIAL PERFORMANCE IMPROVEMENT SKILLS

The organizations interviewed for the Value Project are actively engaged in clinical process redesign focused on reducing the variability of clinical practice patterns and identifying and removing waste from clinical processes. Success of these efforts depends on identifying the right opportunities, ensuring that projects stay on goal, and promoting the development and adoption of evidence-based practices.

Identifying and Prioritizing Improvement Opportunities

In virtually all organizations, opportunities for improving clinical processes outnumber the resources available to implement process redesign, so prioritization of these opportunities is a critical first step.

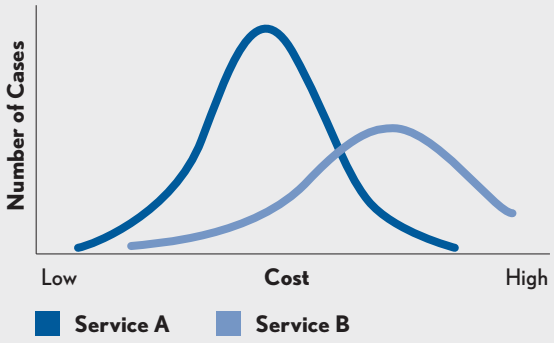
At Rush University Medical Center in Chicago, Ill., the prioritization process begins with examining data to identify quality opportunities where there are higher costs per discharge and greater variation in costs across the practice group. In the exhibit at right, Service B would be a better target for performance improvement because it has higher average costs and greater variation in costs than Service A.

But examination of the data is just a first step. Equally important is identifying and engaging physician groups where there is a willingness to take on change. "Our approach is data-driven, but making a decision on where to start involves a mix of data, gut instinct, and physician engagement," says Raj Behal, MD, associate chief medical officer at Rush. "You don't want to start with your toughest cases first."

At Sharp HealthCare, projects that are considered for implementation must fall under one of the system's six strategic pillars and must align with the system's strategy. Qualifying projects are then prioritized through multiple senior leadership meetings where competing priorities are brought to the table, discussed, and ranked. Sharp recognizes that successful implementation depends on the availability of adequate resources, so it limits the number of initiatives under way at any one time, demonstrating the system's focus and commitment to the initiatives that do make it to implementation. The reasoning behind the senior leadership's prioritization of projects is communicated to the staff to help mitigate frustration over projects that are not selected.

IDENTIFYING IMPROVEMENT OPPORTUNITIES

Cost Distribution for Clinical Value Bundles



Once a project has been functional for one year, Sharp performs an assessment to determine how the initiative's outcomes compare with goals and expectations for the project. If alignment isn't sufficient between the project's goals and actual outcomes, the project is stopped so that the system can dedicate resources to other initiatives.

Organizations skilled in identifying and prioritizing performance improvement projects must, in other words, know both when to begin a project and when to end it. Not every project will be a success, and organizations must be ready to redeploy their resources to pursue more promising opportunities.

Developing Processes to Ensure Projects Meet Goals

Several of the Value Project interviewees have developed well-defined processes for clinical reengineering initiatives. These processes ensure that initiatives are both viable and kept on track for implementation.

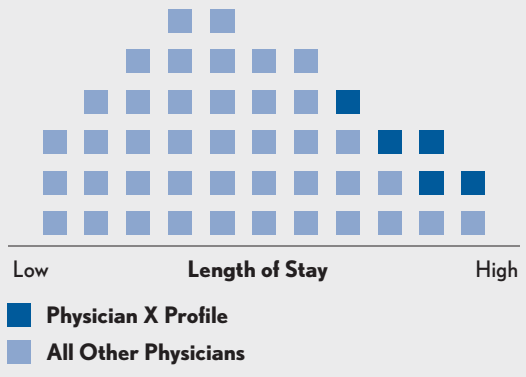
Rush University Medical Center has developed a 12-week rapid cycle improvement process, which begins with prioritization of possible process improvement areas. The clinical department chair and other physicians within a potential target area are engaged to consider undertaking a process redesign, with the understanding that clinicians will control the elements of the redesigned care protocol. The physicians review data provided by the hospital to identify practice variations among individual physicians, analyze the reasons for these variations, and then define metrics and processes intended to reduce the variations. For example, in the exhibit on page 22, an analysis of physician practice variations in length of stay

indicates that Physician X displays higher cost patterns among his peers, and his practice patterns would warrant further analysis and discussion.

Following the development of the fact base and initial metrics for the area, the improvement plan is introduced at a formal kickoff with the clinical resource management steering committee, which is chaired by Rush's CEO. Physicians, nurses, and pharmacists are brought in for this meeting. The group reviews the initiative's quality and cost targets as well as potential for growth for the practice area, and it assigns accountability for the initiative goals. Final consideration comes at the end of the 12-week period, when quality and cost targets and metrics have been approved, are aligned with potential growth opportunities, and are adopted as the standard for tracking performance improvement within the area.

The performance plan at Bellin Health is based on the Juran trilogy[16] of quality design, quality control, and quality improvement. *Quality design* focuses on new innovations for performance improvement. Performance improvement initiatives that make it to the system-wide agenda must meet two criteria: They must affect multiple departments, and they must address the system's three priorities of clinical outcomes, patient satisfaction, and financial viability. *Quality control* focuses on current processes that have gone off target in terms of reliability, predictability, or safety. In the case of both quality design and quality control, innovations or corrective actions follow a 120-day planning and review cycle. During this period, system and initiative leaders monitor and track performance and outcomes and adjust resources toward improvement initiatives that are showing the greatest promise. To support *quality improvement,* processes with proven impact on the advancement of the priorities are incorporated into the system's balanced scorecard metrics.

PHYSICIAN PRACTICE VARIATIONS



For hospitals and health systems to improve quality, they need to ensure that their processes for supporting high performance are able to accommodate and adapt to new knowledge. At the same time, processes with clear parameters and time schedules, such as those employed by Rush and Bellin, keep stakeholders focused and on task.

Creating Consensus Around Evidence-Based Practices

The ability to establish consensus among clinicians around evidence-based practices is critical for both the initial and long-term success of performance improvement efforts. An effective model for building consensus has been developed by Bon Secours Health System as part of its Clinical Transformation initiative.

Performance improvement initiatives are identified and approved at the system's senior leadership level, and then they are rolled out to local interdisciplinary teams, which include both clinicians and finance and administrative staff at the system's individual hospitals. The system leadership defines general "guardrails" for the local transformation teams, but the teams are encouraged to experiment with process improvements within these constraints. After the local interdisciplinary teams trace the patient experience through the care process to identify practice variations, possible safety issues, and waste in a manner that mirrors industrial process redesign efforts, practicing clinicians on the team are tasked with developing practical care delivery solutions to the problems identified, which helps ensure clinician buy-in.

All of the local teams working on a common initiative meet monthly by phone to share knowledge, discuss problems, and identify emerging "best practices." Once a best practice is identified and agreed on, it is standardized across the system. An internal audit follows after implementation to ensure that once a process is put in place, it is adhered to across the system.

[16] Named for 20th-century quality management theorist Joseph M. Juran.

A best practice might be identified internally, as in the Bon Secours example, or through external research. In either case, the key to consensus-building is a collaborative approach that reflects the input of stakeholders across the system who ultimately will be asked to implement the practice.

The need for collaboration runs throughout the performance improvement capability. Clinicians and administrative staff must partner to identify opportunities for change; create processes and metrics for performance improvement that are actionable, measurable, and sustainable; and promote the adoption of proven practices throughout the organization. Performance improvement cannot be a one-time collaboration; it must represent a continuing, system-wide effort to improve the quality and efficiency of care.

CONTRACT AND RISK MANAGEMENT

For most providers, contract and risk management is probably the capability with which they have the least experience (although they may have had historical experience with capitation during the managed care experiments of the 1980s and 1990s). But as both government agencies and health plans initiate programs piloting various forms of value-based care, from episode-of-care-defined bundled payments to ACOs that assume responsibility for defined patient populations, the need to develop contract- and risk-management capabilities will increase.

Management of care episodes or the delivery of "accountable care" will in many cases require an extension of care across a network of providers. Providers will need to develop capabilities in assessing the potential risks and benefits of acquiring other providers or engaging with them contractually to build a care network. Considerations will include how to divide the care services, accountability for outcomes, and revenue among network members. Also, providers will need to predict and manage different forms of patient-related risk under different payment methodologies. For example, providers will need to evaluate performance risk for patient outcomes under an episodic or bundled payment system for acute-care procedures, or they will need to understand utilization risk under a bundled payment system for chronic disease management or a per-member-per-month capitated payment system.

In the near term, providers will need skills to perform the following:

- Create partnerships with payers to meet mutual needs, collaborate on payment system evolutions, and discuss progress toward quality and cost goals
- Develop cross-functional collaboration among clinical, finance, and contracting departments to ensure that agreements can be successfully implemented and managed
- Effectively manage utilization among the organization's patient population, ensuring that the right care is provided at the right time at the right location

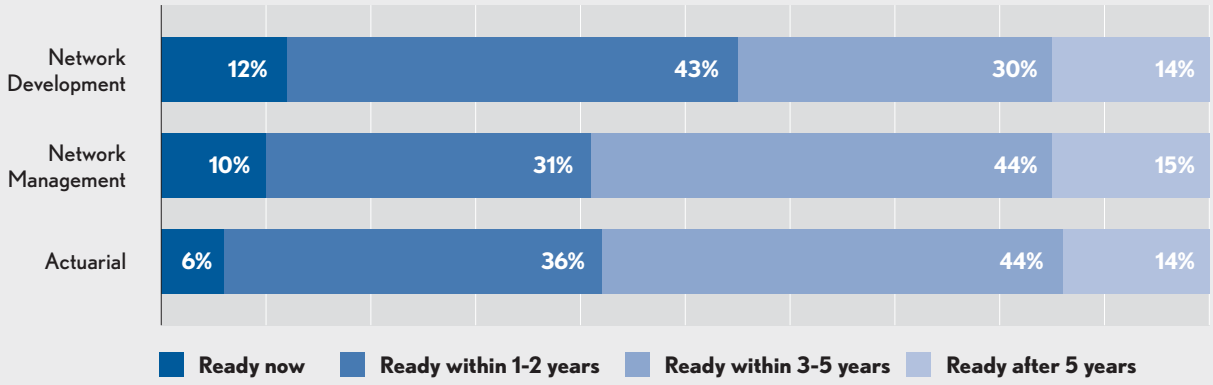
STATE OF THE INDUSTRY TODAY

The results of the HFMA current state survey show that very few providers are ready to take on the network development, network management, and actuarial activities that will be necessary under value-based payment methods that involve episodic bundling, partial capitation, or global risk. Only 12 percent of providers say they are ready now to take on network development. Slightly fewer—10 percent—are prepared today for network management, and just 6 percent are ready today to engage in actuarial activities. Many, however, anticipate readiness within the next five years.

The need for contract- and risk-management capabilities is emerging quickly, however, as public and private

READINESS TO MANAGE UNDER OUTCOMES-BASED PAYMENT

Please rate your organization's readiness to execute the key finance activities necessary to manage under outcomes-based payment (e.g., episodic bundling, global or capitated risk).*



*Totals may not equal 100% due to rounding.

Source: HFMA Value Project Survey, January 2011.

purchasers of care move forward with new payment models. CMS's regulations for ACOs, for example, offer one model under which providers would accept risk for their ACO population immediately ("track two" ACOs); under the second available model ("track one" ACOs), providers would have to accept risk after two years. Private purchasers and health plans are already actively negotiating with willing providers on models that involve greater performance risk and shared savings. And in some areas of the country, especially the West Coast, capitation has never gone away.

ESSENTIAL CONTRACT- AND RISK-MANAGEMENT SKILLS

Few of the providers interviewed for the Value Project have exposure today to payment methods that require the strongest skills in contract and risk management. But many have been working on better collaborations with payers, stronger internal collaborations, and improved utilization of their facilities—all important skills for successful contract and risk management.

Creating Partnerships with Payers

San Diego-based Sharp HealthCare receives over one-third of its revenue under capitation and has managed capitated payments for the past 25 years. Stacey Hrountas, Sharp's vice president, managed care, has this advice for any provider considering a capitated payment arrangement: "Get a commitment from your payer partners to look at the arrangement as a collaboration, not a negotiation. They must be willing to meet with you frequently and tweak and adjust the arrangement as you go."

Minnesota-based Fairview Health Services and Medica Health Plans are developing this sort of provider-payer collaboration to transition from fee-for-service payment to a shared savings model and, ultimately, population health management. They have developed this list of principles for commercial payers and providers in a value-based world:

- Shared commitment to create value
- Shared commitment to multi-year partnerships
- Focus on population health and the engagement of patients and consumers
- Collaboration on and investment in new care models (both primary and specialty) and defined payment models that recognize the value created
- Sharing of real-time, transparent data and information to drive improvements
- Shared savings models in which providers retain the majority of savings
- Commitment to creativity and innovation
- Dedication to better outcomes and reduced administrative costs
- New products to expand covered lives[17]

The principles defined in this list will furnish a collaborative roadmap for Fairview and Medica as they work to implement a payment pilot in which Fairview's guaranteed fee-for-service payments diminish, while its incentives to improve quality and cost of care increase. Creating such an understanding with a payer in advance helps to ensure that both parties agree on the goal and the flexibility that may be needed to achieve it.

Sharp HealthCare also emphasizes that a payer partner must be willing to share historical claims data on the full managed population, especially if—as will usually be the case—the provider organization does not have its own data providing a complete picture of historical utilization. Without access to the full claims history for a population, a provider will not have sufficient information to understand utilization and take measures to positively affect quality or cost of care. Organizations that choose to pursue capitated contracts without this crucial information will expose themselves to substantial financial risk.

Developing Collaborations Among Clinicians, Finance, and Contracting Departments to Ensure Success

Sharp HealthCare emphasizes the importance of having relationships with clinicians to understand variations in cost that may appear in the data. Josh Schmidt, Sharp's director of managed care finance, connects with clinicians daily to get information from specific cases that stand out in his review of data for the system. "The relationships with clinicians are essential to make the numbers actionable," says Schmidt. "Numbers mean nothing without actionable information."

Equally important are relationships between the contracting department and finance. "You need to get agreements that can actually be implemented," says Sharp's Stacey Hrountas. "Finance needs to know what the system is committing to before the agreement is signed."

[17] Presentation of Terry Carroll, PhD, senior vice president for care transformation and CIO, Fairview Health Services, and Charles Fazio, MD, chief medical officer, Medica, at HFMA's *Leadership Conference on Value*, April 1, 2011, Chicago, Ill.

Hrountas also cautions that capitated lines almost always operate best within an environment that has centralized finance, administrative, contracting, and clinical functions, where it is easier for the left hand to know what the right is doing.

Managing Utilization Effectively

Providers who are considering an arrangement involving assumption of risk for a patient population will need to develop two essential skills for utilization management: First, they must ensure that patients are properly utilizing the right facilities for their care needs. Second, they must try to ensure that patients stay within the provider's network when they do need care, so the provider that has assumed the risk of managing the patient's health can make sure that care for the patient is being properly coordinated and delivered.

Adventist HealthCare, a five-hospital healthcare system based in Rockville, Md., assumes the financial risk of providing health care to its employees and their dependents through its own health plan, Adventist HealthNet, a self-funded employee benefit plan. The organization examines and manages factors affecting this risk carefully. As an example, expenditures for the plan rose at a rate of approximately 4.2 percent from 2004 to 2008, but then rose by more than 12 percent in 2009. Analysis revealed that this increase was driven by 454 plan participants whose costs represented 60 percent of the plan's total costs for the year. The system responded with the launch of a pilot patient-centered medical home focused on caring for the needs of what they define as "poly" users—those participants who saw at least 15 providers and had at least nine prescribing physicians within a year—within the group of 454 high-cost participants. The system identified 46 "poly" users to participate in the pilot and assigned eight primary care physicians to manage their care needs. A personal health nurse was also assigned to each of the primary care physicians to develop a personal health plan addressing such items as dietary counseling, baseline screening appointments, or exercise plans for each of the pilot participants and to facilitate the participants' compliance with the plan.

The first year of the pilot showed significant success, with improved overall health of pilot participants, more efficient use of the healthcare system, and reduced costs per member in the plan. The number of high-risk patients enrolled in the pilot was reduced by 48 percent, a reduction represented largely by patients who were able to move from high-risk to moderate-risk or low-risk categories as a result of improved health. Reductions in overall utilization of the healthcare system led to a 35 percent reduction in per-member-per-month (PMPM) costs for the pilot participants (from $1,981 in 2009 to $1,290 in 2010), even as overall PMPM costs for non-pilot plan members increased slightly over the same time period (from $296 in 2009 to $299 in 2010).

To help ensure that patients within its capitated population of approximately 279,000 lives are receiving properly coordinated care, Sharp HealthCare has developed a centralized, system-wide department focused exclusively on patient "repatriation," or bringing those patients admitted through out-of-network emergency departments back into the system, where access to their medical record supports better coordination of care and minimizes the likelihood for duplicative tests and procedures. Sharp's repatriation department employs nurse case managers who work with out-of-network providers in the area so they know to contact Sharp if a Sharp patient is admitted to their facility. If the patient is stable for transportation and Sharp has the right bed available for the patient's care, then the patient is brought to the appropriate Sharp facility. If it is not feasible to transport the patient back into the network, Sharp's nurse case managers go out daily to review the patient's care. "Our efforts add up to better care for our patients," says Hrountas. "Families of patients who are in non-Sharp facilities are wowed when Sharp nurses come by to check on their family member's care."

Sharp manages a sizeable capitated population, but providers should not think that development of contract- and risk-management capabilities is contingent upon the return of capitation. Various forms of risk—from performance to utilization—are quickly emerging as part of the new healthcare landscape. Providers can prepare themselves by developing relationships with payers in their market; promoting the collaboration of clinicians, finance, and contracting departments on new payer contracts; and better understanding who their patients are and how they utilize internal services.

CHAPTER 3

The Future State of Value in Health Care

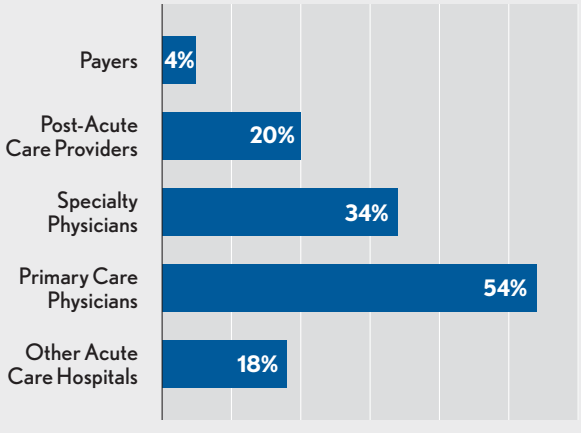
The trends toward value-based payment outlined in the previous section are likely to intensify in the future. Looking forward, it is important to understand key assumptions for the future state of health care, industry perspectives on readiness in light of these assumptions, and the types of care models that will be most likely to succeed.

ASSUMPTIONS GOING FORWARD

Payment cuts. Growth of healthcare costs at the current rate will almost certainly lead to government-imposed price controls in the form of slowed payment rate growth or rate reductions. Although providers have historically been able to cost-shift these payment reductions to the private sector, strong resistance to this approach means it will no longer be sustainable.

INTEGRATION TRENDS

Over the next five years in your market, what level of consolidation/integration do you expect to see between hospitals and the following?



Source: HFMA Value Project Survey, March 2011.

Increased market demand for value, transparency. System stakeholders—including patients and consumers, employer and government purchasers, and health plans—will demand greater value for their healthcare dollar, pushing for increases in quality outcomes and cost savings. Greater transparency of quality and pricing information will allow stakeholders to identify and use high-value providers.

Push for innovation. To meet the demand for value, providers will have to innovate with service-line mix and cost structure and consider revenue models that hold them accountable to some degree for performance-based patient outcomes.

Focus on primary care and controlling high-cost acute care utilization. Attention will focus increasingly on healthcare cost "hot spots"—including neonatal intensive care, chronic disease management, and end-of-life care—and on a primary-care led system that controls utilization and coordinates care across the continuum. Although a need for acute care will remain, hospital admissions will in many cases be viewed as a potentially avoidable cost of care.

Shifting risk dynamics. The drive for accountability will increase provider partnerships and integration, and providers will need to develop contracts, manage networks, and absorb risk in the most optimal manner, depending on what role an organization chooses to play in a value-based payment ecosystem.

INDUSTRY PERSPECTIVES ON THE FUTURE STATE OF VALUE

In a survey on the future state of health care, HFMA found that many providers anticipate significant change, even if they have not yet begun preparing for it.

Over half of the survey respondents expect considerable integration between hospitals and primary care physicians over the next five years, and a third also expect considerable integration between hospitals and specialty physicians.

Providers also anticipate that within the next 10 years their payments will be subject to increasing levels of performance risk through value-based payment methodologies such as bundled payments, capitated payments, or shared savings with penalty contracts.

A clear majority of survey respondents anticipate a future need to invest in population health management capabilities; only 17 percent are not planning to invest.

As the exhibit at lower right indicates, many of the providers that see a likely need to invest in population health-management capabilities are planning to wait for clarification on the future direction of payment methodologies. Several of those methodologies—and the care delivery models that might best respond to them—are taking shape now.

FUTURE CARE DELIVERY MODELS

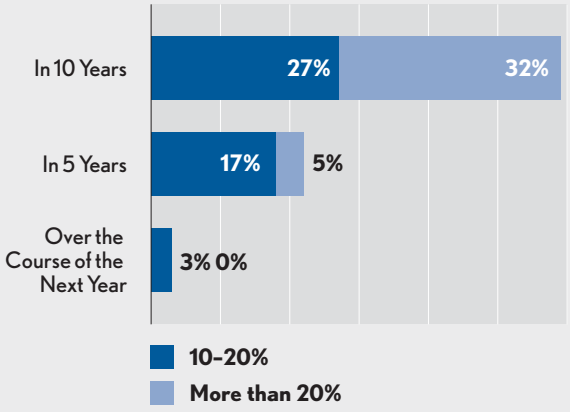
The capabilities grid illustrates particular skills within the four capabilities of people and culture, business intelligence, performance improvement, and contract and risk management that providers will need to develop to accommodate the demands of different payment methodologies requiring varying levels of provider integration and assumption of risk. As payment methodologies shift to the right side of the grid the need to create integrated networks of providers (formal or informal) to coordinate care across the continuum intensifies. Providers also assume more risk as payment methodologies shift to the right. Performance risk emerges almost immediately under a pay-for-performance methodology. Population risk and the attendant need to manage utilization effectively become critical considerations under disease and chronic care management and total health management methodologies.

For the foreseeable future, it is likely that a range of payment methodologies will coexist, although emphasis will shift toward the center and right of the grid. Similarly, a range of strategies will be available to healthcare providers, depending on their desire or need to integrate with other providers and their ability to assume risk. Decisions regarding integration and assumption of risk will be driven by a number of factors:

- Alignment of medical staff
- Sophistication and use of IT for clinical and financial decision making
- Access to human and financial capital
- Market share and competitive environment
- Record of success with performance improvement
- Skills in the medical management needs of the provider's patient population

EXPOSURE TO RISK

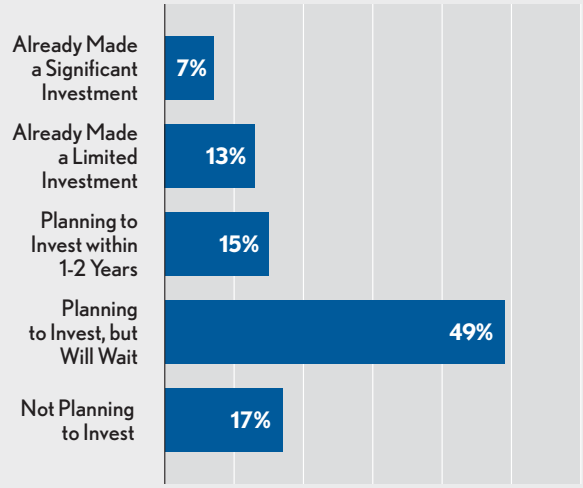
How much of your payment do you predict will be exposed to performance risk (e.g., value-based reimbursement based on bundled payment, capitated payment, or shared savings with penalty contract):



Source: HFMA Value Project Survey, March 2011.

POPULATION HEALTH MANAGEMENT PLANS

What are your plans related to investing in population health management capabilities?



Source: HFMA Value Project Survey, March 2011.

A provider with strength in all these areas will have considerable flexibility in considering future strategies, but a provider with weakness in any of these areas should carefully consider whether it can survive independently or should pursue a strategy involving integration with a stronger entity.

The range of future state strategies displayed in the exhibit below does not represent an exhaustive list. Instead, it is a highlight of strategies currently taking shape that hold promise for a value-based future state; each of these strategies involves varying degrees of integration and risk assumption.

Price-Taking Providers

Many industries have already gone through a value-based transformation. The retail industry, for example, has been reshaped over the past few decades. The rise of "big box" retailers, focused on generating large sales volumes through a nationwide network of stores, challenged smaller, independent retailers by offering a wider breadth (e.g., Wal-Mart) or depth (e.g., Barnes & Noble) of inventory at lower prices than independent retailers could match. Some of the big box retailers have, in turn, been challenged by the rise of e-commerce. Barnes & Noble has struggled against Amazon's online business, and the increasing popularity

CAPABILITIES GRID

Lower ← **Degree of Risk and Integration Required** → Higher

Organizational Capabilities	Focus Area	Fee for Service	Pay for Performance	Penalties for Adverse/ Preventable Events	Episodic Bundling	Disease/Chronic Care Management	Total Health Management
People & Culture	Cultural Emphasis	Establishing Learning Organization	Leading with Quality			Managing Long-Term Conditions	Engaging the Community
	Management and Governance	Informal Physician Leadership	Formal Acute-Care Physician Leadership		Communities of Practice		
	Operating Model	Department Structure		Episode-Focused Service Lines		Cross-Continuum Product Lines	Community Collaboratives
	Performance and Compensation	Productivity-Based		Outcomes Based			
Business Intelligence	Financial Reporting and Costing	Procedure-Level		Activity-Level	Longitudinal	PMPM	
	Quality Reporting	Core Measures	Process Measures	Outcome Measures		Condition Measures	Population Indicators
	Business Case	Supply/Drug and Productivity		Medical/Surgical Interventions		Lifestyle Interventions	
	Decisions Support Systems	Financial Data	Acute Quality Data	Ambulatory Indicators	Claims and Prescription Info	Health Risk Assessment, Biometrics, and Predictive Modeling	
Performance Improvement	Process Engineering	Identifying Service Variability	Increasing Reliability within Clinical Value Bundles		Optimizing Care Pathways Across the Continuum		
	Evidence-Based Medicine	Increasing Patient Safety	Developing Clinical Value Bundles			Managing Conditions	Improving Wellness
	Stakeholder Engagement	Creating Transparency		Informing Patient Alternatives		Developing Accountability	
Contract and Risk Management	Contract Management	Negotiating Pricing	Balancing Cost and Quality Aims		Network Development Funds Distribution		
	Risk Modeling and Management	Profit/Loss Analysis	Estimating Exposure			Predicting Outcomes	

Low Degree Medium Degree High Degree

of e-books further threatens the status of their bricks-and-mortar outlets.

Changes in the retail industry have had a significant impact on independent retailers, which cannot compete on either selection or cost. Many—but not all—have gone out of business. Those that have survived have done so because of other factors, such as quality of service, quality of products offered, or convenience of location, that retain a sufficient customer base to maintain profitability. But success for these retailers requires vigilance: A slip in the quality of service or product offered, the introduction of a new competitor, or too great an increase in the differential between the independent retailer's prices and those of its larger competitors can erode the customer base.

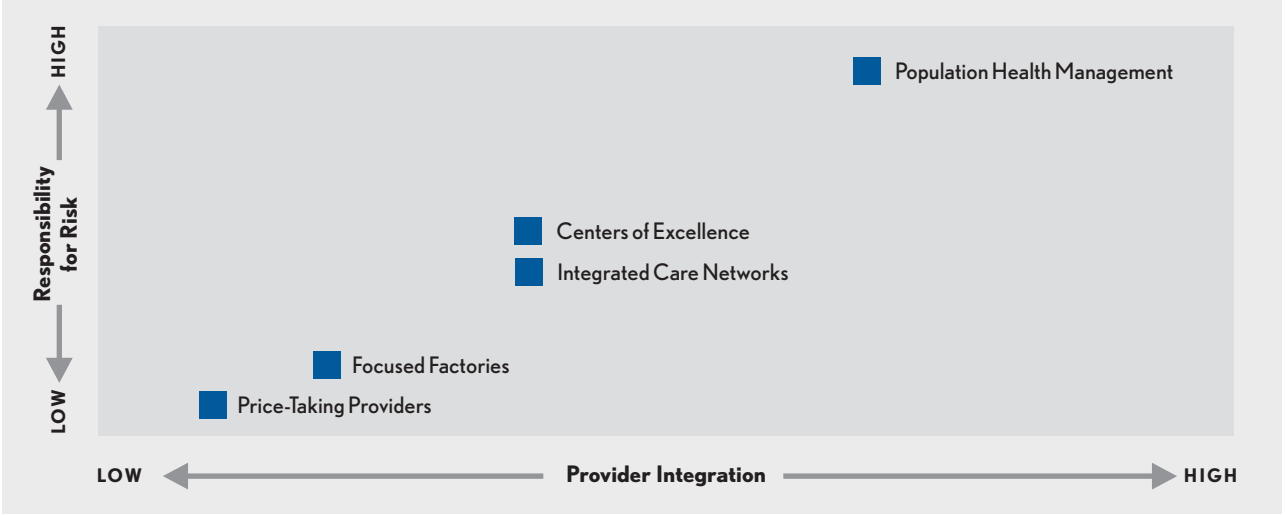
Just as some independent retailers have survived the transformation of retail, some healthcare organizations may be able to adapt to and survive the value transformation of health care relatively unchanged. These organizations will most likely be the dominant provider in their local market. They will need to offer a consistently high level of care for the services offered and do so at prices that are attractive or perhaps fully competitive with the lowest cost providers. These providers will have to maintain a high level of vigilance with respect to both quality and cost. People may prefer to use a local healthcare provider, but quality of life—and sometimes life itself—is at stake with health care. If patients have any reason to doubt the quality or safety of their local care option, many will go elsewhere for their care, especially if they will not have to pay more to do so. Price-taking providers will also face the threat of competition from new entrants in their market—and, as in retail, these entrants might be virtual or bricks-and-mortar. Price-taking providers will also have to prove continually their value proposition to other purchasers of care—employers, government agencies, and health plans—which will always be looking for better value providers. They will also need to maintain their flexibility, remaining open to alliances that may expand the services they can offer or lower the cost of the care they provide. If the pressures of a value-based system become too great, they may ultimately need to merge with other organizations.

For organizations that prefer to exist as price-taking providers, the following capabilities will be essential.

People and culture. Price-taking providers will have difficulty matching the cost-effectiveness of larger, more integrated networks. Therefore, they will need to focus on leading with quality—including safety and clinical outcomes. Respect for their patients' comfort and needs—maximizing the patient experience—will also augment these providers' value proposition.

Business intelligence. Price-taking providers will need to keep their prices as low as possible to minimize the risk of losing patients or being dropped from a health plan's network, and they will have to accept the price they receive from government programs. As a result, activity-level costing will be necessary to ensure that the prices paid for care generate a sufficient operating margin for the provider. These providers will also need meaningful, comparative data on quality outcomes and patient

DEGREE OF RISK, INTEGRATION IN FUTURE STATE VALUE-DRIVING STRATEGIES



satisfaction to communicate their value message to patients and other purchasers.

Performance improvement. Identifying and eliminating service variability will be needed to ensure a constant level of quality for the services provided. Consistent quality and high patient safety will be essential to retain customer loyalty and optimize revenues under Medicare's value-based purchasing program.

Contract and risk management. Price-taking providers will have little flexibility in negotiations with employers and health plans. They will have to enter negotiations with a clear sense of the patient volumes and prices needed to maintain their viability.

Focused Factories

The "focused factory" strategy in health care has been most fully developed in the work of Harvard Business School professor Regina Herzlinger. In focused factories, providers integrate around treatment of specific conditions or procedures, emphasizing consumer needs regarding the price, efficiency, and convenience of care. Retail clinics, such as CVS Caremark's MinuteClinics or Walgreens' Take Care Clinics, are an example of focused factories. They offer a limited menu of services—typically vaccinations, treatment of minor illnesses and injuries, physical examinations, and disease management services (e.g., high blood pressure or blood sugar testing)—with set prices and offer convenient locations and service hours.

Hospitals and health systems are also entering the market with primary care clinics tailored to the needs of employers and patients. Southwest Florida-based Lee Memorial Health System established primary care clinics for its own employees several years ago. In conversations with human resources officers from other industries, the system's chief human resources officer realized that there was a demand for such services from local employers. Working with the city of Cape Coral, one of the largest local employers, Lee Memorial developed primary care clinics that are run out of four of the system's hospitals. The clinics offer a limited menu of primary care services, such as flu shots, treatments for cold and flu, and blood pressure screening, that was developed in collaboration with the city. Plans are in the works to equip the clinics for physical examinations as well. Up to three medications can be prescribed per visit from a formulary of approximately 30 medications. The city pays a flat fee for each visit and for medications prescribed from the formulary, and employee copayments are waived for visits to the clinics.

Lee Memorial's clinics offer the city and its employees several advantages. The clinics reduce high-cost employee visits to emergency departments. They also have a strong positive impact on productivity through convenience of location. Most city employees work within five minutes of a clinic, are seen within 10 minutes of their arrival, and can be back in the office within another 20 minutes. Also, early treatment of common illnesses has reduced absenteeism. What's more, the clinics will soon be connected with Lee Memorial's electronic health record, enabling the system to build a complete record of care for city employees who stay within the system.

Lee Memorial benefits from the clinics as well. The clinics build positive relationships with local employers—the success of the city's experience has attracted the interest of other local employers. The clinics also create referrals to the system's employed physicians and to its hospitals. The clinics have also helped move the system toward a more purchaser-centric culture. "For too long, healthcare providers have simply told patients what they need," says John Wiest, Lee Memorial's chief operating officer for business and strategic services. "Developing these clinics in collaboration with the city and its employees has made us more responsive to what the customer wants."

For organizations pursuing a focused factories approach, the following capabilities will be needed.

People and culture. With their emphasis on consumer needs, focused factories require a strong patient- and purchaser-centric culture. As in the case of Lee Memorial, focused factory providers should actively seek conversations with patients and other purchasers of care to ensure that convenience, price, and service needs are being met.

Business intelligence. To keep prices low, focused factories will typically operate on a tight margin. Accurate costing of services—including both direct and indirect costs—is important to ensure that focused factories generate a positive margin. Focused factories that are part of a larger provider organization should also be part of the organization's integrated electronic health record to ensure continuity of patient records.

Performance improvement. Efficiency of operations is a major strength of focused factory models. Performance improvement efforts should focus on minimizing patient wait times and streamlining the patient visit to maximize the focused factory's value proposition. Focused factories will also need to standardize care around clearly defined sets of evidence-based protocols.

Contract and risk management. Exposure to performance risk will be low for most focused factories, given the limited menu of services they offer. Contract management efforts (with large employers, for example) should focus on simplicity of the terms for care (flat fees, guaranteed wait times, etc.) to make apparent the value of the focused factory model. These terms should be based on a clear understanding of customer needs and what the customer values most in a service.

For many providers, a focused factory strategy will supplement the provider's broader strategy. For example, the approach may serve to complement a strategy of managing population health. Focused factories will typically require some level of integration (a retail clinic, for example, requires integration with primary care providers). Also, if the focused factory charges a flat fee for service, then it should be prepared for a limited degree of performance risk.

Integrated Care Networks

An integrated care network model involves both a formal integration of providers and a greater assumption of performance risk spreading across part or all of the care continuum. Providers collaborate to create integrated bundled services defined around an acute-care procedure (which may include pre- or post-acute care) or a chronic condition, such as congestive heart failure or diabetes. Providers could be integrated through consolidation or contractual relationships.

A number of payment methodologies are possible with an integrated care network. The network could offer a flat price (potentially risk-adjusted) for a bundle of services, or it could participate in a shared savings relationship with a purchaser in which a maximum price is established for the bundle of services, with the integrated care network sharing in any savings produced by improving the efficiency of care while maintaining the quality of patient outcomes. As multiple providers within a market begin to offer similar bundles, providers could use retail-type pricing to compete for patients and other purchasers of care.

Early examples of integrated care networks include the Medicare Acute Care Episode demonstration projects and the PROMETHEUS Payment model. Payments for care under the PROMETHEUS Payment model, for example, were based on evidence-informed case rates (ECRs). An ECR is a budget for an entire care episode that includes all covered services, bundled across all providers that would typically treat a patient for a single condition or procedure. ECRs have several components: the clinically indicated costs of treating a condition or performing a procedure, adjusted for the severity and complexity of each patient's condition; an allowance for potentially avoidable costs (reductions of which create a bonus pool to be shared among the providers); and an allowance for a margin to account for return on capital assets and reinvestment in business operations.

Within the capabilities grid on page 29, integrated care networks would fall on the right side of the grid, below episode bundling and disease and chronic care management. In building their capabilities, integrated care networks will need to focus especially on the following.

People and culture. To deliver effective bundles of services or coordinated care for a specific population (e.g., patients with diabetes), integrated care networks will need to develop cross-continuum "communities of practice." Communities of practice are microsystems comprised of related clinicians working collaboratively on the treatment of a specific condition or disease.

Business intelligence. Longitudinal costing skills become critical as integrated care networks attempt to bundle services and pricing across a continuum of providers. The networks must also be able to compare those costs with procedural outcome and condition management measures for the patients they serve and the purchasers of their bundled services.

Performance improvement. Integrated care networks will need to focus on delivering a consistently high level of quality across the care continuum. Also, they will need to effectively deploy their clinical communities of practice to optimize cross-continuum care pathways—including care transitions between providers along the pathway.

Contract and risk management. Network development and funds management emerge as critical skills for integrated care networks to effectively motivate and manage their cross-continuum communities of practice.

Developing an algorithm for distribution of revenue from bundled payments or from shared savings will be complicated, especially in cases where the network is not consolidated, but bound contractually. Factors contributing to this algorithm would include such considerations as the amount of savings a provider generated relative to a baseline for the network, amount of time or activities the provider contributed in delivering care, or the provider's contribution to achieving positive patient outcomes.

Another complication will be the participation of hospital providers in chronic condition management care networks, where hospital admissions represent potentially avoidable costs. Hospitals will need to be part of such networks for treatment of acute conditions that do arise. However, they will likely experience reduced admissions and revenues and may require a share of savings from reduced admissions to mitigate financial impacts as they adjust to lower volumes.

Centers of Excellence

A centers of excellence model combines attributes of both focused factories and integrated care networks. Centers of excellence are organized around treatment of specific conditions and related procedures, typically at the complex tertiary end of a care delivery scale. They require tight integration of the medical specialties involved in treating the condition and performing the procedures that are the center's focus. Participants in the model are usually not multi-site providers. More frequently, they are organizations that draw from a regional or, in some cases, national patient population, with patients traveling to receive care. Centers of excellence differ from integrated care networks in that they typically are part of fully consolidated organizations, not members of a more loosely integrated, multi-provider network.

The Cleveland Clinic's institutes, in which departments of related medical specialties collaborate as unified institutes to offer patient-centered care, offer examples of centers of excellence. In 2010, Cleveland Clinic's Heart and Vascular Institute announced an arrangement with home-improvement retailer Lowe's Companies, Inc., to provide Lowe's employees and their dependents in the company's self-funded medical plan with the option of scheduling qualifying heart surgery procedures at the Cleveland Clinic at an enhanced benefit rate. Under the plan, Lowe's covers all qualified patients' medical deductibles, coinsurance amounts, and travel and lodging expenses for the patient and a companion. Cleveland Clinic, in turn, charges Lowe's a flat rate for all services related to the procedure.

A flat-rate payment involves potentially significant performance risk for centers of excellence, corresponding to the complexity of the condition or procedure at issue and the possibility for complications. At the same time, centers of excellence can limit their performance risk to the services and procedures within their direct control—especially with respect to surgical procedures. In the Cleveland Clinic heart surgery model, for example, there is no guarantee— or continued exposure to risk—if a patient is discharged in stable condition but later develops a complication. Instead, the Cleveland Clinic relies on maintaining high-quality outcomes to minimize purchasers' concerns about additional costs related to complications. Negotiation of performance risk exposure for centers of excellence focusing on treatment of chronic diseases or conditions would be complex, given both the duration and range of services needed for effective treatment.

Centers of excellence may exist within a network of providers assembled by an integrator, such as a health plan, disease management company, or large employer (or its third-party administrator). A provider organization could also technically take on the role of integrator, but as the main contact point for the purchaser of care, it would have to be able to take on many payer-like attributes—something that few providers would have the skills or capital to assume. Centers of excellence have a contractual relationship with the integrator (not with other providers in the network).

On the capabilities grid on page 29, a centers of excellence delivery model would fall toward the center to right, requiring capabilities for payment methodologies through episodic bundling and—in the case of a chronic-disease focused center—chronic condition management. Capabilities needed for those pursuing a centers of excellence strategy would include the following.

People and culture. Centers of excellence will be responsible for organizing themselves and their care delivery around specific conditions or procedures, which will often require both intradepartmental and interdepartmental integration. A culture intensely focused on quality and process improvement will also be necessary for centers of excellence to maintain a "best in class" standing.

Business intelligence. Accurate data for both costing (activity-level) and quality will be needed to set pricing for service bundles and to demonstrate value to healthcare purchasers.

Performance improvement. To sustain the level of performance demanded by purchasers, centers of excellence will need to apply evidence-based practices to develop clinical value bundles, with a focus on optimizing the quality and price of the bundles.

Contract and risk management. Centers of excellence will need to manage performance risk to thrive in an episode-of-care, bundled payment environment. Also, they will need to be able to organize contracts with institutional purchasers of their services.

As indicated earlier, a center of excellence model could be adapted to a wide range of providers and care services. There are, however, caveats: Some not-for-profit providers could find that defining themselves around a limited set of services will challenge the provision of community benefits that provides the rationale for their not-for-profit status. Also, centers of excellence might work best on a regional level, unless significant numbers of patients are willing to travel outside of their "comfort zone" near home for complex procedures.

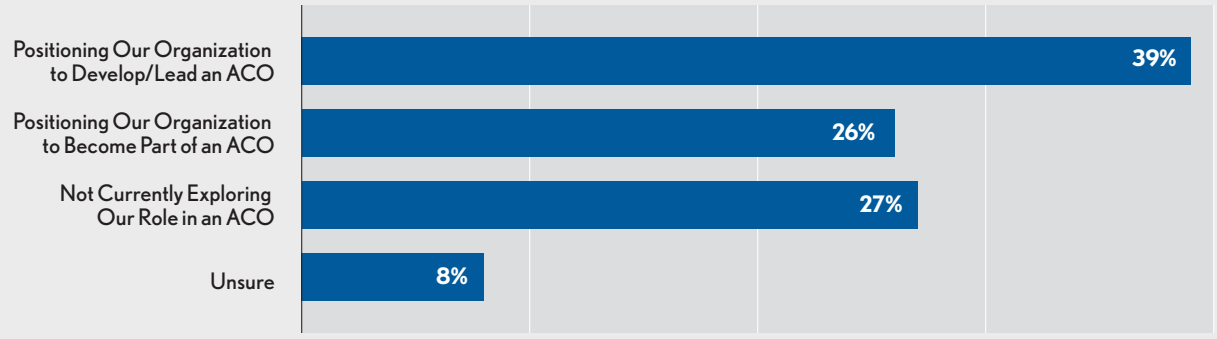
Population Health Management

In this model, providers organize into an integrated, cross-continuum organization that contracts with employers, government purchasers, or health plans to manage the health of a defined population. This model will involve the most significant degree of risk, and it will require a patient-centric care delivery strategy emphasizing primary and preventive care to improve the health of the managed population and minimize more costly acute-care episodes.

Examples of population health management today include medical homes, Medicare's Physician Group Practice demonstration project, and the ACO models defined in CMS regulations implementing the Affordable Care Act's shared savings program. CMS's ACO models have drawn significant attention. As part of its current state of value survey, HFMA asked organizations about their ACO strategy.[18] Almost 40 percent of respondents indicate that they are positioning their organizations to develop or lead an ACO, while another 26 percent are positioning their organization to be a part of an ACO.

HOSPITAL PLANS REGARDING ACOS

How would you describe your organization's accountable care organization (ACO) strategy?



Source: HFMA Value Project Survey, January 2011.

[18] The survey was conducted before CMS published proposed rules for ACOs in the shared savings program.

CMS is predicting that between 75 and 150 ACOs will participate in the first three-year phase of a voluntary shared savings program defined by the Affordable Care Act, with up to 5 million Medicare beneficiaries receiving care from these ACOs.

ACOs participating in the three-year shared savings program had the option of accepting both upside and downside risk for all three years of the program, or postponing acceptance of downside risk until year three. Those that accept two-sided risk will be entitled to a greater percentage of shared savings on the upside, while those accepting one-sided risk accept a lower percentage of shared savings by avoiding the risk of downside loss. In both cases, shared savings are at risk if the ACO does not achieve a range of quality metrics (the proposed regulation identifies 65 such metrics in five domains). On the downside, ACOs that perform well on quality metrics but miss performance benchmarks on expenditures will share fewer losses than ACOs that are low quality and low performance. The three-year program will continue to use Medicare's fee-for-service payment methodology, with savings or losses calculated at year end based on an ACO's ability to achieve quality metrics and reduce expenditures below that year's benchmark. CMS could eventually shift the payment methodology toward a partial or full capitation model if the three-year project is successful.

Assuming that a future population health management organization would operate under a PMPM capitated payment system, the organization would fall to the far right of the capabilities grid on page 29. Those pursuing a population health management strategy would need to develop the following capabilities.

People and culture. Population health management organizations will need to orient themselves around the effective management of long-term chronic conditions and other key drivers of cost. Leadership will also have to drive significant changes in culture. Compensation models will have to change from volume-based incentives to incentives focused on improving general measures of population health and on improving outcomes for specific conditions and procedures. Organizations will also need to recruit staff whose skills extend beyond the range of "normal health care" to experience in managing population health outcomes related to socioeconomic factors, such as housing, education, and nutrition.

Business intelligence. Business intelligence in a population health management model will center on per-member statistics such as PMPM costs. Decision support systems must enable predictive modeling and health risk assessment to support the organization's ability to manage utilization risk.

Performance improvement. Condition management within the population will be a key factor driving the success of a population health management organization. These organizations will also have to create means for developing accountability for outcomes among members of the managed population.

Contract and risk management. The ability to effectively predict outcomes will be fundamental as population health management organizations accept greater performance and utilization risk. Organizations will want to acquire or contract for actuarial skills to help estimate risk within the managed population.

The population health management business will be fundamentally different from an acute-care-focused healthcare system. Success will be defined by the ability to identify condition-specific standards to maximize population health outcomes and minimize preventable utilization of acute-care facilities. Costs will be measured longitudinally, on a per-member basis across the continuum of care, not per incidence of care provided. Organizations will focus on maximizing the number of lives covered, not the units of care provided. If the healthcare system moves toward population health management, hospitals will have to prepare for a much different future by reducing overhead costs and eliminating excess capacity.

CHAPTER 4

Recommendations for Supporting Value-Based Transformation

The future state alternatives described are all in an early stage of development, and their viability will be tested over the next few years. What is clear, however, is the industry's movement toward value. Providers should begin now to plan for a value-based future, using these four steps:

1. **Assess your organization's current and desired state on the value continuum.** HFMA offers a web-based tool tied to the four value capabilities and related skills that is available on the Value Project's website (www.hfma.org/ValueProject). The tool includes a self-assessment questionnaire that identifies where you are on the value continuum, and what skills you should develop to achieve foundational and advanced status as a value provider. Or users can simply browse the tool to see what skills are recommended for the value capabilities. The skills are supported by strategies, tactics, and tools contributed by the providers interviewed for the Value Project. Organizations should also assess conditions in their local market to help predict future directions for change, considering such factors as alignment with clinicians, access to capital, sophistication and use of IT for clinical and financial decision making, success with performance management, market share, and competitive environment.

2. **Prioritize the development of capabilities for your organization.** After assessing your organization's current capabilities and those needed to reach the desired state, it will be important to examine areas in need of greatest skill development. What forces within your organization could constrain or accelerate your development of value capabilities, and how could you constrain negative forces and strengthen positive forces for change?

3. **Institute proven practices to develop necessary capabilities.** Reference the Value Project's future web-based tool for specific strategies and tactics to build skills within the four value capabilities.

4. **Develop a process to measure the progress of your organization's capability development.** Align goals across your organization to create a uniform emphasis on achieving your value objectives, establishing realistic targets for short-term and long-term goals. Identify the right metrics for scorecards that cascade these goals throughout your organization. Be disciplined in measuring and reporting progress toward these goals by establishing baseline performance, seeking to understand the causes of progress and delay, and adjusting your goals accordingly. Prepare for missteps, but commit to learn from them as your organization moves toward a stronger value position.

The following chapters in this section are dedicated to each of the four value capabilities outlined in this document, describing how providers can begin to bridge the gap between current practices and a value-based future.

In his 2008 letter to Berkshire Hathaway stockholders, Warren Buffett wrote about a lesson he learned from his mentor, economist and investor Ben Graham: "Price is what you pay; value is what you get." We as a nation are now demanding that the price we pay for health care gets us value in return. It is our job as an industry to determine how we can best produce that value.

SECTION 2

Building Value-Driving Capabilities

EXECUTIVE SUMMARY

HFMA's Value Project has defined four areas organizations should cultivate to adapt to a value-based healthcare system:

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

This section examines each of these four value-driving capabilities in detail, identifying skills, strategies, and tactics that will help organizations build these capabilities. Our focus is on ways that providers can develop their people and culture to drive value within their organizations.

There are four key ways providers can develop both a value-driving staff and culture.

Define a strategic vision for value. This includes adopting a common understanding of value, redefining an organization's vision, and communicating and reinforcing the value message throughout the organization.

Build multidisciplinary teams focused on achieving value. Interviews with leading providers that have effectively cultivated collaboration throughout their organizations yield several lessons for developing multidisciplinary teams. Start at the top, by assessing the composition, expertise, and priorities of the organization's board and senior leadership team. A balanced board and senior leadership team set the stage for promoting collaboration between clinicians and finance and administrative professionals to improve value throughout the organization. Make the teams' top priority improvements in quality of care. Recruit willing players for multidisciplinary initiatives, and build trust with consistency.

Manage and reward employee engagement. Engagement of hospital staff has been shown to be a key indicator of positive quality outcomes for patients. Organizations seeking to increase employee engagement should start by building an understanding of what employees value most. This information should then be used to shape an organization's compensation structures, employee development opportunities, leadership development programs, and internal communications and identify areas for improvement. Organizations should regularly monitor employee satisfaction and should move to quickly address issues that decrease satisfaction.

Reorient care around the patient experience. As hospitals and health systems devote more attention to accessing the system from the patient's perspective, they are discovering improvements in patient access, navigation, and organizational structure that can enhance both the quality and cost-effectiveness of care. Organizations should ensure that patient advisory councils are in place and that patient input is incorporated into decisions that affect care delivery and patient interactions with the system. They should also work to improve patient access and align the organization's structure around the patient experience.

Additional strategies and tactics for developing the skills necessary for a value-driving people and culture are available in HFMA's Value Project web tool. The tool, along with additional resources, can be accessed on the Value Project website at www.hfma.org/valueproject.

CHAPTER 5

People and Culture

An organization's people and culture serve as cornerstones for value. Without a culture focused on value and a staff continually engaged in creating value, efforts to drive value are unlikely to succeed. But an organization's people and culture can resemble a cornerstone in other respects: set firmly in place and difficult to move. Engaging people in the need for culture change requires strong leadership, clear communication, persistent effort, and patience.

The task of developing a value-driving people and culture involves significant effort, but establishing realistic goals and expectations will help make change more manageable. This chapter outlines four key elements in creating a people and culture capability for value.

- Define a strategic vision for value.
- Build multidisciplinary teams focused on achieving value.
- Manage and reward employee engagement.
- Reorient care around the patient experience.

DEFINING A VALUE-FOCUSED VISION

In the area of people and culture, the adage "change starts at the top" is true. It is essential that an organization's board and senior executive team unite around the need to create value and clearly and consistently communicate the need for value creation throughout the organization.

There are three strategies providers should consider in defining a value-focused vision.

Adopt a common understanding of value. Defining a vision for value depends, of course, on a common understanding of value. In the previous chapter, we, identified key components of the definition of value in health care, including the following:

- Value is defined from the perspective of the purchaser: the patient and other purchasers, including employers and government agencies
- Value is a function of the quality of the care received over the total amount paid for the care (the value equation)
- Quality comprises patient access to care, the safety of care, the outcomes of care, and respect for the patient
- Value is enhanced by improving the quality of care, reducing the price of the care, or both
- Value requires a culture in which all people are focused on value creation

Healthcare leaders should use these assumptions as a starting place for a discussion among their organizations' board and senior leaders on the definition of value. Is there agreement on these components? Would the organization add any additional components to this definition? The ultimate goal is to arrive at a definition of value that is explicitly and unanimously endorsed by the board and senior leadership team.

Redefine the organization's vision. Once an organization's leadership team has adopted a common understanding of value, it should review the organization's mission and vision statements and strategic goals to see if they align with a goal of creating value.

THE VALUE EQUATION RECONSIDERED FOR HEALTH CARE

$$\text{Value} = \frac{\text{Quality}^{*}}{\text{Payment}^{\dagger}}$$

* A composite of patient outcomes, safety, and experiences
† The cost to all purchasers of purchasing care

Source: HFMA's Value Project.

COMPONENTS OF AN ORGANIZATION'S VISION

Most organizations have defined a mission statement, vision statement, and strategic goals or objectives. Together, these documents define an organization's vision, but each plays a distinct role:

- **Mission.** This statement defines what the organization represents (a religious affiliation, for example), the community and stakeholders it serves, the services it provides, and the standard of care it strives to achieve.
- **Vision.** This statement is aspirational. Although an organization's vision should be attainable, it should also require the organization to stretch its capabilities significantly.
- **Strategic goals.** These goals identify priorities for the organization and suggest how the organization plans to achieve them.

A variety of factors will influence an organization's vision—for example, whether it is a teaching hospital or critical access hospital, the demographics of the population it serves, and more—but a value-focused organization should be committed to:

- Respecting the needs of patients and their families
- Improving the safety and outcomes of care
- Improving the affordability or cost-effectiveness of care for the purchasers of care
- Supporting the development, competency, and commitment of the organization's people in providing value
- Improving the health of the population served

There are, of course, many ways in which these concepts can be incorporated into an organization's vision. In the case study from Bellin Health featured below, the vision statement focuses on the health of the population served, while the mission statement and strategic goals provide

CASE STUDY: BELLIN HEALTH FOCUSES ITS VISION ON VALUE

Bellin Health, a community-owned, not-for-profit health system serving northeast Wisconsin and Michigan's Upper Peninsula, has made a strong commitment to value through a mission statement, vision statement, and set of strategic objectives adopted in August 2010. "Defining our vision required thinking about each role in the organization from a quality and cost perspective, and being patient-centered," says Jim Dietsche, Bellin's CFO.

Bellin's mission statement reads:

> Directly, and in partnership with communities, employers, schools, and government officials, we guide individuals and families in their lifelong journey toward optimal health. We are committed to providing safe, reliable, cost-effective total health solutions with respect and compassion. Our innovative work will impact healthcare delivery in our region, as well as throughout the world.

The mission statement is complemented by a vision that "the people in our region will be the healthiest in the nation" and supported by the following four strategic objectives:

- **Patient, family, and customer-centered organization.** Included in this objective is a commitment to encouraging and including the active participation of patients and their families in their care.
- **Engaged staff and partners.** This objective defines a positive culture based on the values of people, superior service, continuous improvement, learning and development, and innovative thinking.
- **Improved health of the population.** This objective commits Bellin to providing high quality healthcare products and services at an affordable cost, while offering a positive experience.
- **Growth and prosperity.** This objective sets a goal of lowering the cost of healthcare services for Bellin's region to the lowest in the nation, while maintaining a bond rating at or above investment grade.

Bellin's vision notable in its consistent focus on improving population health, optimizing patient experiences and engagement, cultivating and supporting a committed, competent staff, and continuously improving the value of care, both in terms of both quality and cost-effectiveness.

While focusing on the region Bellin serves, the statements also incorporate aspirational goals that will position Bellin as a national healthcare leader—a source of pride for Bellin's employees and for the population they serve.

A full copy of the Bellin mission, vision, and strategic objectives is available in the Value Project web tool at www.hfma.org/valueproject.

more details on specific partners, strategies, and benchmarks the organization will pursue to create value.

Communicate and reinforce the value message throughout the organization. After the leadership team has incorporated a focus on value into the organization's vision, it faces the critical and ongoing task of communicating and reinforcing the organization's value message throughout the organization. The goal of this task is to ensure that the value message penetrates all aspects of the organization's operations; accordingly, it must be pursued using multiple vehicles and tactics.

Successful organizations use multiple channels in combination to create a value-focused culture. Examples include:

- Distilling the organization's vision into a single, focused statement that summarizes the organization's value goals and consistently incorporates that statement in communications with staff
- Scheduling regular recognition events for departments and individuals that have improved or sustained the value of care
- Aligning compensation and incentives with the organization's value goals, balancing the weight given to financial results with the weight given to improving the quality of care

Most important, the value message carried through these channels must be applied consistently across the organization and all members of the organization must be held accountable to it.

BUILDING MULTIDISCIPLINARY TEAMS

The two factors driving the value equation—quality and cost-effectiveness of care—make the development of multidisciplinary teams comprised of both clinicians and finance and administrative staff essential to the creation of value. Clinicians must understand the cost implications of the decisions they make, while finance and administrative professionals must understand the processes necessary to improve quality—and that quality outcomes are at least as important as cost efficiencies.

Interviews with leading providers that have effectively cultivated collaboration throughout their organizations yield several lessons for developing multidisciplinary teams.

Begin at the top. Start with an assessment of the composition, expertise, and priorities of the organization's board and senior leadership team. A balanced board and senior leadership team set the stage for promoting collaboration between clinicians and finance and administrative professionals to improve value throughout the organization.

Competencies for new board members should represent a forward-looking, value-focused perspective, including, for example, experience with delivery of care across the continuum or perspectives on patient, employer, or health plan priorities. Clinical, financial, and administrative expertise should be represented on the board. The board's agenda and committee structure should also reflect a value-based balance between clinically-driven quality concerns and financial results.

Board members should consider shadowing clinicians on the floor to better understand the issues involved in clinical process redesign, rather than solely receiving the results of such initiatives (both clinical and financial) through reports and meetings.

A hospital's senior leadership team should also include balanced representation of clinical, financial, and administrative officers. To help ensure that these leaders function effectively as a collaborative team, the organization should develop or identify leadership training programs to make clinical leaders conversant in finance and business issues and finance and administrative leaders conversant in clinical issues. Finance and administrative officers should also be encouraged to periodically round with the chief medical officer or chief nursing officer and sit in on physician or nurse meetings to stay apprised of the relationship between financial decisions and delivery of care.

Lead with quality. This lesson will often require a leap of faith from finance members of the team, but clinicians will be much more engaged in an initiative that focuses first on improved quality of patient care. HFMA's Value Project surveys indicate that most finance officers see a link between quality and cost improvements; their role is to quantify cost improvements as they work with clinicians on quality. Value Project interviews with CFOs at organizations that have taken the "quality leap of faith" find that the CFOs have become true believers in the link between quality and cost-effectiveness.

Begin team-building initiatives with willing players. Within an organization, different departments will have different cultures. Don't start the effort at team-building with groups that are most resistant to change. Seek out departments with strong leaders who will champion the drive for value. Establishing early wins with these groups should lessen the resistance of others.

Build trust with consistency. Finance professionals and clinicians share a mutual respect for data. The finance side of the team can go a long way in building trust among team members by ensuring the consistency and accuracy of data used to identify value improvement opportunities and report on the progress of initiatives.

MANAGING AND REWARDING EMPLOYEE ENGAGEMENT

As healthcare organizations work to develop a people and culture focused on value, managing and rewarding the engagement of staff and monitoring their satisfaction will be essential to delivering on patient's expectations for quality of care.

From the patient's perspective, quality is driven by a variety of components: access to care, safety, quality outcomes, and respect. Most of these are driven by the patient's interactions with hospital staff. And engagement of hospital staff has been shown to be a key indicator of positive quality outcomes for patient. For example, a 2005 Gallup study of more than 200 hospitals found that nurse engagement was the No. 1 predictor of mortality variation across the hospitals, exceeding in importance the ratio of nurses to total patient days and the percentage of overtime hours per year.[19]

Bon Secours Virginia's experience with clinical transformation teams, highlighted in the case study on page 43, illustrates the quality/engagement link. As quality outcomes improved, so did engagement of the system's RNs.

Employee engagement is important in other respects as well. Value creation will depend on attracting and retaining high-potential talent in both clinical and finance and administrative positions. Shortages of talent are already predicted for clinicians key to value creation, including nurses and primary care physicians. Healthcare organizations will need to understand what motivates high-potential talent—especially in those areas where there is likely to be competition for talent—and manage to these motivators.

Understand employee value drivers. Organizations seeking to increase employee engagement should start by building an understanding of what employees value most. Miami-based Baptist Health South Florida (BHSF) used a conjoint analysis of 23 job attributes (a research method that requires respondents to rate or rank attributes in order of preference) to identify five key value drivers: culture and core values, skills development and career growth opportunity, total rewards, quality of leadership, and work content.

Organizations should also consider segmenting certain groups—such as employed physicians or nurses—to better understand value drivers for employees that will be central to value-improvement efforts. Hospitals and health systems with large, independent medical staffs should also seek information on what independent physicians value in their partnership with their organizations.

The information on value drivers gathered from employees should help shape an organization's compensation structures, employee development opportunities, leadership development programs, and internal communications strategies and content. It can also help identify "pain points" for employees generally or specific employee groups, identifying areas that the organization should prioritize for improvement to increase employee engagement and satisfaction.

PATIENT QUALITY CONCERNS

Source: HFMA's Value Project.

[19] Blizzard, Rick, "Nurse Engagement Key to Reducing Medical Errors," Gallup, Dec. 27, 2005, www.gallup.com.

CASE STUDY: CLINICAL TRANSFORMATION TEAMS AT BON SECOURS VIRGINIA

As part of a clinical transformation initiative at Bon Secours Virginia Health System, clinical collaboratives comprised of clinical nursing executives, chief medical officers, CFOs, and other key leaders have been formed at the corporate office and for each local system. Transformation teams that similarly pair clinical and financial and administrative expertise are then deployed within each hospital, tasked with developing workable solutions for specific issues, such as reducing hospital-acquired infection rates.

The local teams begin by "walking the line," as would be done in an industrial reengineering process, to uncover variances in processes and possible sources of waste. Team members then work together to determine best practices and quantify any potential cost savings that may result from implementing those practices. Local teams from across the system that are working on common problems meet monthly by phone to share lessons learned. Although finance leads are on hand to help with consistency in calculations and uniformity of reporting across the local teams, the focus is always on improving quality and the patient experience. "The entire senior leadership team needs to communicate this message with one consistent voice and resist the temptation to steer the conversation to cost reduction," says Kathy Arbuckle, CFO of Bon Secours Health System.

In 2011, Bon Secours Virginia launched "Accelerating Clinical Transformation Now" (ACT Now), with a focus on engaging every employee throughout the system in clinical transformation. The message is infused through all employee communications—daily huddles, newsletters, and more—and is supported through goal cascading, friendly competition among departments, clinical fairs, and giveaways that provide incentives for high-performing departments and individuals.

Bon Secours Virginia's clinical transformation teams have achieved numerous successes. Engagement of RNs went from the 67th percentile in 2008 to the 93rd percentile in 2010 for the seven hospitals in the system. Over the same two years, there has been a 31 percent reduction in pressure ulcers and a 46 percent reduction in hospital-acquired infections. And clinical transformation savings were reported at $12 million for FY09 and $19 million for FY10.

Monitor engagement. All employees in the organization should be surveyed annually to monitor employee engagement and satisfaction. Survey instruments can be developed internally; there are also a number of tools available from national organizations (including Gallup, the Corporate Leadership Council, and the Great Place to Work Institute) that allow benchmarking against other organizations. A hospital should assess survey tools developed by external organizations to ensure that the tool measures employee attitudes and values that align with key value drivers the hospital has identified for its employees. Once a survey tool is selected, it should be used consistently to enable longitudinal tracking of changes in employee engagement.

Annual employee surveys can be supplemented with more focused, qualitative surveys of employee engagement. At BHSF, qualitative feedback is garnered from quarterly focus groups with department leaders and monthly discussions with employee advisory councils. The feedback helps BHSF understand any changes it sees in employee engagement trends and allows it to diagnose and resolve any potential issues before they develop into larger problems.

Manage engagement. When problems with employee engagement arise—and especially when they persist—organizations must be prepared to take action. BHSF tracks employee engagement by department, and focuses its attention on department leaders when it sees signs of slippage in a department's employee engagement scores (see the case study on page 44).

Rewarding engagement. Senior leaders should clearly make the connection between employee engagement and patient satisfaction. One of the most powerful ways of doing so is providing incentives and rewards—both financial and nonfinancial—to employees who make an engaged effort to improve patient satisfaction.

Organizations are giving an increasing amount of attention to patient satisfaction, as well as employee satisfaction, in determining management compensation. Financial

incentives need not, of course, be limited to managers. Patient satisfaction goals can be set for many departments in a hospital—both clinical and administrative—with all members of a department rewarded appropriately when those goals are met.

Nonfinancial incentives can be powerful motivators as well. Several organizations interviewed for the Value Project have implemented award programs that recognize employees who have gone above and beyond expectations in improving patient care or the patient experience.

REORIENTING CARE AROUND THE PATIENT EXPERIENCE

Health care has always been patient-focused; it has not, however, always been centered around the patient experience. As hospitals and health systems devote more attention to accessing the system from the patient's perspective, they are discovering improvements in patient access, navigation, and organizational structure that can enhance both the quality and cost-effectiveness of care. Many of these improvements also heighten patients' engagement with their care—a key component in improving quality-of-care outcomes.

Establish patient advisory councils. Organizations that have not already done so should strongly consider forming patient advisory councils to ensure that patient perspectives are being incorporated into decisions that affect care delivery and patient interactions with the system. Spectrum Health, based in Grand Rapids, Mich., has been a leader in this area and offers suggestions for forming councils in the

CASE STUDY: A FOCUS ON LEADERSHIP SKILLS AT BAPTIST HEALTH SOUTH FLORIDA

Miami-based Baptist Health South Florida (BHSF) is a recognized leader in employee engagement. It has earned recognition as one of *Fortune* magazine's "100 Best Companies to Work For" every year since 2003, and has twice been awarded Gallup's Great Workplace Award (in 2009 and 2011) for having a productive and engaged workforce.

To sustain its high levels of employee engagement, BHSF devotes significant attention to the performance of department leaders. In departments where employee engagement is low, BHSF uses root-cause analysis to understand why scores are lagging. In some instances, lower scores may be due to a new department manager who is holding employees accountable. No intervention is typically necessary in these cases; often, the manager just needs more time to implement change. But in other instances, lower scores may be attributable to a manager's leadership skills. BHSF approaches these situations on a case-by-case basis. "Occasionally, a talented clinician has moved into a leadership role, but lacks management skills and doesn't enjoy the role," says Corey Heller, BHSF's corporate vice president and chief human resources officer. "In these cases, we work to reassign the clinician to a more appropriate position with a higher probability of success."

In other cases, a manager has potential to improve. Here, HR professionals will begin with a career discussion with the manager to ensure that they want to be in a management role, and if so, will prepare a developmental action plan to address the manager's deficiencies. Performance improvement is monitored for up to six months, depending on the severity of the situation and the manager's tenure with the organization.

BHSF also believes that organizations will need to invest heavily to attract and retain high-potential talent in coming years. To this end, it:

- Provides specialized training to employees through its in-house Baptist Health University System
- Identifies cross-functional assignments for potential leaders to provide on-the-job training and develop problem-solving skills
- Uses a mentorship program to cultivate future leaders

BHSF also has begun to base promotions and succession planning not just on results, but also on how results were achieved. It has established 10 core competencies that influence 20 percent of the leadership performance appraisal to ensure that results are being achieved in the right way. A copy of BHSF's leadership competencies is available on the HFMA Value Project web tool at www.hfma.org/valueproject.

case study on page 46. With the patient perspective in place, organizations can begin to assess changes that create value for the patient—and potentially, for the organization as well.

Improve patient access and navigation. Patient access to care is often complicated by financial, logistical, and social barriers. Patient-centered hospitals and health systems are implementing both human and technological solutions to guide patients around these barriers.

Patient navigators. The concept of patient navigation originated in the late 1980s, and has grown significantly since. Patient navigators are specially trained individuals who help patients around the complexities of the healthcare system. The use of navigators was initially focused on uninsured and underserved patients, who often face especially daunting financial and social barriers to care. In recent years, the value of navigation to patients and providers alike has led to expanded use of navigators.

Patient navigators can play different roles within the patient experience of care. Financial navigators focus on helping uninsured or underinsured patients access financial assistance programs. Diagnosis navigators—used especially in such areas as oncology—help patients through the process and challenges of being diagnosed with a serious disease. Closely related to diagnosis navigators are treatment navigators (a single navigator may function as both), who help patients assess treatment options, schedule appointments, and follow care protocols for complex or chronic conditions. Some organizations are also using outreach navigators, who speak to community groups and schedule appointments for recommended screening tests.[20]

Funding for patient navigators originally came from public health and foundation grants, but some hospitals and health systems are now funding navigators themselves, citing both improvements to the quality of patient care and the cost-effectiveness of patient navigation through reductions in missed appointments. Financial navigators can also reduce bad debt and charity care rates.

Patient kiosks. Patient kiosks can supplement or serve as a more limited option to a patient navigator program. Kiosks are especially helpful for preregistered patients, who can use the kiosk to complete their registration automatically upon arrival. Kiosks can also be programmed with more advanced technologies that notify a nurse or physician that a patient has arrived for an appointment, allow patients to print out maps of the hospital, or produce barcoded patient wristbands that can track a patient through the hospital stay and send text updates to family members on the patient's progress.

Patient web portals. Many hospitals already have patient portals in place that allow online payment of bills or appointment scheduling. The value of these portals can be greatly increased, however, by integrating the portal with the patient's electronic health record (EHR). Patients can then access lab results, diagnoses, and appointment schedules and receive reminders for follow-up visits. Patients with chronic conditions or those undergoing extensive treatments also can enter information (e.g., results of glucose-level testing) in the portal, which can be programmed to automatically alert clinicians if the reported information exceeds certain thresholds. Portals integrated with an EHR should, of course, be password-protected to protect the patient's privacy.

MANAGING AFFILIATED PHYSICIANS

Advocate Physician Partners, a joint venture with Advocate Health System in Oak Brook, Ill., adopted the goal of "creating a culture of committed physicians" as one of four strategic pillars in a 2006 update to its strategic plan. To that end, it has defined a set of criteria that all 3,800 physician members of the joint venture (including 900 employed and 2,900 independent physicians) must maintain to remain members of the organization. A designated credentials committee of the board of directors defines and oversees compliance with the physician membership criteria (20 criteria as of 2011, in such areas as access and availability, internet connectivity, and participation in clinical integration programs). Physicians who fail to meet the membership criteria are asked to leave if they cannot remedy the deficiency. At the same time, maintaining membership criteria is a point of pride for the vast majority of the physicians, and forges deeper engagement with the organization.

[20] For more information on different navigator types, see "Ralph Lauren Center Provides Financial Navigators for Patients," *Patient Friendly Billing e-Bulletin*, HFMA, March 2009.

Align the organization's structure around the patient experience. The access and navigation aids described above can do much to improve operational efficiencies and the patient experience. The next step is to examine how well organizational structures—and possibly facility design—align with the patient experience.

Patients who are undergoing complicated procedures or are receiving treatment for chronic conditions are often required to access a variety of services within a hospital—and sometimes among different providers. Several of the providers interviewed for HFMA's Value Project have redesigned organizational structures to bring these disparate services together. The Cleveland Clinic, for example, has begun reorganizing care into institutes centered on disease or organ systems such as cardiology, neurology, and oncology. Bellin Health is organizing care around "brands"—such as brain, spine, and pain or heart and vascular—that house related patient services within a single center. The goal for both institutions is to make the patient experience of care as seamless as possible.

Organizations that are in the position to replace or redesign facilities should take the opportunity to examine the new facility design through the patient perspective. Here again, a patient advisory council can be invaluable.

CASE STUDY: EMBRACING THE PATIENT'S PERSPECTIVE AT SPECTRUM HEALTH

In 2006, Spectrum Health established its first patient and family advisory council. Today, 10 such councils are used throughout the system, including an executive council, councils focused on specific conditions or patient groups, and councils for individual facilities within the system.

Kris White, Spectrum Health's vice president for innovation and patient affairs, believes that the patient perspectives Spectrum Health gains from the councils will help Spectrum Health and like-minded hospitals and health systems differentiate themselves in the future. "Pricing and patient outcome issues will eventually settle down," says White. "The differentiating factor will be the consumer-centrism of the organization. The ability to organize and function as an integrated delivery system with the patient and family at the center and fully engaged will be what sets organizations apart."

The input of patient and family advisory councils has become an essential part of planning at Spectrum Health. White notes that input on facility and environmental design and feedback or guidance on patient-directed communications have been particular "sweet spots" for the councils' work. In addition, patient representatives serve on the ethics committee, patient education council, safety committee, hospital board quality committee, and other oversight bodies.

White offers the following tips for organizations that are seeking to establish a patient advisory council.

- **Think through the interview and training process in advance.** What are the characteristics of the community served by your organization, and how should the interview process ensure that those characteristics are reflected in members of the council? Once members have been selected, preparing the patient advisors and leadership is essential. Having frank and open discussions is critical to having true impact.
- **Look for "constructively discontented" individuals.** Councils should not be populated only with patients or family members who have had positive experiences. Individuals who see gaps within care and processes of care—and can talk about them constructively—will add much value to the council's input.
- **Pay attention to the structure and management of the councils.** The work of councils should be focused on consumer concerns and should address strategic issues the hospital or health system is facing. A skilled facilitator can help keep the council's work on track.

White notes that success of patient advisory councils also depends on the philosophy, values, and commitment of the hospital's or health system's leadership. Members of advisory councils are volunteering their time to improve the organization. They need to see an active interest in and respect for their contributions from the organization's decision makers.

For more information on the composition and work of Spectrum Health's patient and family advisory councils, visit www.spectrumhealth.org/pfac.

Kris White, vice president of innovation and patient affairs at Spectrum Health, notes that feedback from a patient advisory council caused the system to redraw the infusion center at a new oncology facility. "Our patient advisors helped us to understand the critical role of their family and the need to plan space for their family to be present and support them while receiving care," says White. "They also felt that options either to have care in a more private setting or to engage with others undergoing treatment was important, depending on their physical or emotional needs at the time of care."

It is difficult to quantify the ROI on a patient-centered organizational structure or facility redesign. But patient experience of care will have a tangible impact on payments to hospitals with the start of Medicare's value-based purchasing (VBP) program in 2012. By 2017, two percent of Medicare payments will be at risk under VBP, and 30 percent of this at-risk amount will be attributable to patient experience of care as measured by HCAHPS (Hospital Care Quality Information from the Consumer Perspective). To the extent that organizational structure or facility redesign efforts improve the quality of care, increase patient satisfaction, and facilitate patient throughput, they are likely to prove winning solutions for patients and providers alike.

CONCLUSION

Focusing an organization's people and culture on value is an effort that should involve everyone from the organization's senior leaders to the patients it serves. Given the breadth and depth of the effort required, organizations should take a measured approach to developing a value-based culture and staff while maintaining a consistent focus on the need for change.

Additional strategies and tactics for developing the skills necessary for a value-driving people and culture are available in HFMA's Value Project web tool. The tool, along with additional resources, can be accessed on the Value Project website at www.hfma.org/valueproject.

CHAPTER 6

Business Intelligence

Healthcare providers are on the verge of a transformation in the field of business intelligence.

As providers work to implement and achieve meaningful use of electronic health records (EHRs), they are gaining access to new levels of clinical data, the accuracy of which will be heightened by the switch to ICD-10. Meanwhile, the prospect of new forms of payment—including episode-based payment bundles, shared savings programs, and capitated payment models—is exposing the limitations of traditional cost accounting methods. This has prompted providers to consider costing systems that can provide greater levels of detail regarding the costs related to specific services, processes, and physicians. For example, the ability to "drill down" into the costs associated with bundled services, specific patient groups, or practice patterns can help decision makers better understand variation and costs related to variation—and make changes that will improve value. The exhibit below illustrates how business intelligence needs will be driven by value-based payment and care delivery strategies involving varying degrees of integration and risk assumption.

As healthcare organizations gain access to more and better data, their need for business intelligence—the ability to convert data into actionable information for decision making—is growing. To drive value, healthcare organizations will need to use business intelligence to:

- Develop a business intelligence strategy focused on converting financial and clinical data into actionable, accessible information that clearly supports an organization's strategic goals and decision making
- Accurately capture and quantify the costs of providing services and the costs and benefits associated with efforts to improve quality of care
- Develop business cases that prioritize and reliably quantify expected clinical outcomes, financial impacts, resource needs, and "go/no go" points of value improvement projects

Although business intelligence is still in its adolescence at many healthcare organizations, organizations should begin to develop value with the data and resources available to them now, rather than wait to improve value until they have implemented systems capable of providing more refined business intelligence, organizations interviewed by HFMA's Value Project agree. As Kevin Brennan, CFO of Geisinger Health System in Danville, Pa., notes, "The tools we have available to us are sufficient to the task. We just have to redeploy them in a manner that supports value."

BUSINESS INTELLIGENCE NEEDS IN AN ERA OF REFORM

Lower ← **Degree of Risk and Integration Required** → Higher

Focus Area	Fee for Service	Pay for Performance	Penalties for Adverse/ Preventable Events	Episodic Bundling	Disease/Chronic Care Management	Total Health Management
Financial Reporting and Costing	Procedure-Level		Activity-Level	Longitudinal	Per Member, Per Month	
Quality Reporting	Core Measures	Process Measures	Outcome Measures		Condition Measures	Population Indicators
Business Case	Supply/Drug and Productivity		Medical/Surgical Interventions		Lifestyle Interventions	
Decision Support Systems	Financial Data	Acute Quality Data	Ambulatory Indicators	Claims and Prescription Info	Health Risk Assessment, Biometrics, and Predictive Modeling	

Low Degree Medium Degree High Degree

MAKING INFORMATION ACTIONABLE

HFMA's 2011 survey on the current state of value indicated that, while many organizations have begun collecting data in such areas as costs of adverse events, financial implications of readmissions, and the financial effects of waste in care processes, few organizations are using the data they collected as a basis for action. A significant number of respondents also indicated that they are not yet actively measuring these costs. Although these numbers may have improved over the past months as the Medicare value-based purchasing program draws closer to implementation, the findings of this survey indicate that many organizations have much room for improvement in both collecting the data needed to measure quality and cost outcomes and making that data actionable.

To move from a data-collecting organization to a data-driven organization, providers should:

- Create an enterprisewide data strategy to ensure the accurate and consistent calculation and reporting of data across the organization
- Establish clear lines of sight from individual metrics for departments and staff to organizationwide goals and executive dashboards
- Make information available to inform the decision making of front line staff in as close to "real time" as possible, optimizing the possibility for interventions that can avoid adverse events or waste and improve results

MEASUREMENT AND USE OF BUSINESS INTELLIGENCE

To what extent does your organization measure and utilize business intelligence related to value in the following areas?

	Not	Measure	Manage
Costs of Adverse Events	43%	37%	20%
Margin Impact of Readmissions	38%	42%	20%
Cost of Waste in Care Processes (i.e. duplicative/ unnecessary tests or procedures)	50%	29%	21%

Not We do not measure.
Measure We have measured the impact, but do not manage to the metrics.
Manage We manage to these measures (e.g. data drives actions to reduce costs or improve margin).

Source: HFMA Value Project Survey, January 2011.

CREATING A DATA STRATEGY

For information to be actionable, it must be credible. And the credibility of information depends on several factors. First, all interested stakeholders must agree that what needs to be measured is being measured. Second, there must be assurance that metrics are being recorded and reported consistently—and, if more than one department is measuring the same item, that each is doing it in the same way. Third, information needs context for meaning.

Agreeing on metrics. Some metrics will be prescribed by government and private purchasers as a condition of reimbursement. In other instances, organizations will want to define and track their own metrics to gauge the success of an initiative or assess the quality or cost of care. In all cases, it is important that both finance and clinicians understand and agree upon the metrics that should be tracked, where and how the information should be collected, and how the data should be calculated and reviewed.

Consistent reporting. Value initiatives may require tracking the same metric across different departments or, in the case of a system, across different facilities. Organizations must ensure that information is being collected and reported consistently if that information is to be credible, comparable, and, ultimately, actionable.

Providing context. Simply reporting data on quality and cost outcomes is insufficient. Data should be presented within the context of a dashboard or scorecard that defines clear performance goals and clearly illustrates progress toward those goals. Users should be able to understand the significance of the data within the context of both internal and external performance benchmarks and use the data to identify areas most in need of improvement and areas where goals have been met or are being maintained.

At Partners HealthCare in Boston, the organization's office of clinical affairs uses a three-color system—green, yellow, and red—for its quality dashboard to indicate whether facilities are above, at, or below performance goals on a wide range of quality metrics, including both publicly reported and internal metrics. Information is arranged to allow easy comparison between facilities within the Partners system and, for publicly reported metrics, comparisons with peer academic medical centers around the country as well as competitors within the local market.

ALIGNING METRICS WITH ORGANIZATIONAL GOALS

Internal dashboards should create clear lines of sight between organization-wide goals and the efforts of individual departments and staff. Many hospitals and health systems interviewed for the Value Project noted the problem of "data overload" within their organization: Too many targets and metrics are being tracked without a clear sense of their significance to the organization.

An effective strategy to counter data overload is to define a clear—and concise—set of strategic goals for the organization. Improvement initiatives, and the metrics and data collected to measure progress on them, can then be prioritized according to their alignment with one or more of the organization's goals. Dashboard metrics—from the system level to the individual—should then be aligned beneath organizational goals so that everyone within the organization can understand how their performance on metrics furthers the organization's goals.

TIMELINESS OF DATA

For data to be actionable, it must be put in the hands of decision makers in time for them to take action on it.

Different data have different life spans. For quality measures—especially those affecting patient safety and clinical outcomes—an organization's ultimate goal should be to make reporting as close to "real time" as possible. At Geisinger, which has an advanced, integrated electronic health record in place, evidence-based practices and treatment protocols for various procedures and conditions are embedded within the system. The system's monitoring and tracking capabilities allow section leaders to identify noncompliance within a day, often allowing corrective action while a patient is still in the hospital. For example, after 40 separate criteria for coronary artery bypass graft (CABG) procedures were embedded within the system, compliance with all 40 criteria increased from 59 percent to 99 percent, infection rates declined by 21 percent, and readmissions fell by 44 percent.

ENGAGING CLINICIANS IN DEVELOPING A DATA STRATEGY

Spectrum Health, based in Grand Rapids, Mich., has been deeply engaged in building consensus between finance and clinicians through its work as a pilot site for the PROMETHEUS Payment® program. PROMETHEUS is a bundled payment program that pays an evidence-informed case rate for designated services within an entire episode of care, such as care related to chronic conditions, acute medical conditions, and specific procedures. Part of the PROMETHEUS case rate includes an "allowance" for *potentially avoidable conditions*—the more these conditions are avoided, the greater the potential shared savings for the provider.

Among the lessons learned as finance and clinicians at Spectrum worked to come to terms with the PROMETHEUS case rates were the following.

Words matter. A term like "potentially avoidable" may seem perfectly acceptable to finance, but suggests a failing to clinicians. Finance leaders may want to work with a small group of physician champions on the language used to describe a value initiative and the metrics involved before engaging with a broader clinical audience.

Be selective. Don't try to measure—and improve upon—everything at once. Identify a few metrics that seem most significant, and that clinicians perceive as within their control, and focus efforts on improving these.

Lead with quality; follow with cost. Clinicians will engage more readily with metrics that relate to the quality and safety of patient care.

DEVELOPING CONSISTENCY IN DATA REPORTING

At Bon Secours Health System, based in Marriottsville, Md., clinical transformation efforts combine significant leeway for problem solving within local facilities with standardized reporting that allows the corporate office to compare the cost-effectiveness of local approaches.

Bon Secours' clinical transformation represents a true partnership between clinical and finance professionals. Together, they work to uncover variances, determine best practices, and quantify any potential cost savings that may result from implementation. The corporate office gives local transformation teams uniform goals, but allows them to experiment with process improvements to determine what will work best under local circumstances. For example, when the corporate office targeted aggressive reductions in the hospital-acquired infection rate (a composite rate of seven infections) over a three-year period, targets were made uniform across the hospitals, but efforts varied from facility to facility depending on specific infections that needed the most attention locally.

For all systemwide initiatives, finance leads are included in each systemwide group to help ensure consistency in calculations and uniform reporting. The system also defines a standardized system for calculating savings related to quality improvements. A finance steering committee at the corporate level serves as the governor for all calculations, and reviews all calculations submitted by local systems before they are compiled into a single playbook that is disseminated back to the local systems.

Data on costs need not be supplied on a daily basis, but quarterly or annual cost reports are not sufficient, especially in high-volume areas where wide variations in physician preference items can quickly drive overall costs up or down. Section leaders need to be able to regularly monitor trends in the cost of supplies and labor on at least a monthly—if not weekly—basis. To the extent that healthcare organizations are exposed to financial risk through a bundled or capitated payment model, the need for more timely cost reports will intensify.

An organization's ability to deliver timely data will be driven largely by the degree to which data collection and analysis can be automated. As healthcare organizations work to implement electronic health records and healthcare IT systems, the ability to deploy these systems to drive timely reporting of quality and cost data should be a priority from both a clinical and financial perspective.

IMPROVING THE ACCURACY OF COSTING DATA

Although the timeliness of data is an issue, the healthcare industry faces a bigger challenge with respect to the accuracy of cost data. "To put it bluntly," said Harvard Business School professors Robert Kaplan and Michael Porter in a *Harvard Business Review* article, "there is an almost complete lack of understanding of how much it costs to deliver patient care, much less how those costs compare with the outcomes achieved."[21]

The continued prevalence of ratio of cost to charges (RCC) in hospital cost accounting contributes significantly to the healthcare industry's difficulty in accurately estimating the costs of patient care. Over the past 50 years, charges for many services have become untethered from the actual amount paid as cost-shifting and cross-subsidization have inflated charges for some services and artificially repressed charges for others. RCC, which assumes a consistent relationship between costs and charges, makes an assumption that simply doesn't exist because of the way in which hospitals have set charges, leading to an inaccurate allocation of costs—especially indirect costs.

A 2011 Value Project survey confirms a continued reliance on RCC for cost accounting in many hospitals. When all hospitals responding to the survey are considered, RCC was the most prevalent method of costing. However, the survey also showed that larger hospitals and health systems are beginning to move away from RCC in favor of specialized cost accounting systems; other costing methods, including standards-based costing (RVUs) and activity-based costing, follow close behind RCC at these larger organizations.

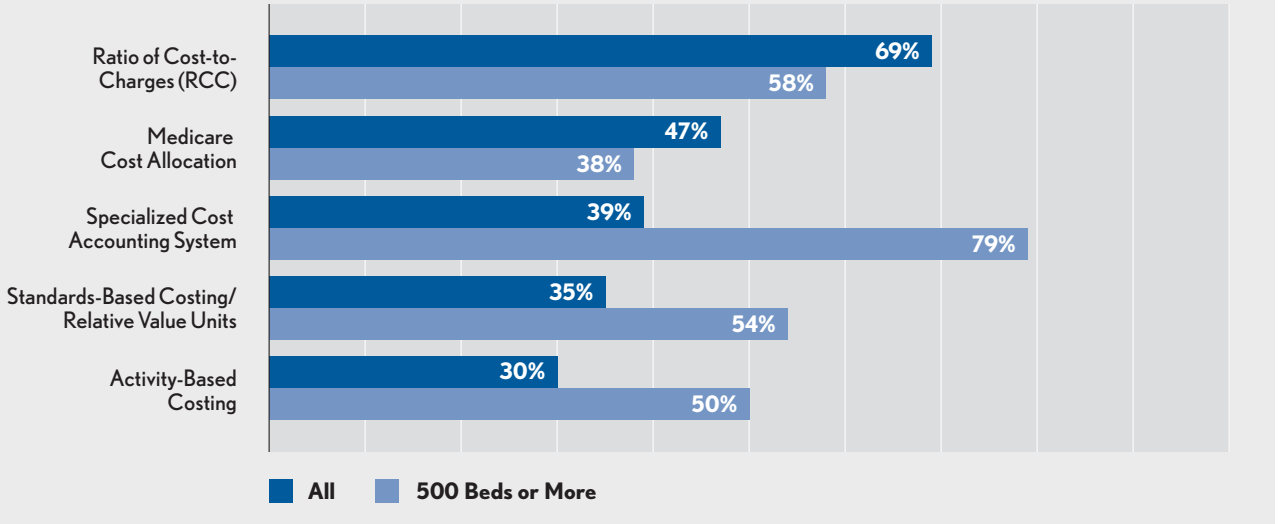
Other evidence suggests that healthcare organizations are coming to terms with the limitations of current costing methods in a value-based payment setting. At HFMA's 5th Annual Thought Leadership Retreat, held in 2011, attendees were asked whether they thought that decision makers at most provider organizations would say that costing data is accurate, timely, appropriate, and reported in a useful manner. Only 22 percent of attendees thought this statement would hold true "always" or "most of the time." The remainder thought this statement was true only "sometimes" (61 percent) or "never" (17 percent).

WHY COSTING METHODS NEED TO CHANGE

Healthcare veterans may understandably feel a sense of déjà vu when the issue of inadequacies in costing is raised. Calls for a move from RCC to more accurate costing methods, such as activity-based costing, were made during the 1980s

COSTING METHODS USED BY HEALTHCARE ORGANIZATIONS

What methods are in use to allocate indirect and overhead costs to departments, procedures, or activities?



Source: HFMA Value Project Survey, January 2011.

[21] Kaplan, R.S., and Porter, M.E., "The Big Idea: How to Solve the Cost Crisis in Health Care," *Harvard Business Review*, September 2011, available at hbr.org/2011/09/how-to-solve-the-cost-crisis-in-health-care/ar/1

and 1990s, when healthcare organizations faced the prospect of capitated managed care contracting. Several things are different this time around.

The era of cost shifting is drawing to a close. Most hospitals and health systems have maintained that Medicare reimburses below cost, and have accordingly shifted the unreimbursed costs of care for Medicare beneficiaries to private payers. Faced with rising healthcare costs, employers have responded by asking employees to take on an increasing share of the burden in the form of higher premiums, deductibles, and copayments and by shifting costs to their employees in other ways. The Kaiser Family Foundation/Health Research & Educational Trust Employer Health Benefits Survey, released in September 2011, noted that 31 percent of the insurance plans offered by employers are high-deductible plans ($1,000 or more deductible for single coverage), up from 10 percent in 2006. Premiums for family coverage have increased 113 percent since 2001, compared with 34 percent for workers' wages and 27 percent increase for inflation. Such increases in healthcare costs eclipse increases in employee earnings and are clearly unsustainable.

Other measures that employers are considering as ways of pushing back on rising healthcare costs include reference pricing and moving employees toward state-run health insurance exchanges if, as required by current law, they become operational in 2014. At least one report has indicated that up to 30 percent of employers are considering dropping employer-sponsored coverage after 2014; however, the report's findings are controversial.[22]

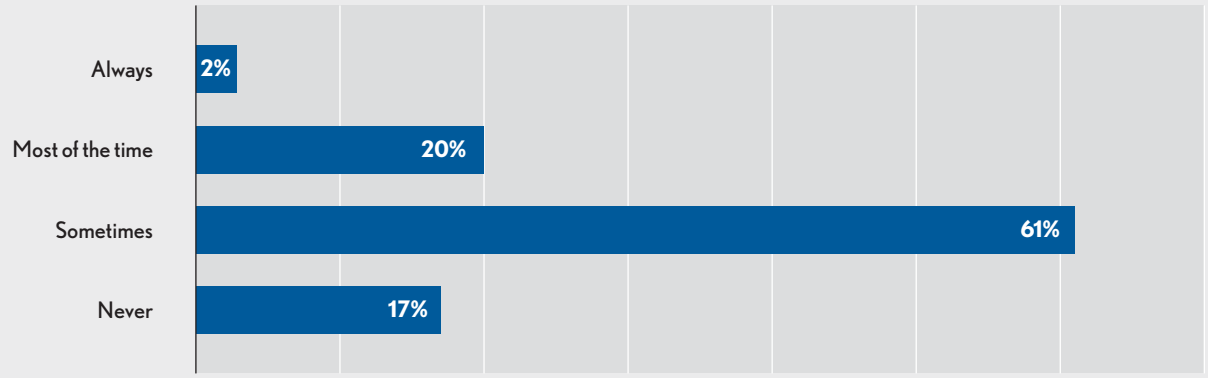
In response to such measures, some healthcare organizations are seeking to rebut the assumption that Medicare pays below cost. For example, Novant Health, based in Winston-Salem, N.C., has analyzed payment trends and sees all payers moving in the direction of Medicare levels of reimbursement. Novant also noted that best performance across its top hospitals would put costs at 97 percent of Medicare reimbursement. Accordingly, it established a five-year goal for the system as a whole to bring costs below Medicare level. From 2008 to 2010, the system's cost percent of Medicare reimbursement has improved from 113 percent to 106 percent.

Healthcare providers face increasing pressure for price transparency. Healthcare organizations are already being asked to make public quality data relating to clinical processes and outcomes, patient safety, and patient satisfaction. A demand for similar transparency in pricing has already begun, and providers should expect this demand to intensify as consumers are asked to shoulder an increasing portion of their healthcare expenses.

A report by the U.S. Government Accountability Office highlighted the difficulty most provider organizations have in providing accurate price estimates for common services.[23] The GAO anonymously contacted 39 providers (19 hospitals and 20 primary care physician offices) in a Colorado healthcare market to request price information for full knee

MEASURING THE VALUE OF HOSPITAL COSTING DATA

Decision makers at most provider organizations would say that costing data are accurate, timely, appropriate, and reported in a useful manner:



Source: HFMA Thought Leadership Retreat Survey, October 2011.

[22] See Singhal, S., et al., "How US Health Care Reform Will Affect Employee Benefits," *McKinsey Quarterly,* June 2011.

[23] *Health Care Price Transparency: Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care,* U.S. Government Accountability Office, September 2011.

replacement surgery from the 19 hospitals and for diabetes screening from the 20 physician offices. Providers could at best provide only incomplete estimates or estimates within such a wide range of price (between $33,000 and $101,000 for knee replacement surgery) as to severely limit the usefulness of the information for identifying a "value" provider in advance of the procedure.

The GAO acknowledged that many of the difficulties providers face in providing accurate pricing information are products of both the nature of health care and the current system. For example, the unique circumstances of patients can cause significant variation in the final price for a service, and the services involved in an episode of care are often provided by multiple providers who bill for their services separately. Providers may also have difficulty accessing an insured patient's health benefit structure, making it difficult to estimate out-of-pocket costs under a specific benefit plan, or may have contractual obligations with an insurer that prevent them from disclosing negotiated prices. Yet the GAO was able to identify two existing price transparency initiatives (New Hampshire HealthCost and Aetna Member Payment Estimator) that are able to provide complete cost estimates to consumers. This led the GAO to conclude that despite the complexities of pricing in health care, price transparency is "an attainable goal."

New payment models will reward providers that can accurately cost services, and penalize those that cannot. New payment models designed to overcome some of the systemic issues affecting pricing identified in the GAO's report on price transparency will reward providers that are able to accurately cost their services and price them accordingly. Providers that cannot accurately cost and price their services will either be shut out of these models or put themselves at risk of significant losses.

As an example, consider bundled payments for an episode of care. An organization without an accurate sense of the actual direct and indirect costs for the services rendered across the episode is at risk of either overpricing the bundle, making it less attractive to purchasers, or underpricing the bundle, exposing the organization to financial risk.

Underlying this example is the point that new, value-based payment systems will ask providers to reconsider how they define and price units of care. A costing method that might have been sufficient under a fee-for-service payment system may well prove inadequate within a bundled payment system or a per-member, per-month capitated system that requires close tracking of utilization and costs. Changes in costing will be driven by provider realization that new payment mechanisms are exposing them to risk.

MAKING THE MOVE TOWARD IMPROVED COSTING

Realistically, fee-for-service payment still represents the bulk of payments for most hospitals today, and the urgency with which hospitals and health systems respond to the need for improved costing will be driven by market composition, treatment focus, penetration of managed care, and prevalence of value-based payment models (see the exhibit below).[24] Nonetheless, few hospitals will suffer from improving the accuracy of their costing system. Benefits include:

- The ability to better analyze contract underpayment
- The ability to develop a more defensible pricing structure reflective of actual costs

EVALUATING THE NEED FOR COSTING SYSTEM ENHANCEMENT: 4 KEY FACTORS

Factor	Low Need	High Need
Market composition	Solo provider	Multiple hospitals Freestanding providers Entrepreneurial physicians
Treatment focus	Treat-and-street or transfer	Regional referral or specialty
Managed care penetration	Up to 10%	20% or more with anticipated growth
Payment models	Charges, discounted charges	Case rates, capitation carveouts, bundling

[24] See Selivanoff, Paul, "The Impact of Healthcare Reform on Hospital Costing Systems," *hfm*, May 2011.

- A better understanding of profitability per physician
- Improved ability to review service lines for profitability
- The ability to understand the financial outcomes of different care alternatives
- A better understanding of the efficiency of care (including opportunities to identify where excess capacity exists)

Many hospitals and health systems have postponed investments in improved cost accounting, focusing instead on investments in electronic health records and healthcare IT infrastructure to improve the quality side of the value equation. Improved cost accounting should be next on the list, so that healthcare organizations will be better able to understand and drive both the quality numerator and price denominator of the value equation. To begin, healthcare organizations should consider these initial steps.

Prioritize cost enhancement efforts. Begin by focusing costing enhancement efforts on priority areas for better cost management—where high costs are producing low or nonexistent margins or where wide variations in cost suggest opportunities for cost containment. Such areas, which hold potential for significant cost savings, might be chosen as the focus of a value-based initiative with a government or commercial payer that enables an organization to experiment with improved costing on a defined bundle of services or management of a defined population.

For example, Partners HealthCare has piloted defined episodes of care for five major procedures and chronic conditions (acute myocardial infarction, CABG, colon cancer, stroke, and diabetes). It maps care redesign processes for each procedure or condition across the episode, identifying sites of care, providers (e.g., physician specialist, nurse, nurse navigator), tests and procedures, and timing involved for each step, as well as "pause points" at which an action or intervention is indicated and where there is an opportunity to influence both care and costs by standardizing procedures or supplies, eliminating unnecessary tests, or reducing length of stay within best practice guidelines. These care redesign process maps serve both clinicians and finance staff by defining what must be managed—and, accordingly, measured—across the episode of care. Finance staff can use the maps as an inventory of labor, supply, testing, and facility costs for both a standard procedure and common variations from the standard process of care. Then, working with clinicians, finance staff can help identify realistic goals for cost savings at "pause points." Bundled payments for episodes can then be priced to account for typical costs across the full episode of care, anticipated variations, and cost-saving goals.

Review working definitions and methods of allocating cost categories. Depending on the relevant time frame, almost all costs are variable. Staff size can be increased or decreased; wages and benefits can be renegotiated; facilities can be downsized or repurposed. Instead of permanently assigning a group of costs to the "fixed" category, organizations should define both the period within which costs operate as "fixed" and the point at which those costs might become variable so they do not lose sight of the opportunity to change "fixed" costs.

Organizations should also consider how factors like volume fluctuations might affect the categorization of a cost as fixed or variable. For example, minimum staffing needs may establish fixed labor costs on a unit below a certain volume, but additional staffing needs above the minimum to accommodate increased volumes would represent variable labor costs.[25]

The distinction between direct and indirect costs should also be examined, with an eye toward identifying those indirect costs that can be assigned more directly. Overhead costs for lab and radiology, for example, should be assigned only to lab and imaging services.

Enhance the specificity of costing data. The more specific the costing data, the better the information available for decision support. Greater specificity will typically require a greater dedication of resources, so initial efforts might focus on high-volume procedures or procedures with wide variations in costs, where better cost information might help in identifying opportunities for significant savings.

For healthcare organizations that have an acuity system, a first step might be developing costs per acuity level for a given procedure. At a more advanced level, organizations should consider adopting "job costing" over "standards costing"—capturing actual labor, supply, and pharmaceutical costs as they are consumed by individual patients.[26] Although this is a potentially laborious effort, technological solutions—such as bar coding, radio frequency identification, and "smart rooms" that identify staff—can be deployed to automate accurate capture of costs.

[25] See Selivanoff, "Impact of Healthcare Reform," pp. 113-14.

[26] Selivanoff, pp. 112-13.

DEVELOPING BUSINESS CASES FOR ACTIONABLE DATA

Even with actionable, accurate data in hand, every organization has a limit on the number of projects it can pursue at any given time. Defining a clear process for business plan development and review helps ensure that decision makers are getting the appropriate information they need to prioritize projects that have the greatest potential benefit for the organization.

A consistent business case development process that requires the identification of clear project goals, metrics to measure progress toward those goals, and solid estimates of the resources required to reach those goals also will serve an organization's business intelligence needs by focusing attention on information-based approaches to value improvement and the collection and analysis of quality and cost data.

The first step is to establish basic priorities for the organization against which individual business plans can be judged. For example, organizations may wish to prioritize projects that:

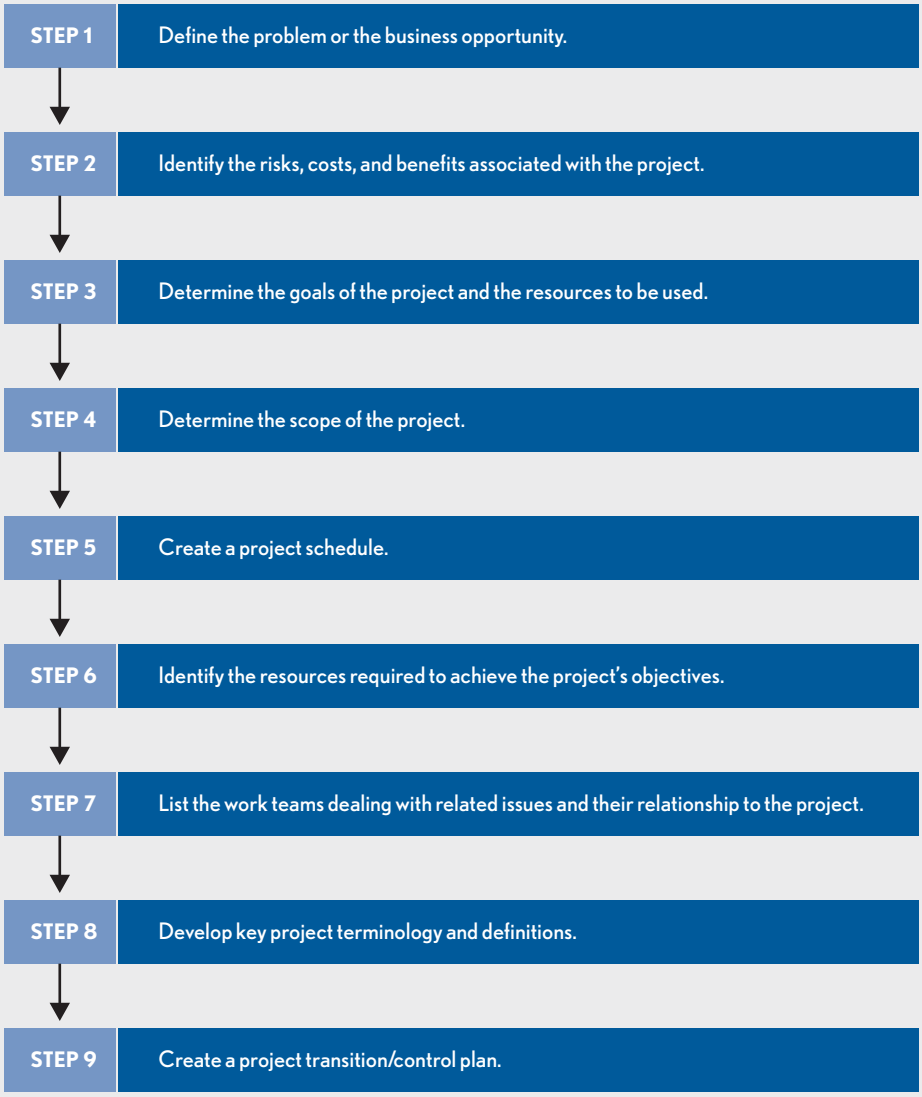
- Align with the organization's strategic vision and goals
- Are designed to strengthen one or more fundamentals of value creation: patient satisfaction, clinical outcomes, and financial results
- Have an impact across multiple departments
- Focus on areas that are primary drivers of the organization's costs or volume
- Demonstrate growth potential for the organization
- Have clearly defined metrics for determining the project's success in terms of quality, cost, or both
- Have clear sponsors or champions within the organization

For organizations that are just beginning to focus on value improvement, it is especially important that early projects take on "easy wins"—areas where improvements are clearly needed, staff are motivated to make improvements, and sufficient data are available to quantify successes clearly.

Based on these priorities, the organization can then develop a template or "project charter" for use throughout the organization on value improvement projects. The use of a standard template or charter ensures that similar information is being gathered for each proposed initiative so that decision makers can easily compare and prioritize projects. (An example of a project charter template, provided by Bellin Health in Green Bay, Wis., is available in the "Business Intelligence" section of the Value Project web tool, under the "Business Case Development" focus area. The web tool can be accessed at www.hfma.org/valueprojecttool. View the steps for Bellin Health's project management process on page 57.)

Organizations should also use a project charter to define "no-go" points for new initiatives. If an initiative is not meeting quality improvement or cost saving objectives specified in the project charter within a defined period of time, organizational resources can be dedicated to other initiatives with greater potential to improve value.

A TOOL FOR PROJECT MANAGEMENT: BELLIN HEALTH



View the project charter that teams at Bellin Health use in managing projects at www.hfma.org/valueprojecttool.

CONCLUSION

Health care is an industry awash in data, but the industry is just beginning to unlock the potential of that data to drive the changes in the quality and cost of care that a value-based healthcare system will require. To fully realize the potential of business intelligence in creating value, healthcare organizations will have to reach beyond their walls to collaborate with payers, government agencies, and other providers on the collection, sharing, and analysis of quality and cost data.

Business intelligence should be a focus for all healthcare organizations. Healthcare organizations should take steps now to harness the data they have on hand to prepare for the shift toward value-based business models of care. Such actions will help providers adjust to these new models—and, ultimately, improve value for consumers and purchasers.

CHAPTER 7

Performance Improvement

The shift toward a value-based business model in health care will be accompanied by shifts in care delivery models—and performance improvement will drive this transformation.

To create better value, hospitals and health systems must maintain or improve the quality of patient outcomes while controlling the costs required to achieve these outcomes. These efforts will not be confined within the hospital's walls: Pressures to improve outcomes and reduce total costs across the continuum of care are increasingly focusing attention on better coordination and collaboration among primary and preventive, ambulatory, acute, and post-acute care providers—as well as with patients themselves.

Sustainable performance improvement. in hospitals and health systems will require:

- A focus on process reengineering, first within the hospital and then across the continuum of care
- Identification and implementation of evidence-based best practices for clinical care
- Increased patient engagement in maintaining health, managing chronic diseases, and achieving desired care outcomes

A recurring theme of HFMA's Value Project has been the need for close collaboration between clinicians and finance and administrative professionals. Nowhere is that theme more important than in the area of performance improvement. Many organizations have gone through cost containment initiatives. A value-driving capability in performance improvement requires organizations to go the next step, working toward transformation of the care delivery system to improve the quality and cost-effectiveness of clinical care.

Needless to say, clinicians will play a significant—and often leading—role in these efforts. However, they must be supported by finance and administrative professionals' skills in the collection and analysis of data on quality, cost, and utilization and the structuring of compensation agreements and contracts to align both internal and external stakeholders with the organization's performance improvement goals. An integrated approach to performance improvement requires that clinical leaders as well as leaders in finance and administration work together to foster effective collaboration between departments, divisions, and affiliated services and providers—both inside and outside the hospital.

GETTING STARTED

A commitment to performance improvement is not a short-term affair; instead, it requires long-term dedication to continuous improvement throughout the organization. A first step is signaling the organization's commitment to performance improvement, which requires making performance improvement part of an organization's strategic vision.

A number of organizations dedicated to improving health care have implemented initiatives that healthcare providers can adapt as part their strategic vision. The Institute for Healthcare Improvement (IHI), for example, has defined the IHI Triple Aim, focused on the simultaneous pursuit of three aims:

- Improving the experience of care
- Improving the health of populations
- Reducing per-capita costs of health care

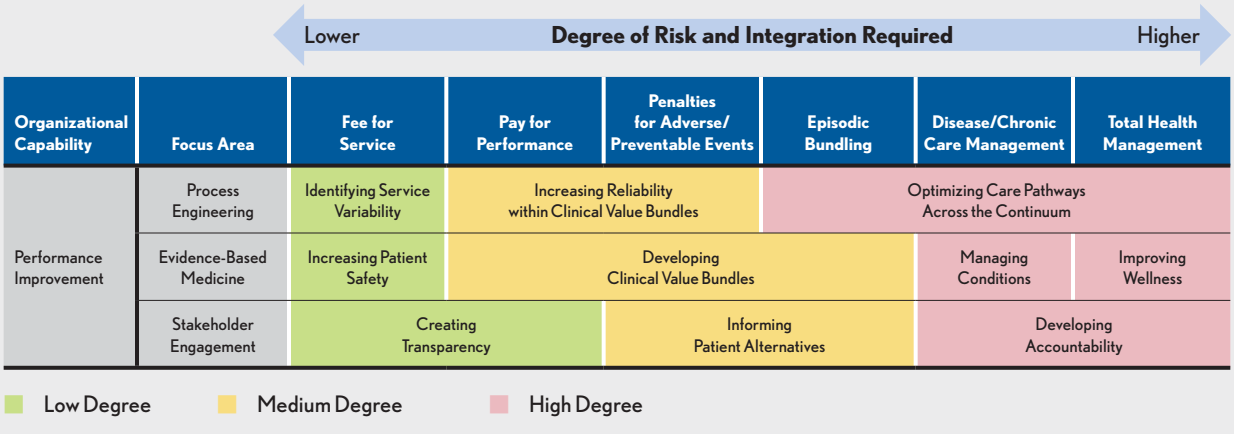
Similarly, the Leapfrog Group, a coalition representing large employers, offers participation in an annual hospital survey organized around four "leaps" in computerized provider order entry (CPOE), ICU physician staffing, evidence-based hospital referral, and National Quality Forum-defined safe practices. Hospitals participating in the survey publicly report their results to Leapfrog and are able to benchmark their progress in improving the quality, safety, and efficiency of care delivery.

These and similar initiatives provide ready-made performance improvement goals for an organization.

In addition, the grid below highlights areas of importance for performance improvement as evolving payment and care delivery models ask provider organizations to assume more risk for patient outcomes or push development of more integrated care delivery networks. Within the still dominant fee-for-service environment, for example, performance improvement priorities include identifying service variability issues to reduce internal costs and increasing patient safety—a natural goal of any healthcare provider that also builds skills in avoiding adverse events and readmissions that can affect publicly reported quality scores.

As providers become more exposed to risk under pay-for-performance and episodic-bundling scenarios, process improvements across an episode of care or "clinical value bundle"—which may require hospital coordination with other providers—are gaining priority. These improvements help to reduce avoidable readmissions or other adverse conditions that may have a negative impact on payment. Under a total health management scenario involving per-member, per-month payment, performance improvement initiatives increasingly become centered on optimizing care pathways across the continuum, managing chronic conditions, and improving population health. A shift to the right on the grid also requires healthcare providers to consider new approaches to engaging patients in their care and, ultimately, cultivating a sense of accountability for health outcomes among the population being served.

PERFORMANCE IMPROVEMENT UNDER VALUE-BASED MODELS: CAPABILITIES AND RISKS



Building performance improvement capabilities along this continuum positions an organization to provide better value for purchasers of care while ensuring the organization's sustainability within a more value-based payment and care delivery system. Hospitals and health systems are understandably concerned about the timing of a transition from volume-based to more value-based methods of payment: Progressing too far or too quickly with efforts that reduce utilization, for example, can negatively affect revenues. But against these concerns, hospitals and health systems should balance the following considerations.

Opportunities for growth. In areas of population growth, or where other opportunities exist to increase market share, performance improvement initiatives that reduce internal costs or more effectively manage patient flow can free up resources to invest in growing practice areas or can enable organizations to increase volume without adding additional beds or staff.

External pressures in the marketplace. In some areas of the country, such as Massachusetts, both government and private payers are already moving quickly to implement new payment methodologies that require fundamental changes to care delivery models. Hospitals and health systems that have developed their performance improvement capabilities—and have reached outside their walls to collaborate or partner with other providers—will be in a better position to adapt as similar changes take hold in their states and localities.

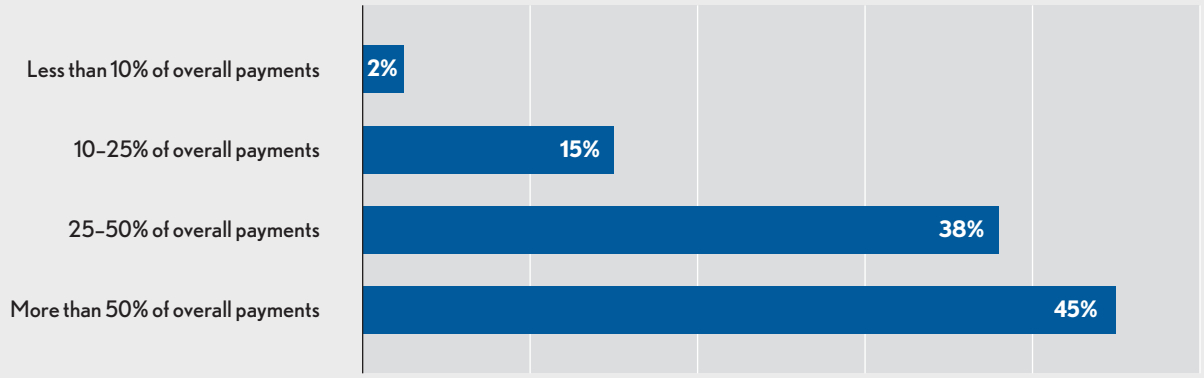
Opportunities to establish a competitive value advantage. Hospitals and health systems need not wait for change to happen to them; instead, they can be agents in driving change. The more success an organization has with performance improvement, the more confident it can be in demonstrating its value proposition to health plans and employers in its marketplace—and in securing contracts and agreements that provide better value to payers while establishing a competitive advantage over other providers.

Put bluntly, there is significant risk in taking a wait-and-see approach to performance improvement. Attendees at HFMA's 5th Annual Thought Leadership Retreat in 2011 anticipated significant change, with more than 80 percent predicting that more than 25 percent of their overall payments will involve performance-based risk within the next 10 years.

Ten years may seem like an eternity in health care, but the ability to drive performance improvement does not come easily: One industry leader in healthcare delivery transformation, Intermountain Healthcare, has been working on performance improvement for 20 years. In an interview with *hfm* magazine, Intermountain's chief quality officer, Brent James, MD, offered this lesson from Intermountain's experience: "Don't wait. Even though it may not be immediately financially advantageous, you will need these skills within your organization. You'll need the cultural shifts that go with it, too" ("Brent James, MD: Using Data to Transform Healthcare Delivery," *hfm*, March 2012).

LEVEL OF PERFORMANCE-BASED RISK UNDER VALUE-BASED MODELS

Within the next 10 years, I predict provider organizations will accept performance-based risk on:



Source: HFMA Thought Leadership Retreat Survey, October 2011.

PROCESS REENGINEERING

The concept of process reengineering has become increasingly prominent in health care, as process improvement and quality management philosophies and techniques developed in manufacturing and business contexts—including Lean, Six Sigma, and the work of quality management leaders such as W. Edwards Deming and Joseph M. Juran—have been adapted by healthcare providers. Given the recognized need to improve quality, reduce costs, remove waste, and improve efficiency in health care—the very needs that spurred the development of process improvement and quality management techniques in manufacturing—a commitment to process reengineering is essential to performance improvement.

Health care is distinct from most manufacturing and business contexts, however, in that the focus of its services is individual human beings, and the outcomes at stake can be literally a matter of life or death. This has several implications for process reengineering within a healthcare setting:

- A push to minimize variations in clinical procedures must be balanced against an understanding of what variations may be clinically necessary to meet the needs of individual patients.
- Process reengineering efforts focused on clinical processes should be led by clinicians, with finance taking a supporting role in data collection and analysis with respect to the quality and efficiency outcomes of these efforts.
- An emphasis on quality improvement will often be the most effective way to engage key physicians, leaders, and staff, especially clinicians. As in other contexts where process reengineering has been applied, better and more consistent quality outcomes should in most instances lead to lower costs.

With these considerations in mind, hospitals and health systems can begin to develop a framework for process reengineering efforts designed to minimize clinical practice variations, especially those that have an adverse impact on care outcomes or costs.

A FRAMEWORK FOR PROCESS REENGINEERING

There are five strategies hospitals and health systems should consider in developing a framework for process reengineering initiatives.

Identify areas of opportunity. A strategic vision for performance improvement should be supported by a clear process for identifying areas with the greatest opportunities for quality and cost improvements. A logical starting point is areas with high volumes or high costs, or areas in which patient safety or poor quality outcomes (e.g., high rates of readmissions) are a concern. When beginning process reengineering efforts, it is also helpful to identify service lines or practice groups with clinicians open to change or eager to achieve cost savings to help grow their practice area. Early successes are more achievable when all parties are motivated to change, and these successes can then help motivate other groups within the organization.

Assemble a multidisciplinary team. Once an area for process reengineering has been identified, the focus should turn to identifying causes for significant variations in patient outcomes or physician costs. A common theme among provider interviews for the Value Project was the use of multidisciplinary investigatory teams. For example, Rush University Medical Center of Chicago uses teams comprising members of its clinical, quality, and finance staff (see the sidebar on page 63) to support physician team leaders; additional support is provided by an IT team, and oversight is provided by a senior leadership team that includes the CEO, CMO, Chief Quality Officer, and CFO. At Partners HealthCare in Boston, Mass., care redesign teams include:

- *Nursing and other clinical experts* to consult on care coordination and opportunities for expanded clinical roles
- *Administrative experts* to consult on the feasibility of design proposals, cost reduction opportunities, and financial modeling
- *IT representatives* to leverage current IT and system capabilities and plan for future improvements

ENGAGING FRONT-LINE STAFF IN PATIENT SAFETY AT NEW YORK-PRESBYTERIAN HOSPITAL

Launched in 2008, New York-Presbyterian's hospitalwide patient safety initiative is a model for disseminating information on clinical and environmental issues affecting quality and patient safety throughout the organization (e.g., communication, hand hygiene, medication reconciliation, and fire safety). It also provides a model for ensuring a two-way flow of information between leadership and frontline staff.

Every Friday, senior leaders, department heads, and key personnel at the hospital's five sites gather simultaneously to present an hour-long, structured curriculum around one or more of these clinical or environmental issues. Following the presentation, the group sends teams of two to three members to work with staff in all areas of the hospital using "tracers"—focused interviews in which team members discuss the topics presented with the patient care directors and identify issues that need to be addressed at either a unit level or a hospitalwide level. The interviews bring hospital leaders together with frontline staff at the unit level in open discussions that encourage staff to participate in identifying factors that may contribute to incidents, interventions that prevent patient harm, and other ways to encourage a culture of patient safety. "Patient Safety Fridays" have fostered collaboration throughout the hospital on advancing the common goal of providing an environment of quality and patient safety.

- *Primary care physician liaisons* to ensure continuity of the patient experience and consideration of referring physicians' needs
- *Ad hoc subject matter experts* as needed
- *Project management experts* to facilitate and support development of project deliverables, provide overall project support, and compile best practice research and support analysis

Assess the current state of care processes, quality, and cost. Assessment of the current state should draw on both data analysis and observation of current care processes. Key data for the current state assessment include:

- A breakdown of costs per case within the area (As demonstrated in the exhibit "Pinching the Curve" exhibit on page 66, opportunities are most significant where the cost curve is wider, shorter, and has a longer tail, which indicates a wider degree of variation per case.)
- A breakdown of costs per category (e.g., pharmaceuticals, medical/surgical supplies, labor, imaging & diagnostics, etc.) to identify the highest cost—and highest savings potential—categories within the area
- An analysis of complication rates and their associated costs
- Analyses of other quality outcomes for the service area and population mix

Team members should also adopt the practice of "walking the line," which, in a manufacturing context, means walking the shop floor to observe and engage in conversations with team members who are building a company's products. In the healthcare context, walking the line means following the path of a patient through a unit, talking with front-line caregivers about current care processes and opportunities they see for improvement. Teams also should solicit feedback from patients and their families, who may have questions or observations about their care that also identify areas for improvement. There are tools available to assist in the efforts to identify waste. For example, IHI has published a Hospital Inpatient Waste Identification Tool that relies upon a frontline staff approach (available at www.ihi.org).

Identify best practices for process redesign. Clinicians should lead research into best practices for clinical care, identifying evidence-based practices wherever possible. Beyond traditional literature reviews, providers can access resources from a variety of clinically-focused organizations dedicated to identifying and disseminating best practices in clinical care (see the sidebar on page 64). Several organizations also provide resources and tools that identify best practices.

IDENTIFYING CLINICAL BEST PRACTICES

The ideal in clinical care redesign is to identify and implement processes that reflect evidence-based medicine—processes that are firmly rooted in treatments, procedures, and interventions that have been tested on relevant populations and have been demonstrated to improve the quality or efficiency of care. In reality, there are many areas of clinical practice where clearly superior evidence-based practices have yet to be defined.

At the same time, many organizations are working to identify clinical approaches that can achieve quality or efficiency gains and represent "best practices" that can help drive performance improvement. Examples include the following.

The Agency for Healthcare Research and Quality's Quality Indicators™ Toolkit for Hospitals. AHRQ's toolkit focuses on the agency's 17 patient safety indicators (PSIs) and 28 inpatient quality indicators (www.ahrq.gov/qual/qitoolkit). Currently included in the toolkit are selected best practices and improvement suggestions for eight PSIs.

The toolkit also provides tools for educating board members and staff on the clinical and financial implications of quality indicators, identifying priorities for quality improvement, implementing and sustaining improvements, and estimating the ROI from interventions implemented to improve performance on quality indicators. It is available to hospitals free of charge.

The Institute for Healthcare Improvement's Knowledge Center. The "tools" section of IHI's website (www.ihi.org) offers multiple best-practice-based resources, including guides on preventing surgical site infections, central line-associated bloodstream infections, and pressure ulcers, as well as tools on improving transitions to reduce avoidable rehospitalizations.

The Society of Hospital Medicine's Mentored Implementation Model. The Society of Hospital Medicine (SHM), the nation's medical society for hospitalists and their patients, pairs hospital teams with a mentor—a physician expert in quality improvement—to improve specific quality indicators. Under the mentor's guidance, sites assess current processes, identify resources and deficiencies, and pilot interventions tailored to the unique needs of the local hospital. Successful interventions are hardwired through system changes to sustain improvements in patient outcomes. Throughout the program, hospitals collaborate with peer sites through an SHM online community in addition to their work with their mentor.

The three signature programs of SHM's mentored implementation model to date include the following:

- Project BOOST, focusing on better outcomes for older adults through safe transitions (The aim of this project is redesign of admission and discharge processes to reduce unnecessary 30-day readmissions, length of stay, and adverse events, and to improve patient satisfaction.)
- The Glycemic Control Mentored Implementation Program, focused on optimizing the care of inpatients with hyperglycemia and diabetes and preventing hypoglycemia
- The Venous Thromboembolism (VTE) Prevention Collaborative, which provides practical assistance on blood clot reduction by designing, evaluating, implementing, and sustaining a VTE prevention program

The National Quality Forum and The Joint Commission awarded SHM the 2011 John M. Eisenberg Patient Safety and Quality Award for Innovation in Patient Safety and Quality at the national level for SHM's work on the mentored implementation program. Additional information is available at www.hospitalmedicine.org.

Clinicians also should take the lead in an examination of medical and surgical supplies, pharmaceuticals, and imaging, diagnostic, and laboratory services to identify significant variations in cost, utilization, and outcomes. The goal of this examination is to identify areas where greater standardization in all these areas can be achieved. Although finance, administrative, and IT professionals will take a secondary role in clinical care redesign, their skills in data collection and analysis, benchmarking, and costing are essential in efforts to quantify outcomes of clinical care redesign.

In addition to clinical care redesign, process reengineering should also work to redesign nonclinical processes that produce inefficiencies or waste. These efforts often will be informed by the results of "walking the line" and conversations with frontline staff, who can identify areas where unnecessary steps are required, the number of staff exceed the needs of the unit, patient transfers are delayed, or materials are wasted.

Organizations may wish to consider a two (or more)-pass approach to implementing process redesign efforts. At Rush University Medical Center, for example, the first pass might focus on improving the quality of outcomes, reducing physician practice variations, and standardizing utilization of high-cost items such as implants. A second pass might then focus on managing utilization of low-cost, high-use items; refining the care delivery model to reduce inefficiencies (for example, inefficiencies that slow down patient flow); investigating the possibility of more efficient care settings; and identifying growth opportunities for the redesigned service.

Reinforce and monitor process improvements. As an organization identifies successful process reengineering efforts, its next task is to ensure that the improved quality and cost outcomes produced through performance improvement initiatives are sustained. This requires careful monitoring of outcomes over time to ensure that new processes and protocols continue to be followed.

For example, many organizations that have fully implemented electronic health records (EHRs) will have the ability to embed adverse drug event warnings, clinical protocols, and other recommended clinical interventions within the system. In the absence of a fully functional EHR, hospitals also can adopt manual tools such as checklists based on reengineered clinical processes. In either case, protocols or checklists must be subject to physician override, but instances of such overrides should be monitored to ensure that individual physicians are generally adhering to agreed-upon process redesigns.

Sustaining cost savings through standardization of medical supplies and devices within a practice area requires ongoing collaboration with finance and the physicians and clinicians who support the area. A crossfunctional team should regularly review practice patterns to track any shifts in utilization. The team should also, as necessary, review new technologies or products that may offer improved quality outcomes and adjust cost projections and contracting strategies as needed. Similarly, labor usage should be tracked to ensure that productivity gains secured through process reengineering do not slip over time.

Extend process reengineering across the care continuum. Most hospitals and health systems are taking a logical approach to process reengineering, beginning with a focus on inpatient care. But as changes to the payment and care delivery systems move organizations to the right of the grid shown on page 60 in terms of increased integration and heightened risk, efforts at process reengineering will need to extend across the care continuum. Integration of healthcare providers will also require integration of their performance improvement strategies, clinical performance improvement systems, electronic health records, and costing systems to ensure that efforts at process reengineering can be accurately measured and analyzed across the care continuum.

REENGINEERING CARE DELIVERY AT RUSH UNIVERSITY MEDICAL CENTER

Rush University Medical Center, Chicago, is located within a dynamic and competitive local market where value-based payment reform is beginning to make significant inroads. Internally, the hospital had adopted a strategic focus on quality, safety, and efficiency, and had made significant investments in electronic health records (EHRs). It also recently opened a new patient tower, which offered new opportunities for the transformation of care delivery on the medical center's campus.

Intrigued by the notion of variations and their impact on quality and cost, Rush developed a process for reengineering care delivery defined by an approach intended to accomplish the following:

- Minimize variations, unless they were driven by patient needs
- Put physician leaders of clinical programs in the lead to with an emphasis on how care is delivered to patients, not cost reductions
- Deploy the support of multidisciplinary teams comprising representatives of medical leadership, quality, and finance

The operational framework for Rush's process—described as a "Lean Care Map"—follows five steps, supported by a goal of better care coordination:

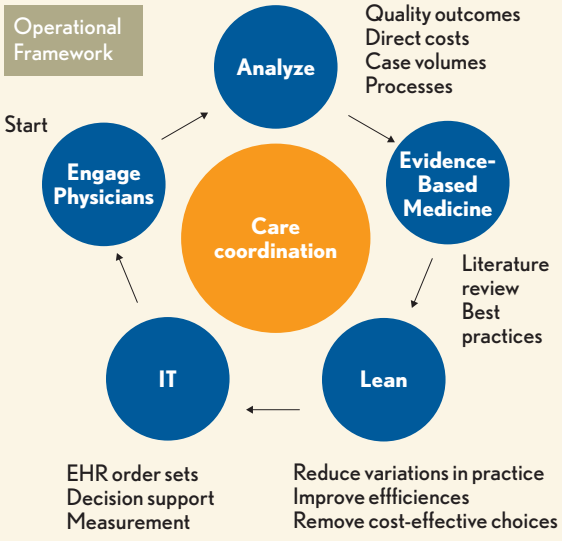
- Engage physicians in areas with clinical populations that have significant variations in cost.
- Analyze current processes, quality outcomes, direct costs, and case volumes.
- Identify evidence-based best practices.
- Apply Lean principles to reduce variations in practice and improve efficiencies.
- Hardwire new processes through IT-enabled EHR order sets, clinical decision support, and impact measurement.

Rush emphasizes that effective care redesign often requires a two-pass process. "On the first pass, our goal is to 'pinch the curve' by reducing variations," says Raj Behal, MD, Rush's associate CMO. "On the second pass, our goal is to 'shift the curve' by resetting to a lower cost per case."

Since launching its clinical initiatives plan in FY10 with its bone marrow transplant and stroke programs, Rush has expanded the initiative into more than 10 clinical programs, with additional initiatives in blood utilization, imaging, targeted drugs, and observation cases that cut across program areas. The cumulative financial impact over the first two years of the initiative was about $8 million. Quality outcomes improved or were maintained in all clinical areas. Rush also has been able to secure efficiency gains to free up capacity: In the bowel surgery clinical area, for example, the proportion of patients discharged in less than eight days has risen from 35 percent pre-initiative to 61 percent post-initiative.

LEAN CARE MAP

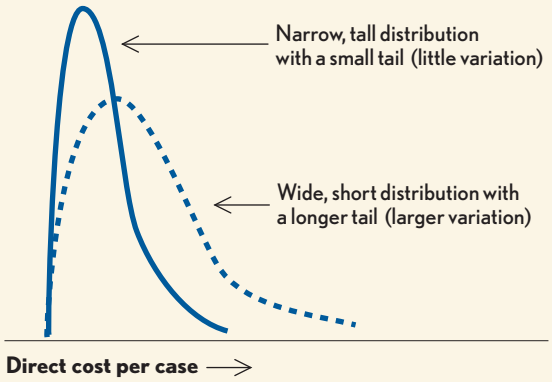
RUSH UNIVERSITY MEDICAL CENTER



Source: Rush University Medical Center.

'PINCHING THE CURVE'

REDUCING VARIATIONS IN CARE



Select clinical populations with significant **variations in costs**. The goal is to reduce variation (**pinch the curve**) and to re-set to a lower cost per case (**shift the curve** to the left)

Source: Rush University Medical Center.

PATIENT ENGAGEMENT

Significant improvements in the performance of the healthcare system, in terms of both quality and cost, also will depend on increasing the engagement of patients and their families in their care. Beginning this year, a failure to effectively engage patients may affect hospital revenues, as Medicare begins to implement payment penalties based on 30-day readmission and mortality rates for acute myocardial infarction (AMI), heart failure, and pneumonia under its hospital readmission reductions and value-based purchasing programs.

Additionally, hospital payments under Medicare's value-based purchasing program will hinge in part on a hospital's scores on the HCAHPS survey of patient experience. Although the HCAHPS survey addresses a range of issues related to the patient's experience in the hospital, a number of the survey questions align closely with issues of patient engagement, including the extent to which nurses, physicians, and other care providers did the following:

- Explained things in a way the patient could understand
- Offered clear explanations of new medications and possible side effects to the patient and his or her family, where appropriate
- Discussed a patient's need for assistance after leaving the hospital
- Provided the patient with information in writing about symptoms or health problems to look out for post-discharge

Such actions represent basics of patient engagement. If an organization is not scoring well in one or more of these areas, it has a clear focus for improvement efforts.

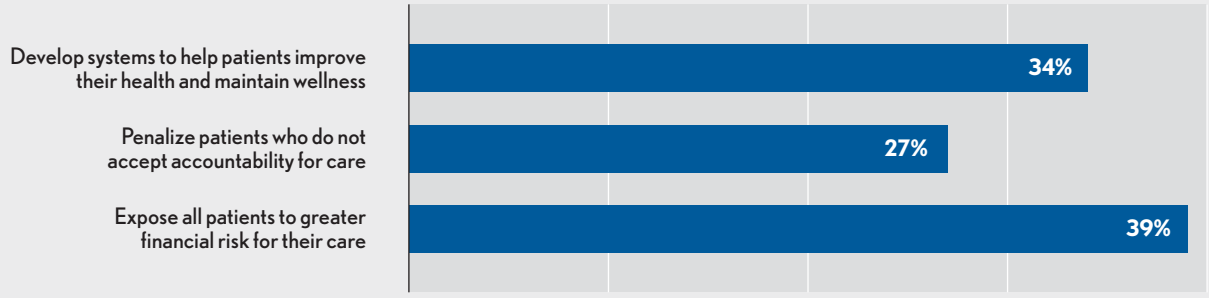
The new Medicare readmission and value-based purchasing programs provide immediate motivation to improve an organization's ability to engage its patients in the fundamentals of their inpatient and post-discharge care. But healthcare organizations should view these efforts as only a beginning. As payment structures shift to place more risk on providers, hospitals and health systems will need to strengthen and deepen their efforts at patient engagement to keep their patients well or ensure their recovery.

Healthcare organizations understandably feel some ambivalence over the issue of patient engagement, as patient behavior is something that these organizations cannot fully control. This ambivalence was evident at HFMA's 5th Annual Thought Leadership Retreat, held in 2011. Attendees were asked to identify from a selection of three options the most effective strategy to make patients more accountable for their health. As the exhibit below illustrates, responses were decidedly mixed.

A key takeaway from these results may be that improving patient engagement is best viewed as a collaborative effort among patients, healthcare providers, employers, and payers—an effort that will require aligned incentives to focus all stakeholders on the goal.

STRATEGIES FOR PATIENT ENGAGEMENT

The most effective strategy to make patients more accountable for their health would be to:



Source: HFMA Thought Leadership Retreat Survey, October 2011.

The reality is that today's healthcare providers are feeling much of the financial pressure to improve patient engagement. They should begin by focusing on those aspects of improved patient engagement within their control. Following are three strategies providers should consider.

Incorporate patient perspectives. One of the recommendations from the Value Project report on building a value-driving capability in people and culture was the establishment of patient and family advisory councils. Such councils ensure that healthcare organizations regularly and easily gain patient perspectives on decisions that affect the patient experience and their ability to be engaged with their care. Councils can be structured to give perspectives on the organization overall, or on specific disease conditions or patient populations for which improved patient engagement may be particularly critical or challenging.

In a previous chapter, Kris White, vice president for innovation and patient affairs at Grand Rapids, Mich.-based Spectrum Health, noted that feedback or guidance on patient-directed communications is a "sweet spot" for the work of patient and family advisory councils. The effectiveness of such communications is also, of course, a key element of the HCAHPS patient experience survey and important to the ability of patients and their families to understand and follow instructions for post-discharge care. (For additional tips on the formation of patient and family advisory councils, access the report at www.hfma.org/valueproject.)

Focus on areas or patients of greatest need. The initial Medicare rules' focus on 30-day readmission and mortality rates for acute myocardial infarction (AMI, or heart attack), heart failure, and pneumonia will provide for many organizations a condition-based starting point for patient engagement efforts. Patients with these conditions will nevertheless vary in terms of their engagement with recommended care protocols to recover and avoid readmissions. Moreover, other conditions—especially chronic diseases such as diabetes or asthma—are high on the list of government and commercial payers and employers seeking to reduce costs. Healthcare providers can anticipate pressures to increase patient engagement with management of these conditions soon, if they have not already felt them.

Disease registries—databases on all patients with a specific disease who are diagnosed and treated within a hospital or health system—are a particularly effective strategy for a condition-based focus on patient engagement. Such registries, especially when incorporated within an organization's electronic health record, can generate patient reminders of upcoming appointments or other care-management tasks and identify patients who have not followed up on recommended care.

Disease registries also can generate lists of patients most in need of additional care management, based on data indicating a pattern of failure to follow recommended care guidelines. Additionally, some healthcare organizations are experimenting earlier in the care process with tools that can help identify patients most in need of more intensive care management interventions. The University of Oregon, for example, has developed a 13-question survey known as the "Patient Activation Measure." This survey uses feedback from patients to place patients in one of four categories that predict their likelihood to understand their condition and follow recommended care guidelines (Chen, Pauline, "Getting Patients to Take Charge of Their Health," *The New York Times'* "Well Blog," Jan. 12, 2012). Providers can then effectively focus potentially resource-intensive care management interventions on patients most likely to need additional assistance.

Experiment with patient engagement techniques. There is a wide range of strategies and tactics that a healthcare organization can deploy in an effort to improve patient engagement. For example, the Health Research & Educational Trust has published a *Health Care Leader Action Guide to Reduce Avoidable Readmissions* (January 2010) that outlines strategies for reducing readmissions at three different stages of care (during hospitalization, at discharge, and post-discharge), ranked by the level of effort (low, medium, and high) required for implementation. Higher

REVENUE CYCLE CUSTOMER SERVICE PLAYS AN IMPORTANT ROLE IN PATIENT SATISFACTION

Patients take into account more than just the efforts of clinicians when forming an opinion of a hospital or health system: They are also strongly influenced by the level of customer service they receive from the organization's finance staff.

Patient interactions with finance professionals have a big impact on their perceptions of a healthcare organization and on their satisfaction with the services they receive. For example, many of the hospitals that earned HFMA's MAP Award for High Performance in Revenue Cycle found success by putting their focus on the patient experience within revenue cycle operations.

Savvy revenue cycle leaders at hospitals and health systems are creating their own survey tools to understand how patients feel about the nonclinical aspects of their hospital experience.

"The patient satisfaction surveys that are out there currently do not drill down to reveal where within the revenue cycle the process may have failed the patient and created a negative experience," says Suzanne Lestina, HFMA's former director of revenue cycle MAP. "Creating an internal survey—or even scripting so that staff members ask patients about their experience at the end of an interaction—allows you to get feedback from the patient in a more timely and more detailed way."

At Texas Health Presbyterian Hospital in Plano, every patient who calls the patient access intake center or the billing office receives a question: "How would you rate the level of service I provided today?" Patients are asked to rate the service on a scale of 1 to 5. Results are recorded for every call and tabulated weekly and monthly by a customer representative. Patients who give less than satisfactory scores receive a follow-up call from a manager. The reasons for low scores are discussed in department meetings, and two trainers help staff members improve not only the technical knowledge of their jobs, but also customer service.

"This effort—to survey patients at the time of preregistration and after calling the billing office—sends a message to the patients that, at the bookends of their hospital experience, we truly care about providing great service," wrote Texas Health Presbyterian in its MAP Award application. "We're not just concerned with the hospital/clinical experience, but also with the entire experience, including the revenue cycle."

effort typically requires higher cost; although a low-effort strategy can usually be implemented with existing resources, a high-effort strategy may require significant investments in additional staff or new systems.

Healthcare finance professionals should play a significant role in identifying the right patient engagement strategy for an organization by assessing the financial risk an organization faces for failure to improve patient engagement in areas such as reducing readmissions or managing chronic conditions, and by projecting the cost of recommended engagement strategies. The greater the risk, the more aggressively an organization will want to pursue efforts to increase engagement. Finance skills also will be required in determining the success or failure of implemented strategies and in validating the impact of reduced readmissions, actual costs of the strategy as implemented, and other financial indicators of success or failure (e.g., reduced average costs per patient in a bundled or per-member, per-month payment structure).

Increased patient engagement also will require the participation of other stakeholders, including employers and commercial payers. Efforts by these stakeholders to incentivize behaviors that improve wellness are already beginning. Interest is growing in penalties and rewards based on "biometric outcomes" such as weight or cholesterol levels.

CONCLUSION

A value-driving capability in performance improvement builds upon skills already outlined in previous chapters. Performance improvement will require a commitment from the organization's board on down—a need emphasized in the people and culture report. No performance improvement initiative begins as a guaranteed success: Some efforts will achieve their goal of improving the quality or cost-effectiveness of care, while others will fail (but often produce important lessons for future efforts). If an organization's board and senior leaders openly communicate their support for these efforts—acknowledging the inevitability of both wins and losses—they help create the culture of creativity and innovation on which performance improvement depends.

The emphasis on making data actionable, described in the business intelligence chapter, is a prerequisite to providing the information and decision support upon which performance improvement depends. This chapter concludes with a description of the elements of project management that should be a part of any performance improvement initiative, such as a clear definition of goals, projections of the resources needed to implement the initiative, and development of metrics against which progress toward these goals can be measured. Also critical is the definition of clear "go/no-go" points, where decisions can be made as to the viability or sustainability of a performance improvement initiative.

A basic assumption of quality management as applied to other industries has been that increased quality ultimately lowers costs. Both outcomes are essential to the long-term viability of the U.S. healthcare system, and will require constant and consistent attention to performance improvement from all healthcare providers.

CHAPTER 8

Contract and Risk Management

Although virtually all healthcare organizations have experience in negotiating traditional fee-for-service contracts with commercial health plans, few organizations today have experience in negotiating value-based contracts that could potentially expose the organization to substantial financial risk. The willingness and ability to enter into such contracts depends in large part upon the success an organization has had in mastering the other value-driving capabilities (people and culture, business intelligence, and performance improvement), because risk-based contracts require that an organization be able to:

- Respond quickly and agilely to issues that might increase the organization's exposure to financial loss
- Collect, evaluate, and act upon business intelligence regarding cost or utilization trends, in as close to "real time" as possible
- Understand its opportunities for performance improvement, based on a demonstrated ability to identify, target, and reach defined performance improvement goals

As the transition to a more value-based payment and care delivery system accelerates, few healthcare organizations will be able to avoid exposure to some form of risk. But organizations will also have the option to take on different forms of risk, and not all forms of risk will be appropriate for all organizations. The degree of risk and integration required will depend on an organization's value-based future state strategy.

This chapter:

- Describes the main categories of risk healthcare organizations are likely to encounter in the transition to value-based payment
- Discusses various strategies for modeling and managing exposure to risk in value-based payment contracts
- Highlights examples of how healthcare organizations are mitigating their exposure to risk as they pursue value-based payment opportunities

RISK CATEGORIES

Main categories of risk include transition risk, performance risk, and insurance risk. The first will be to some degree unavoidable, the second will be an option many organizations will want to pursue (in varying degrees), and the third is an option that most organizations will want to approach cautiously.

Transition risk. Over the course of research for the Value Project, the dilemma of "a foot on the dock and a foot in the boat" has been mentioned frequently. Although most signs indicate that a transition to a more value-focused healthcare system is under way, that transition is likely to unfold over many years. The complexities and incentives of the existing system must be unraveled while a new system that better aligns hospitals, physicians, and other providers to render better coordinated, higher quality, lower cost care is fashioned.

Putting both feet in the "new system" boat too early can have serious financial consequences if, for example, reduced utilization from better coordinated care reduces revenue under the current payment system. But staying on the "old system" dock too long risks missing the boat altogether if other providers have developed the capabilities they need to take advantage of value-based opportunities as they arise. Transition risk refers to the potential costs inherent in either of these scenarios.

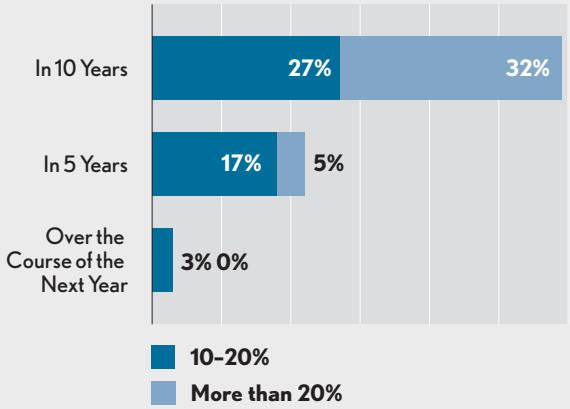
Performance risk. Performance risk encompasses a wide range of payment strategies in which a healthcare provider may face lowered payments or financial penalties for failure to meet quality targets, manage utilization or costs, achieve patient satisfaction goals, or meet other performance-related targets. Prospective payment system hospitals and health systems will be facing some level of performance risk with the Medicare value-based purchasing program, the Hospital Readmissions Reduction Program, potential penalties for failure to achieve "meaningful use" of EHRs under the HITECH Act, and failure to control hospital-acquired infections. At the same time, hospitals will be facing additional revenue pressures from the Medicare market basket productivity adjustments. Although cumulative percentages of Medicare payments at risk under these programs start at relatively low levels (2 percent in federal fiscal year [FFY] 2013), up to 12 percent of hospital Medicare payments could be at risk by 2018.

Many providers are also contemplating—or have entered into—value-based payment initiatives with both government and private payers that involve some potential for performance risk. Indeed, nearly 60 percent of respondents to an HFMA Value Project survey indicated that they believe more than 10 percent of their total payments will be exposed to performance risk within the next 10 years (see the exhibit below).

Performance risks under various types of value-based payment contracts can range from relatively minimal (failure, for example, to receive an incentive payment for meeting quality metrics under a pay-for-performance contract) to substantial (repeated failure to keep costs below the negotiated price for a bundled episode of care). Modeling and accounting for performance risk will be a critical consideration for provider organizations in negotiations for value-based payment contracts.

EXPOSURE TO RISK

How much of your payment do you predict will be exposed to performance risk (e.g., value-based reimbursement based on bundled payment, capitated payment, or shared savings with penalty contract):



Source: HFMA Value Project Survey, March 2011.

Insurance risk. Insurance risk refers to the risk that a possible—but uncertain and typically uncontrollable—event might occur. In health care, insurance risks might include the risk of being involved in an accident that causes traumatic harm or the risk of contracting a serious disease. The degree of insurance risk is a combination of several factors, including the probability of an event occurring and the likely magnitude of harm if the event does occur. From the perspective of a healthcare provider, insurance risk differs from performance risk in that, for performance risk, the patient's condition is known in advance—the element of risk centers on how well the provider performs in treating the known condition. Insurance risk would come into play if, for example, a provider organization had agreed to provide all necessary healthcare services for a defined population of patients, including patients who may at some future date be involved in an accident or contract a serious disease.

Insurance risks can be managed, but healthcare organizations should be wary about assuming risk without access to population data with enough historical depth and population breadth to allow statistically valid modeling of risk exposure.

MODELING AND MANAGING EXPOSURE TO RISK

As provider organizations face new exposure to different forms of risk, it is imperative that they work to model the extent of their exposure and put processes into place to manage their risk.

The capabilities grid below illustrates particular skills within the four capabilities of people and culture, business intelligence, performance improvement, and contract and risk management that providers will need to develop to accommodate the demands of different payment methodologies requiring varying levels of provider integration and assumption of risk.

As payment methodologies shift to the right side of the grid, the need to create integrated networks of providers (formal or informal) to coordinate care across the continuum intensifies. Providers also assume more risk as payment methodologies shift to the right. Performance risk emerges almost immediately under a pay-for-performance methodology. Population risk and the attendant need to manage utilization effectively become critical considerations under disease and chronic care management and total health management methodologies.

CAPABILITIES GRID

Lower — **Degree of Risk and Integration Required** — Higher

Organizational Capabilities	Focus Area	Fee for Service	Pay for Performance	Penalties for Adverse/ Preventable Events	Episodic Bundling	Disease/Chronic Care Management	Total Health Management
People & Culture	Cultural Emphasis	Establishing Learning Organization	Leading with Quality			Managing Long-Term Conditions	Engaging the Community
	Management and Governance	Informal Physician Leadership	Formal Acute-Care Physician Leadership		Communities of Practice		
	Operating Model	Department Structure		Episode-Focused Service Lines		Cross-Continuum Product Lines	Community Collaboratives
	Performance and Compensation	Productivity-Based		Outcomes-Based			
Business Intelligence	Financial Reporting and Costing	Procedure-Level		Activity-Level	Longitudinal	PMPM	
	Quality Reporting	Core Measures	Process Measures	Outcome Measures		Condition Measures	Population Indicators
	Business Case	Supply/Drug and Productivity		Medical/Surgical Interventions		Lifestyle Interventions	
	Decisions Support Systems	Financial Data	Acute Quality Data	Ambulatory Indicators	Claims and Prescription Info	Health Risk Assessment, Biometrics, and Predictive Modeling	
Performance Improvement	Process Engineering	Identifying Service Variability	Increasing Reliability within Clinical Value Bundles		Optimizing Care Pathways Across the Continuum		
	Evidence-Based Medicine	Increasing Patient Safety	Developing Clinical Value Bundles			Managing Conditions	Improving Wellness
	Stakeholder Engagement	Creating Transparency		Informing Patient Alternatives		Developing Accountability	
Contract and Risk Management	Contract Management	Negotiating Pricing	Balancing Cost and Quality Aims		Network Development Funds Distribution		
	Risk Modeling and Management	Profit/Loss Analysis	Estimating Exposure			Predicting Outcomes	

Low Degree Medium Degree High Degree

Managing transition risk. The pace of the transition to a more value-based payment and care delivery system varies widely among states and more local markets across the country. In Massachusetts, for example, commercial carriers and healthcare organizations are moving rapidly toward risk-based contracting and population health management strategies. Other markets have encountered few value-based payment mechanisms beyond pay-for-performance in contract negotiations. But even in markets where no "burning platform" for change exists today, forward-looking healthcare organizations are seeing a "burning horizon" and are taking advantage of a slower pace of change to prepare their organizations for what they see as an inevitable acceleration in that pace.

Healthcare organizations can manage transition risk by balancing experiments in value-based care delivery with the need to remain financially viable. For example:

- *In markets where there is unmet demand for services,* a focus on reducing per-patient utilization of an in-demand service can help develop value-driving performance improvement capabilities while opening up capacity for additional volume that offsets per-patient revenue reductions.
- *For organizations with self-funded employee health plans,* an effort to better coordinate the care of high-frequency users or to better manage the conditions of employees or their family members with chronic diseases can provide experience with value-based care delivery while producing cost savings for the organization. For example, Adventist HealthCare's patient-centered medical home pilot program resulted in a 48 percent reduction in its high-risk patient population and a 35 percent reduction in per-member-per-month costs (Lee, James G., et al., "Medical Home Leads to Healthier Patients—and Savings—for AHC," *hfm*, June 2011). For an innovative twist on this strategy, see the sidebar "Managing Transition Risk: Value-Based Charity Care at Shands Jacksonville Medical Center" on page 76.
- *For all markets,* a focus on lowering costs while maintaining the quality of services provided is critical. As noted in a report from Standard & Poor's, "an almost universal response [to transition risk] among providers is lowering costs"[27]—an imperative for all providers in a healthcare system that must find a way to bend the cost curve, no matter which direction reform takes.

Managing performance risk. As noted earlier, most healthcare providers will have to assume some level of performance risk in the coming years as programs such as Medicare's value-based purchasing and hospital readmissions reduction programs take effect. Many providers are considering taking on additional performance risk through bundled payment programs, either through the Centers for Medicare & Medicaid Services (CMS) and Center for Medicare & Medicaid Innovation (CMMI) programs or with commercial carriers or large employers.

Value-based purchasing. At a minimum, all hospitals and health systems should have modeled their potential financial exposure under the Medicare value-based purchasing program. The amounts at risk under value-based purchasing are relatively straightforward: One percent of each hospital's base operating DRG amounts were at risk in FY13, increasing to 2 percent in FY17. Hospitals will be subject to risk-adjusted comparisons with other hospitals, as well as to hospital-specific benchmarks for improvement, and there will be clear winners and losers in terms of penalties and rewards.

Through CMS, hospitals have access to simulated, hospital-specific reports that flag areas of strength and weakness in the value-based purchasing scoring domains that should help hospitals identify areas for improvement in both clinical quality of care (which accounts for 70 percent of a hospital's value-based purchasing score in FFY13) and patient satisfaction (which accounts for the remaining 30 percent). Hospitals should, of course, be actively working to improve areas of weakness.

Readmissions reduction. Managing risk under CMS's hospital readmissions reductions program is slightly more complicated, as the penalty for excess readmissions must be weighed, in the short-term, against revenue forgone as readmissions are reduced. In the first year of the program (FY13, beginning Oct. 1, 2012), CMS applied an adjustment factor capped at 1 percent of all DRG payments for hospitals with excess readmissions. The adjustment factor rises quickly, however, to 3 percent of all DRG payments by FY15 and beyond. A tool to model the financial implications of the readmissions reduction program is available at hfma.org/reform.

[27] Standard & Poor's, *U.S. Not-For-Profit Health Care Providers Hone Their Strategies To Manage Transition Risk*, May 16, 2012.

MANAGING TRANSITION RISK: VALUE-BASED CHARITY CARE AT SHANDS JACKSONVILLE MEDICAL CENTER

Shands Jacksonville Medical Center in Jacksonville, Fla., is gaining the skills needed to help manage the risk of transition to a value-based healthcare system with a focus on better coordinating the care provided to uninsured and charity care patients. Shands Jacksonville's efforts include reducing the risk of readmission following inpatient care and, more broadly, developing a patient-centered medical home to better serve the healthcare needs of indigent patients in Duval County.

Shands Jacksonville's focus on reducing readmissions for uninsured and charity care patients allows the organization to develop protocols for coordinated postdischarge care that benefit both the patients and the organization. From a financial standpoint, misaligned incentives within the current payment system mean that reducing readmissions for the general population can also reduce volumes—and revenue—for the admitting organization, unless sufficient demand exists within the market to "backfill" reduced volumes. But for the charity care population, there is no positive financial impact from either an initial admission or a readmission. The mission of virtually all hospitals and health systems includes a commitment to providing care to these patients. By ensuring that inpatient care is supported by effective postdischarge care, Shands Jacksonville can improve both the quality of outcomes for charity care patients and the financial impacts of serving the charity care population.

Shands Jacksonville is establishing a postdischarge clinic for its uninsured and charity care patients and ensuring that, upon discharge, a visit to the clinic has been scheduled for within 72 hours postdischarge. An additional follow-up visit with a primary care physician is also scheduled for within two weeks postdischarge. Postdischarge care is further supported by a telehealth component through the hospital's home health agency to help monitor the patient's recovery, vital signs, and compliance with their prescribed medication regimen.

As the Centers for Medicare & Medicaid Services and commercial carriers strengthen penalties for readmissions within the general patient population, Shands Jacksonville will be able to draw upon the protocols developed for its charity care patients to further reduce readmissions for the organization as a whole.

Shands Jacksonville's commitment to improving the effectiveness of charity care extends well beyond its focus on reducing inpatient readmissions. It is also developing a consolidated, multipurpose clinic for serving Duval County's indigent population, using a patient-centered medical home model.

The use of a single clinic for the city contract patients helps address another dilemma of the current payment system, says Michael Gleason, Shands Jacksonville's CFO: "Physicians have to change their care strategy based upon payer and payment method." The traditional fee-for-service system, for example, promotes a "more is better" approach, while new payment methods emphasizing population health management emphasize both the quality and cost-effectiveness of care. Primary care providers and specialists who staff the clinic will know that their focus should be on effective population health management.

Specialists who rotate through the clinic will not simply be seeing patients. Shands Jacksonville envisions that specialists will spend one hour in each four-hour block reviewing cases with primary care physicians, mid-level providers, and case managers, using a team approach. One purpose of these meetings is for the specialists to educate the other clinic providers on the type of patients who truly warrant specialty care. Over time, Shands Jacksonville believes this approach will help avoid unnecessary specialty referrals, while increasing the ability of mid-level providers to treat and address various medical needs directly.

The clinic site has been chosen to ensure accessibility via major bus lines. It will also be staffed to provide a range of behavioral health and other social services tailored to the needs of the county's indigent population. Shands Jacksonville is also considering inclusion of a pharmacy at the clinic site to make it a truly one-stop site for patient needs. The clinic will offer expanded evening and weekend hours to enhance patient access, particularly for those patients who cannot leave work during normal business hours, and to further reduce the need to seek services in the ED.

Shands Jacksonville believes the costs of maintaining the clinic will be offset by a reduced need for more expensive emergency and inpatient charity care services. It will also gain skills in population health management that can be transferred to other populations as payment methods change; in fact, Shands Jacksonville is already working with area employers to develop on-site workplace clinics. At the same time, charity care patients will benefit from better health management and better coordinated care.

Despite the short-term risks to revenue, hospitals should begin developing and implementing strategies to reduce readmissions before the higher penalties for excessive readmissions take effect. There are several obstacles to these efforts within the program as currently structured, which HFMA has highlighted in a comment letter to CMS.[28] For example, hospitals may not have access to timely, cross-continuum data that will allow them to accurately identify and mitigate the impact of readmission drivers. Incentives for physicians and skilled nursing facilities—both key providers of postdischarge care that can affect readmission rates—are not yet sufficiently aligned to ensure coordination of care with hospitals. And the risk adjustment mechanism used in the program fails to account for key patient socioeconomic factors—such as the presence of Supplemental Social Security Income or presence of Medicaid as a secondary payer—that can have significant predictive power to improve risk adjustment (a factor that could especially affect safety-net hospitals). Tactics outlined in the sidebar "Readmissions Reduction Strategies" at right can help hospitals work around some of these limitations.

Bundled payments. Bundled payments are typically anchored on a procedure—a knee replacement, for example, or coronary artery bypass graft—but also include payment for all inpatient services and, in some instances, postacute services related to a defined episode of care associated with the procedure. Bundled payments can also be structured around chronic diseases; in these cases, the payment might be for a yearlong "episode" of care that is renewed annually to cover chronic disease management services and the costs of treating any disease-related complications that arise during the year. Because healthcare organizations are paid under bundled payment programs for each episode of care, or for the care of patients with a known chronic condition, these programs involve performance risk only; there is no assumption of insurance risk.

Hospitals, health systems, and other provider organizations are pursuing bundled payment opportunities through CMMI's Bundled Payment for Care Improvement initiative and through contracts with commercial carriers and large employers. Organizations considering such opportunities should be aware of the following risks:

Administrative costs. Participants in CMS's Acute Care Episode (ACE) bundled payment demonstration project estimated $350,000 in annual ongoing costs associated with the participation in the demonstration. These costs included hiring of patient navigators or case managers to screen lists of patients for eligibility to participate in the ACE demonstration and dedicated patient financial services staff to resolve claims with the Medicare Administrative Contractor (MAC). Participants in the CMMI bundled payment initiative will also need to dedicate staff time for collection and reporting of quality measures. Depending on contract terms, administrative cost risks may be lower in the private sector.

READMISSIONS REDUCTION STRATEGIES

A wide range of tactics is available to hospitals seeking to reduce readmissions. Some of the most commonly cited include:

- Patient risk-screening upon admission to better understand patient needs during the hospital stay and to identify services that may be needed to support the patient postdischarge
- Review of medications and instructions with patients at discharge. To ensure patient understanding of instructions, hospitals employ both multiple reviews of instructions with the patient (e.g., first a physician, then a nurse) and repetition (the patient repeats the instructions to ensure understanding)
- Postdischarge follow-up with the patient, often a phone call from a nurse within three days of discharge to ensure the patient is taking medications regularly, etc.
- Scheduling a primary care physician visit at discharge, to take place within 72 hours of discharge—and following up to ensure the visit occurred.

For patients with more intense needs and a higher risk of readmission, some hospitals are also employing case managers who actively work with the patients and postacute providers following discharge.

[28] HFMA letter on the hospital readmissions reduction program, addressed to Marilyn Tavenner, acting administrator of CMS, Jan. 30, 2012.

Downside financial risk. For bundled payments focused on inpatient procedures, the hospital or health system will often find itself assuming full downside risk, at least initially, to engage physicians and postacute providers in the project and build a relationship of trust with them. Hospitals then need to focus on incentives to encourage other providers to identify cost-savings opportunities and work on reducing complication rates and readmissions, which reduce the amount of cost savings left for the hospital.

Lack of control over patient. HFMA has expressed to CMS its concern that Medicare beneficiaries will not be encouraged to receive their care from providers in the beneficiaries' region who have contracted for conditions bundled under models two and three of the CMMI initiative.[29] This poses obvious obstacles to bundles that require coordination of care among multiple providers.

Outlier risk. The risk of outlier cases—those involving significantly higher costs and more intensive services than contemplated for the bundle—is of particular concern to hospitals with lower volumes of a bundled procedure, and thus lower capacity to absorb outlier costs.

To help mitigate these risks, healthcare organizations have several options. For those organizations considering participation in the CMMI bundled payment initiative, the Health Care Incentives Improvement Institute (HCI3), which also runs the PROMETHEUS Payment program, has assembled a set of resources, including "freeware" analysis and reporting tools to select potential bundled episodes and determine episode price based on Medicare Parts A and B claims data (available at www.hci3.org). For organizations pursuing bundled payment opportunities in the private sector, risk-mitigation considerations when contracting for the bundle include:

- *Clear definition of the episode.* Ensure that the contract clearly defines the start and end dates for the bundled episode, which defines the period for which the provider organization is at risk. Similarly, for organizations that are considering offering a "warranty" or guarantee for the care provided in the bundle, the guarantee should have a clear end date.
- *Coverage of outlier cases.* Provider organizations may want to set a threshold (expressed, for example, as a certain percentage above the contracted price for the bundle) above which they will not be at risk for costs.
- *Incentives for patients to stay "in network."* The commercial carrier, employer, or benefits consultant with which the provider organization is contracting should consider creating strong financial incentives for patients to receive all care covered by the bundle from the provider organization and, if applicable, its contracted provider network.
- *Data sharing.* The provider organization should receive historic claims data for the population that will be covered by the bundled arrangement during the negotiation process to assess any health risks that might complicate or raise the cost of services covered by the bundle, as well as ongoing current claims data on, ideally, a monthly basis once the bundled payment agreement begins.
- *Subcontracts with other providers.* Subcontracts can offer the opportunity for risk-sharing among providers. If a hospital or health system is organizing the bundle, it may encounter initial resistance in convincing physicians to

HFMA RESOURCES ON BUNDLED PAYMENTS

HFMA has produced several reports and resources examining the issues, impacts, risks, and opportunities of bundled payment programs, including:

- *Transitioning to Value: PROMETHEUS Payment Pilot Lessons*, based on interviews with providers working to implement bundled payment pilots with the PROMETHEUS Payment program. Available at hfma.org/Prometheus.
- *Pursuing Bundled Payments: Lessons from the ACE Demonstration*, presenting lessons learned from provider organizations participating in CMS's Acute Care Episode (ACE) demonstration project for orthopedic and cardiology bundled payments. Available at hfma.org/ACEDemonstrationReport.
- *Bundled Payments: An Opportunity Worth Pursuing?*, a compendium of resources from HFMA publications exploring the potential benefits and risks of bundled payments. Available at hfma.org/BundledPaymentCompendium.

[29] HFMA comment letter re the CMMI Bundled Payment Pilot, addressed to Marilyn Tavenner, acting administrator of CMS, May 10, 2012.

assume a portion of downside risk. But if physicians or other contracted providers stand to enjoy a potentially significant "upside" for strong performance, they should also be willing to assume some portion of downside risk if costs cannot be contained within the negotiated bundled payment price.

Managing insurance risk. Responses to an HFMA Value Project survey indicate that many hospitals and health systems are planning to invest in population health management capabilities (see the exhibit at bottom right), although the number that have made a significant investment to date is low. As shared savings programs gain traction as well as—potentially—a move toward capitated or "global payment" contracts, these numbers are likely to grow. In many instances, however, healthcare organizations assuming responsibility for the care of a defined population will want to limit their exposure to insurance risk.

Payment structures typically differ between shared savings and capitated payment arrangements. Shared savings are often built on a fee-for-service chassis, with savings or losses calculated through reconciliation of actual fee-for-service costs against a budgeted cost of care for the attributed population. Capitated payments are typically made in a lump, "per-member-per month" sum for the attributed population. But insurance risk considerations for the two payment arrangements are largely the same. Absent limitations on this risk, provider organizations are on the line for both known and unforeseen costs of care within the attributed population.

Provider organizations are rightly cautious in assuming unlimited insurance risk for a population, and before they consider taking on any significant amount of insurance risk, they should consider their capabilities in terms of:

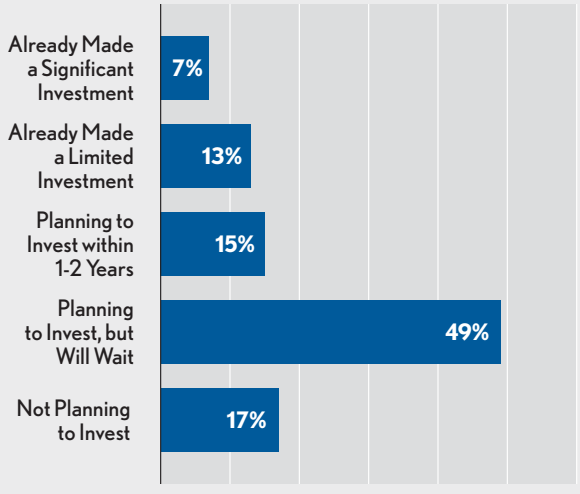
- *Integration of care delivery network.* Population management strategies rely on increased utilization of primary and preventive care services to reduce utilization of more expensive specialist services and inpatient and outpatient procedures. They also rely on coordination of care. From a hospital or health system's perspective, an integrated primary care network is essential to provide primary care, maintain a referral base when more intensive services are required, and coordinate postacute care needs to reduce complications and readmissions.
- *Process improvement.* Success under a value-based population management strategy will require an ability to maintain the quality of patient outcomes while enhancing the cost-effectiveness of care. Organizations should be comfortable with their ability to successfully plan and implement process improvements across the organization.
- *Data access and analytics.* Population management also requires access to historical as well as timely current claims data for the attributed population, combined with clinical data from patient medical records and data on costs of care across the network. Often, access to claims data will require the cooperation of a partner on the payer/purchaser side that is willing to work closely with the provider organization on identifying and fulfilling data needs (see the sidebar "Bellin Health: Finding the Right Partners to Improve Health and Reduce Cost" on page 80). The provider organization also needs the skills of data analysts and actuaries—either in-house or contracted—to mine the data for actionable information and identify cost and utilization trends.

Even with these capabilities in place, provider organizations should consider the following options to limit insurance risk in a shared savings or capitated payment system:

- *Open versus closed network.* The more control the provider organization has over managing the attributed population's

POPULATION HEALTH MANAGEMENT PLANS

What are your plans related to investing in population health management capabilities?



Source: HFMA Value Project Survey, March 2011.

BELLIN HEALTH: FINDING THE RIGHT PARTNERS TO IMPROVE HEALTH AND REDUCE COST

Bellin Health, based in Green Bay, Wis., is offering a full-spectrum of products to both self-funded and fully insured employers in its community, ranging from pay-for-performance based on traditional quality and efficiency metrics to shared savings and loss contracts. Bellin realizes it is not in a "one-size-fits-all" environment. At the farthest end of the spectrum, it will enter into shared savings agreements as a strategic partner in situations where certain requirements are met:

- A long-term contract is in place.
- A willing partner will look at and respond to the data (e.g., claims, health-risk assessment results, and workers' compensation).
- A willing partner will innovate with Bellin on plan design and health and healthcare solutions.

Bellin's willingness to enter into shared savings agreements for bending cost trends downward and achieving quality metrics is unique in its market in that it does not require employer exclusivity. "This is where innovative benefit design and employer willingness to work in partnership come into play," says Peter Knox, executive vice president at Bellin. "We recognize that not requiring exclusivity is what our customers truly want. We can capitalize on our primary care network, business intelligence, and performance improvement capabilities to be successful managing entire populations in an open network environment."

As an example, Bellin worked with one strategic partner to develop a requirement that employees must earn a "wellness certificate" to access the benefit design with the lowest employee cost sharing. The certificate requires that employees meet with a primary care physician, complete basic screenings and a health-risk assessment, and be working on a personal health improvement plan. These requirements help Bellin manage population health and reduce risk, and also help to increase access for patients.

Bellin recognizes that necessary competencies and transitions will be required as the organization moves forward with its payer strategies. In particular, shared savings plans will reach a point at which it is difficult to wring out any additional savings. Bellin believes that if it has managed the relationship with its strategic partners appropriately up to this point, it will be able to work out an arrangement that will continue to be mutually beneficial.

Knox also shares some considerations that provider organizations should be aware of if they are thinking about shared savings plans with employers.

- **Listen to the market and develop a product it wants.** In Bellin's market, for example, there was little employer appetite for exclusivity.
- **Prepare for a significant time commitment, including lots of meetings to review data, plan, and set goals for the program.** A fully engaged partner that understands this at the outset is essential.
- **Listen to the data.** One employer in Bellin's market, for example, had low per-employee spending but troubling health-risk assessment scores. There was little opportunity for savings, but Bellin was able to develop a pay-for-performance contract focused on improving employee health-risk assessment scores.
- **Design benefit packages to create the desired results.** Incentives for employees to complete screenings and health-risk assessments, for example, help manage population health and mitigate risk.
- **Understand organizational strengths, capabilities, and competencies.** Bellin cites its primary care network, business intelligence, and data-mining capabilities as prerequisites to the work it is doing on shared savings plans.
- **Prepare to step outside the traditional comfort zone.** Business models for hospitals and health systems are changing. If your organization is not able to respond to the needs of employers, another organization will.

health, the better able it is to control the quality and cost-effectiveness of the services and care provided. Closed networks can still be a difficult sell, however, given the failures of managed care in many areas of the country in the 1980s and 1990s. Bellin Health, based in Green Bay, Wis., found little appetite for closed networks among employers within its service area, and has constructed open network shared savings programs, balanced with incentives that give it an opportunity to increase market share (see the sidebar "Bellin Health: Finding the Right Partners to Improve Health and Reduce Cost" on page 80). Where greater willingness to consider closed networks exists, copays can be lowered or waived to promote in-network care or significantly increased to discourage out-of-network care.

- *Limitations on downside financial risk.* High-cost individual outlier cases, inaccurate cost or utilization projections, or unforeseen events, such as a disease outbreak, that significantly elevate costs across the population can all pose significant financial risks to the provider organization. Outlier payments similar to those discussed with respect to performance risk earlier in this chapter is an option, but it can be difficult to identify and establish threshold costs in advance for all the procedures and conditions that could affect a managed population. Strategies more appropriate to a population management situation include provider-carried reinsurance to compensate the provider organization for total costs incurred above a certain threshold, or the establishment of "risk corridors," in which the provider is responsible for losses up to a certain percentage threshold above the budgeted or capitated total cost of care for the population, and the payer assumes responsibility for losses above that threshold. Corridors can also be established on the savings side, where the provider retains savings up to a certain percentage threshold below the budgeted/capitated total cost of care and the payer receives any additional savings beyond that threshold.[30]
- *Exceptions and carve-outs.* This consideration applies particularly to provider organizations that offer a more limited range of services. The provider organization takes on accountability for services it provides or controls and receives a capitated payment for those services, but is not accountable for the costs of excluded (or "carved out") services. Provider organizations negotiating carve-outs can anticipate that the payer will in turn seek provisions protecting itself against efforts to shift high-cost patients to excluded services.

[30] For additional information on risk corridors, see Miller, Harold D., *Transitioning to Accountable Care: Incremental Payment Reforms to Support Higher Quality, More Affordable Health Care,* Center for Healthcare Quality & Payment Reform and the Commonwealth Fund, January 2011, pp. 22-24.

CONCLUSION

Risk will be an inevitable factor in the transition to a more value-based healthcare system. But organizations will have many opportunities to control and manage the risks they face—or decide to pursue. Going forward, key strategies will include the following.

Develop the capabilities needed to create value. Effective contract and risk management will require organizations to draw upon the full range of value-driving capabilities.

Experiment with payment and care delivery transformation in a risk-controlled environment. Take advantage of opportunities to gain experience with value-based reforms today to prepare for an almost certain intensification of purchaser demands for greater healthcare value.

Develop relationships of trust across the provider continuum and with the payer and purchaser community. These relationships should support the coordination of care, sharing of data, innovation of benefit design, and appropriate division of risk. Such efforts should will improve population health while maintaining the financial sustainability of the healthcare delivery system.

SECTION 3

Defining and Delivering Value

EXECUTIVE SUMMARY

All stakeholders recognize that the future will focus on value improvement, with an emphasis on effective cost management. Payers recognize the need for a more focused set of value metrics. CMS has indicated that, longer term, the triple-aim based National Quality Strategy will be utilized to align Medicare and Medicaid performance programs and metrics. Based on these findings, HFMA recommends the following guidelines for the development and use of value metrics:

- Work to replace process metrics with patient-centered functional outcomes.
- Align value metrics with the "triple aim" of improving care for individuals, improving the health of populations, and reducing the per capita costs of health care.
- Focus on a limited set of metrics to drive performance.
- Use payment incentives and penalties selectively, emphasizing performance on metrics that have been proven or stakeholders agree are most likely to drive the most desirable quality or cost outcomes.
- Report provider-specific performance to end users in a way that is understandable and actionable.

The findings from HFMA Value Project research and interviews indicate that payers, purchasers, and providers anticipate a real commitment to pursuing value-based payment methodologies over the next three to five years. Stakeholders believe the path forward is largely one of experimentation with payment methods. Leading providers

ABOUT THIS SECTION

This research included interviews with 13 executive leaders at organizations representing payers, purchasers, and government agencies. Additionally, HFMA fielded two surveys of provider organization CFOs, one focusing on value metrics and the other on costing and business intelligence capabilities, and conducted interviews with 12 finance officers at a range of organizations regarding their business intelligence and costing capabilities.

Organizations interviewed for Section 3 include the following:

America's Health Insurance Plans
Catalyst for Payment Reform
Office of Clinical Standards and Quality, the Centers for Medicare & Medicaid Services (CMS)
Center for Medicare and Medicaid Innovation, Medicare Demonstrations Group, CMS
Excellus BlueCross BlueShield
Leapfrog Group
Lockton Companies
MedPAC
National Association of Insurance Commissioners
National Business Group on Health
National Quality Forum
State of Maine
United HealthCare

Additionally, HFMA interviewed hospital, medical group, and health system CFOs to better understand their planning efforts related to business intelligence and costing capabilities.

Individuals from the following hospital organizations participated in these interviews:

Advocate Health Care
Beth Israel Deaconess Medical Center
Bon Secours Virginia Health System
Bothwell Regional Medical Center
Dean Health Clinic
Fairview Health Services
Howard County Medical Center
Longmont United Hospital
Novant Health
Providence Health
UAB Medicine | UAB Hospital
University of Iowa Healthcare

HFMA also conducted two industry surveys. The first, on value metrics, was conducted in December 2011 and focused on trends in contractual payment and other arrangements between commercial health insurance carriers or large employers and provider organizations whose payment arrangements were based on value metrics.

The second survey, conducted in February 2012, focused on the role of costing and business intelligence in a value-based payment environment.

are actively identifying and proposing bundled payment models to payers, and some are leapfrogging to address population risk management. Meanwhile, external stakeholders and providers view care delivery as the key to improving value in health care. Payers and purchasers are encouraging new care delivery models. Leading providers are proactively experimenting with new partnerships and approaches.

Leading hospitals also are investing in core business intelligence and costing capabilities, with a more immediate emphasis on clinical information system enhancements. Some organizations are moving from "directional" costing data to more precise and granular information across care settings.

Additionally, leading providers are creating opportunities for physicians and front line staff to identify and execute on initiatives to improve value, according to Value Project research and interviews. They are actively and purposefully fostering agile environments of aligned physicians and engaged staff who can drive the necessary changes forward.

Providers are encouraged to take the following action steps.

Do not delay in developing the four value-driving capabilities required to adapt in a new payment environment. Leading organizations are making improvements in all four areas, with each determining how best to balance and sequence these initiatives.

Embrace strategic agility for your organization. Providers are laying the foundation to change course successfully, and sometimes quickly, as strategies evolve in a highly dynamic healthcare market environment.

Seek stakeholder alignment around a common set of value metrics that are meaningful to their intended end users. HFMA recommends that, in the near term, provider organizations use contract negotiations with commercial carriers to push for alignment of contract value-based metrics with CMS value-based metrics, to enable greater organizational focus.

Explore strategic partnerships and opportunities with payers, employers and patients. Leading organizations are pursuing unique arrangements with key stakeholders that emphasize focus on the critical healthcare needs of the providers' patient populations.

Prepare to differentiate the effectiveness of care provided by your organization within a value-driven, competitive marketplace. Although the extent to which changing market dynamics will drive purely price-sensitive purchasing of health care remains uncertain, provider organizations need to be thoughtful about the value proposition they intend to offer purchasers.

CHAPTER 9

Exploring Value

As established in the first section, value is located at the intersection of a purchaser's perception of the quality of a good or service and the amount he or she is willing to pay for that good or service.

As in other industries, value is a concept of relative worth. In health care, measuring value remains elusive. The *definition of quality varies* depending upon the stakeholder—and there are many stakeholders in health care, among them patients, employers, payers, and providers. In many cases, because of how health insurance is typically financed, *the full amount paid for health care is not apparent*. And, under the traditional payment system, *providers typically are not compensated for producing value*; instead, they are rewarded for the volume of services they provide:

Value = Quality* in relation to total payment for care**

***= a composite of patient outcomes, safety and experiences**

****= the cost to all purchasers of purchasing care**

This report uses the term *payer* to describe insuring entities, such as CMS or a commercial insurance company. However, insuring entities play a dual role in that they also function in part as purchasers of healthcare services. *Purchasers* include the patient (primary purchaser), employers, and/or state and federal programs, such as Medicaid and Medicare (secondary purchasers), and commercial health plans (serving as an intermediary between purchasers and providers.) *Provider* is intended as an umbrella term encompassing hospitals, health systems, and physicians.

To avoid confusion, we use the term *payment* to describe the cost of purchasing services—the amount paid by the patient, employer, and government purchasers—and the term *cost* to describe the healthcare provider's cost of providing the service. In a purchaser-centered value equation, the provider's cost is relevant to the purchaser only to the extent it drives the amount of payment. But the cost of providing care remains an important consideration for providers, who are tasked with maintaining financial viability while improving quality of care.

Interviews conducted with executive leaders at 13 organizations representing payers, purchasers and government agencies provide the external perspective on value metrics and value-based payment methodologies examined in this section, which summarizes findings related to:

- Purchasers' definitions of value
- The role of care delivery as the key to value improvement
- Approaches to value performance standards and value-based payment
- Commitment to pursuing value-based payment
- Views on the role and likely effectiveness of consumers in driving value
- Predictions about the near-term impact of insurance exchanges in driving quality improvement

PURCHASERS' DEFINITIONS OF VALUE

The interviews revealed that purchasers generally define value as a combination of quality and price—"the right care for the right price"—and believe this is not what they are getting.

Employers. Employers continue to offer health benefits to employees to remain attractive to job-seekers, and to help ensure a healthy and satisfied workforce. Although they generally perceive value in health care to be a function of both quality and payment, employers of all sizes who were interviewed by HFMA are generally much more concerned about containing the cost of health insurance benefits for their employees than they were even a few years ago. Today, human resources directors are increasingly being held accountable for maintaining a budget for health insurance expenditures. In some cases, C-suite executives are becoming directly involved in health insurance negotiations.

Employers use a variety of tactics to contain their healthcare costs. Most employers continue to increase employee cost-sharing in plan design as a primary tactic to contain insurance costs. Some employers are eager to utilize

provider-specific price and quality data to differentiate them into preferred and nonpreferred (e.g., tiered) networks, typically with cost sharing that encourages utilization of preferred providers. More knowledgeable employers and consultants express concern about providers' cost-shifting efforts and attempt to ferret out evidence of cost shifting in contract negotiations.

The interviews revealed significant frustration among employers regarding the topic of value in health care and the difficulties they experience obtaining meaningful quality data and measures of performance. As one interviewee noted, "Most employers don't have the patience to deal with health care's peculiarities. Engaging employers in how hard it will be to provide the right care at the right price won't go far; the employer response will be, 'Be competitive the way I need you to be.'" An employer leader noted that larger employers in general are not particularly interested in process indicators as a measure of quality: "They want to know outcomes."

The employer perspective on the definition of healthcare value varies, depending on the size, sophistication, and level of engagement of the employer in their healthcare purchasing decisions. Employers in the "mid-size" range of 1,000 to 10,000 employees shop on price, in part because quality data that differentiate among providers are hard to obtain and difficult to utilize in practice. Employers of this size in general continue to define quality in terms of network breadth, access, and employee satisfaction. Further, it is very difficult for employers of this size to persuade a health plan to customize a network or plan design.

Larger employers tend to have more leverage in the market, and some are exerting it. For example, a few large employers are beginning to contract directly with preferred providers (Lowe's with Cleveland Clinic, PepsiCo with Johns Hopkins). The state of Maine is an example of a large public employer with sufficient market clout and political cover to utilize quality and price data to drive provider tiering decisions.

Insurers. Insurers—including commercial carriers and CMS—also define value in health care as a relationship between quality and the amount paid for care. CMS's strategies to improve value will be consistent with the National Quality Strategy announced by the U.S. Department of Health and Human Services in March 2011; its core goals are better care for individuals, better population health, and more affordable care. Commercial insurers are pursuing similar aims, although their tactics differ depending on the size and markets of the carriers. For example, one plan reported it is largely pursuing quality-focused metrics in its provider contract negotiations. Another carrier, however, is insisting upon quality *and* efficiency metrics.

CARE DELIVERY TRANSFORMATION

Nearly every interviewee commented on the need to drive changes in the structure and process of healthcare delivery as the key means of improving value. All interviewees are using levers at their disposal to encourage care delivery transformation.

Encouraging new care delivery models. A CMS representative described emerging payment mechanisms as "forcing a level of coordination" in a provider community. Numerous CMS programs, such as the Community-Based Care Transitions Program, are specifically designed to encourage improved care coordination across provider organizations. A commercial carrier described its payment strategies as intended to "move providers along the continuum" of being able to accept financial risk. Some of the interviewees emphasized that payment is a blunt mechanism to improve value, and is not "the end goal." As one stated, "It's about business process reengineering."

Payment mechanisms are generally designed to encourage, but not dictate, delivery system alignment. For example, a CMS leader commented, "As soon as (value-based purchasing) becomes more outcomes-oriented, you have to look outside your walls to be successful." CMS is not aligning the delivery system, but rather "providing opportunities for providers to innovate." An employer representative stated that employers and health plans should lay out their goals—good outcomes, patient safety, efficiency, and reasonable price—and "let providers figure out the solution."

Experimentation with care delivery models. Several of the interviewees indicated that the key to care delivery transformation is through experimentation. "There are many good ideas out there; they need to get more traction and spread across the industry," one person commented.

All of the interviewees are pushing such experiments. For example, the National Association of Insurance

Commissioners (NAIC) sees opportunity to drive value by setting the risk adjustment methodology required for plans participating in the insurance exchange to reward carriers for enrolling and managing the risk of patients with chronic disease, versus "cherry picking" healthy applicants. Employer organizations are pushing payment initiatives that would penalize care practices that are known to put patients at risk, such as nonpayment for elective induction of labor before 39 weeks.

CMS's Innovation Center was established to experiment with different programs to improve healthcare value. Commercial carriers are offering menus of value metrics and payment terms in provider contract negotiations, as well as analytical and clinical consulting services to assist provider organizations in understanding their patient populations and improving care coordination.

Emphasis on primary care and deemphasis on inpatient care. Many interviews revealed a strategic emphasis on shoring up primary care. One commercial carrier is offering incentives and technical support for the development of patient-centered medical homes (PCMHs). America's Health Insurance Plans (AHIP) reported that "contracts for medical homes are appearing in all states now." The state of Maine requires all of its preferred contracted primary care practices to be certified medical homes. Both carriers and employers indicated they are paying additional fees for care coordination as part of their PCMH contracts. These findings are consistent with data presented in a 2011 Medical Group Management Association (MGMA) study,[31] which indicate that 43 commercial health plan or multi-payer PCMH pilots and demonstrations were underway in April 2011.

Commercial carriers generally appear to be focusing more on primary care and medical groups than on inpatient care. One interviewee commented that they are working primarily with medical groups (not hospitals) to reduce readmissions. That individual cited reduced readmissions and the Affordable Care Act provisions on medical loss ratios and insurance rate reviews as having significant implications for hospitals.

The MGMA PCMH study indicates that although physician-owned practices represent about 54 percent of established PCMHs, only 22 percent are represented by hospital-owned medical practices. An insurance executive noted, "Hospitals that are stepping up healthcare IT and changing their business models are the vanguard of the future."

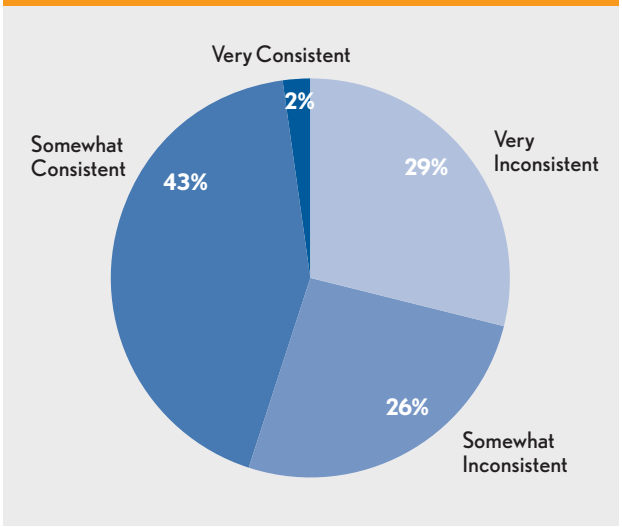
VALUE PERFORMANCE STANDARDS

An HFMA survey of hospital CFOs revealed a high degree of variation among commercial carriers in the type of quality and value indicators in the marketplace. The respondents commented on the internal challenges, such as lack of focus and insufficient resourcing, that can result from managing to a multitude of performance indicators. As one respondent put it, "Different metrics pull the organization in different directions."

Commercial carrier actions. Both commercial carriers and CMS expressed interest in creating more consistency in the value metrics in the marketplace. "We do not see competitive value in having unique measures," one commercial carrier leader stated.

In some ways, the commercial carriers interviewed are taking steps to reduce the variability of performance metrics. For example, both commercial carriers interviewed are pursuing "menu-driven" value metrics that can be tailored to a specific provider organization. These metrics range from process indicators to population management. Reasons for selecting particular metrics include factors like addressing specific performance gaps or accommodating the risk readiness of the provider organization. One carrier is leveraging CMS metrics already in the marketplace, while

CONSISTENCY OF VALUE METRIC DEFINITIONS ACROSS COMMERCIAL CARRIERS



Source: HFMA Value Project Survey, December 2011.

[31] *The Patient-Centered Medical Home: 2011 Status and Needs Study,* Medical Group Management Association, 2011, www.mgma.com/pcmh.

GUIDELINES FOR THE DEVELOPMENT AND USE OF VALUE METRICS

Interviews with purchasers, payers, and provider organizations revealed some dissatisfaction with value metrics in use today. These criticisms highlighted an over-emphasis on processes rather than outcomes, the inconsistency and proliferation of metrics, and the lack of usefulness of performance data to purchasers.

In 2008, HFMA defined five principles to guide reform of the healthcare payment system: quality, alignment, fairness/sustainability, simplification, and societal benefit.[32] Consistent with these principles, and based upon interviews with purchasers, payers, and providers, HFMA proposes to all stakeholders the following guidelines for the improvement of metrics and reporting to promote the quality and cost-effectiveness of healthcare delivery.

Work to replace process metrics with patient-centered functional outcomes. HFMA's 2008 payment reform white paper notes that, consistent with the principle of quality, "wherever possible, payments should reward positive outcomes, rather than adherence to processes." Employer organizations consistently expressed that patient-centered functional outcomes, such as return to functioning or number and kinds of complications after a certain type of surgery, are preferable to process-based measures, and conveyed frustration that the market is lagging in providing these types of metrics. Providers, too, expressed significant interest in functional outcomes measures, with many indicating they are superior to process indicators as measurements of healthcare quality. Organizations requiring process metrics should work to establish the connection between these metrics and quality or cost outcomes.

Align value metrics with the "triple aim" of improving care for individuals, improving the health of populations, and reducing the per capita costs of health care. HFMA's 2008 white paper on payment reform encouraged alignment of payment reform with the nation's health goals. Since that time, there has been broad coalescence around the Institute of Healthcare Improvement's "Triple Aim," including its role as foundation for the National Quality Strategy.

In furtherance of these goals, value metrics should align incentives for providers to coordinate care. Hospitals and health systems note that in some cases they are incentivized to coordinate care, but other providers with whom they interact (e.g., independent physicians) do not have similar incentives available. To optimize payment as a lever to coordinate care, all providers involved in care coordination efforts should be incentivized to work together more effectively.

Focus on a limited set of metrics to drive performance. Although many things can be measured, a much fewer number of metrics should be selected to drive performance. Consistent with HFMA's payment reform principle of simplification, value metrics should be used to judiciously target high-priority areas of improvement for the healthcare system, minimizing administrative burdens and optimizing the use of limited organizational resources. This guidance applies to payers in their contractual negotiations with providers as well as to providers, which may benefit from highlighting a select number of performance metrics for strategic organizational focus.

Use payment incentives and penalties selectively, emphasizing performance on metrics that have been proven or stakeholders agree are most likely to drive the most desirable quality or cost outcomes. Payment mechanisms are a blunt way to drive provider behavior and, if used indiscriminately, can result in unintended consequences such as underuse of services in a capitated model. This issue relates to HFMA's payment reform principle of fairness/sustainability.

Just as stakeholders should focus on a limited number of high-impact metrics and refine them over time, so should payers be careful in how they drive provider performance through experimentation with payment. Understanding the intended and unintended consequences that result from payment experiments will be critical to refine approaches to value-based payment over time.

Report provider-specific performance to end users in a way that is understandable and actionable. Consistent with the HFMA principle of alignment, provider-specific quality and price data should be accessible to purchasers in an understandable format. For example, patients may require straightforward rating systems that distinguish among providers' performance on quality and price.

Further, to be actionable, it is important that performance standards allow for distinction among providers over time. For example, if all providers are incentivized to achieve performance within an extremely narrow range, that may not allow a purchaser to distinguish provider performance. Payers should be careful to convey performance expectations in a way that not only continually focuses on high impact areas, but also at levels that allow purchasers to discern excellent from average performers.

[32] See *Healthcare Payment Reform: From Principles to Action*, HFMA, September 2008, available at hfma.org/reform.

another carrier incorporates metrics based on nationally defined evidence-based standards.

However, in other ways, commercial carriers may be proliferating the number of performance metrics at a facility—and that is a matter of concern for both carriers and providers. "Organizations cannot move a great deal of metrics quickly," one commercial carrier leader said. For example, one carrier may utilize provider-specific claims analysis in contract negotiations to push providers to focus on areas of underperformance, while another carrier may use the data to zero in on something else.

Carriers do not seem to be working among themselves to standardize performance expectations. For example, although each carrier interviewed is attempting to tap into already-defined metrics, one carrier signaled an intention to incorporate both quality and efficiency in its metrics, while the other is utilizing quality-focused metrics without an efficiency component.

CMS strategies. Today, there are many different measures across several different CMS quality reporting and performance programs that impact hospitals. Among these are Inpatient Quality Reporting, Hospital Value-Based Purchasing, Medicare Shared Savings Program, Outpatient Quality Reporting, and the Readmissions Reduction Program. Performance measures within certain programs are numerous, such as those for the Medicare Shared Savings Program, which encompasses standards related to preventive health, care coordination and patient safety, patient/caregiver experience, and at-risk populations. But despite the complexity involved in dealing with a number of CMS programs and metrics, one employer organization leader described a sense of coalescence within the healthcare industry that stems from a convergence around key metrics, such as those used to demonstrate meaningful use and to benchmark quality of care in accountable care organizations.

A CMS representative indicated that eventually, the National Quality Strategy (NQS) will align performance standards across these CMS programs, noting, "We are working toward a common approach to measurement."

The National Quality Strategy contains three national aims, which are based on the Triple Aim. These include:

- *Better care:* Improve overall quality, by making health care more patient-centered, accessible and safe.
- *Healthy people/healthy communities:* Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and environmental determinants of health, in addition to delivering higher-quality care.
- *Affordable care:* Reduce the cost of quality health care for individuals, families, employers and government.

The table at right shows the core principles of the NQS alongside the types of measures to which each principle maps.

Efficiency metrics. Measurements of efficiency can take different forms, from eliminating inappropriate care to reducing overutilization to delivering necessary care more efficiently. Some efficiency metrics, such as those proposed by CMS related to the NQS, will require hospitals to collaborate effectively with other providers. To date, both

CORE PRINCIPLES OF NQS

NQS Principle	Type of Quality Measure
Making care safer	Patient Safety • HCACs, including HCIs • All cause harm
Ensuring person/ family engaged as partners in care	Person and Caregiver-Centered Experience and Outcomes • CAHPS or equivalent measures for each setting • Functional outcomes
Promoting effective communication and coordination of care	Care Coordination • Transition of care measures • Admission and readmission measures • Other measures of care coordination
Promoting effective prevention and treatment practices for leading causes of mortality	Clinical Quality of Care • HHS quality of care and CV quality measures • Prevention measures • Setting-specific measures • Specialty-specific measures
Improving community health	Population and Community Health • Measures that assess health of the community • Measures that reduce health disparities • Access to care and equitability measures
Making quality care more affordable	Efficiency and Cost Reduction • Spend per beneficiary measures • Episode cost measures • Quality-to-cost measures

Source: Patrick Conway, MD., MSc, CMS CMO and director, Office of Clinical Standards and Quality, April 2, 2012.

commercial carriers and CMS have placed more emphasis on the quality component of value than efficiency.

A commercial carrier noted that efficiency measurement could be an area where CMS and national clinical organizations should take a leadership role. CMS is already making moves in this direction. As noted previously, various types of efficiency and cost-reduction metrics are envisioned as part of the plan to deliver on the affordability component of the NQS. Additionally, the Center for Medicare & Medicaid Innovation's (CMMI) Bundled Payments for Care Improvement pilot uses the PROMETHEUS Payment® methodology, which pays evidence-based case rates for processes, structures, and outcomes of care related to particular procedures.[33]

Clinical organizations, too, are contributing to discussions on efficiency measurement by providing leadership on the issue of medical appropriateness. In March 2012, nine national clinical associations, including the American Academy of Allergy, Asthma & Immunology and American Academy of Family Physicians, produced a collective list of 45 evidence-based recommendations to reduce overuse and misuse of specified services. This kind of information could prove useful to payers, purchasers and providers as they focus their efforts to demonstrate and improve efficiency.

The National Quality Forum (NQF) is another stakeholder that is beginning to focus on efficiency measures, which a leader there defined as "quality over resource use, at the population level." NQF sees efficiency measures as a key step to eventually defining value in health care. At this point, NQF is working on measures of resource use. These initiatives are focused on diabetes care, capturing all patient costs (not just those attributed to the patients' diabetes) over a measurement year. The organization is also working on episode-based approaches in two areas: hip and knee replacement and pneumonia. For both approaches, data across all care settings will be gathered so that costs can later be broken down and attributed per care setting.

Employer organizations, too, are pushing measures of efficiency. Several organizations interviewed are sponsoring payment mechanisms related to elective early inductions of labor, with the goal of minimizing or eliminating payment for these unnecessary procedures. Leapfrog is starting to work with employers on identifying other overused procedures, including unnecessary episiotomies.

Functional outcomes metrics. Employer representatives cited "outcomes first" as the most important measures of quality. For purchasers, outcomes research and measurement can identify potentially effective strategies they can implement to improve the quality and value of care. Employer organizations noted that these kinds of metrics are the most difficult to find in health care, aside from CMS's measurements of readmissions and mortality. Some employers and providers interviewed also faulted CMS and commercial payers for focusing heavily on certain process-of-care indicators that "don't deliver value to the patient."

A subset of outcomes measurement is assessment of return to functioning. These types of measures assess how people function after an acute event (such as complications or return to function after a knee replacement), or with management of a chronic condition. According to the Agency for Healthcare Research and Quality, "The difference between traditional clinical measures for a disease and the outcomes that matter to patients can be dramatic."[34]

Functional outcomes measures are generally underrepresented in quality assessment in the United States. CMS requires Medicare Advantage plans to distribute the Medicare Health Outcomes Survey to samples of patients, so that they can self-assess their functional status. Similarly, the Consumer Assessment of Healthcare Providers and Systems survey contains questions related to health and functional status. These approaches, however, do not yet require active participation of the delivery system in understanding and driving to improve functional outcomes. Development of additional functional outcomes measures is among the goals of CMS in assessing progress on the NQS.

The U.S. is lagging other nations in measuring and reporting on functional outcomes. For example, Sweden requires every hospital and county to report annually on certain functional outcomes related to orthopedic services. The Picker Institute, the Foundation for Accountability, and the PROMIS team have produced numerous instruments and measurements of quality, with an emphasis on "symptoms, functioning and outcomes that matter to people."[35]

Process-of-care metrics. As noted above, interviewees confirmed that employers are less interested in process-of-care metrics than they are in performance on outcomes.

[33] For more information on the PROMETHEUS Payment program, see *Transitioning to Value: PROMETHEUS Payment Pilot Lessons,* available at hfma.org/prometheus.

[34] "Outcomes Research Fact Sheet," Agency for Healthcare Research and Quality, www.ahrq.gov.

[35] Lansky, D., "Public Reporting of Health Care Quality: Principles for Moving Forward," *Health Affairs*, http://healthaffairs.org/blog/2012/04/09/public-reporting-of-health-care-quality-principles-for-moving-forward.

However, process-of-care metrics are heavily featured in CMS's approach to value measurement to date. Another concern related to process-of-care metrics is that, as defined, they are likely to drive providers to performance within a narrow band. This approach could have two impacts of concern to providers. First, it could result in providers expending resources to get incremental improvement on an already high level of demonstrated performance. Second, it may not enable providers to compete on the basis of quality, since it will not be distinguishable.

CHAPTER 10

Variations in Value-Based Payment Mechanisms

Although HFMA's interviews suggested that payers and purchasers are interested in creating greater focus in value measurement, they also confirmed that payers and purchasers intend to experiment with a variety of value-based payment mechanisms. When asked what specific type of value-based payment they expected to be most prevalent in three to five years, the typical response from payers was "not to place bets" on any one methodology.

There are several reasons for this approach. A key reason is the lack of certainty about which payment mechanisms most effectively drive results and which might create unintended consequences. As Suzanne Delbanco, executive director and founder of The Catalyst for Payment Reform, states, "The big problem is moving from national standards of performance to a standard method of payment, because no one knows yet what will work best."

For purposes of this report, value-based payment methodologies include:

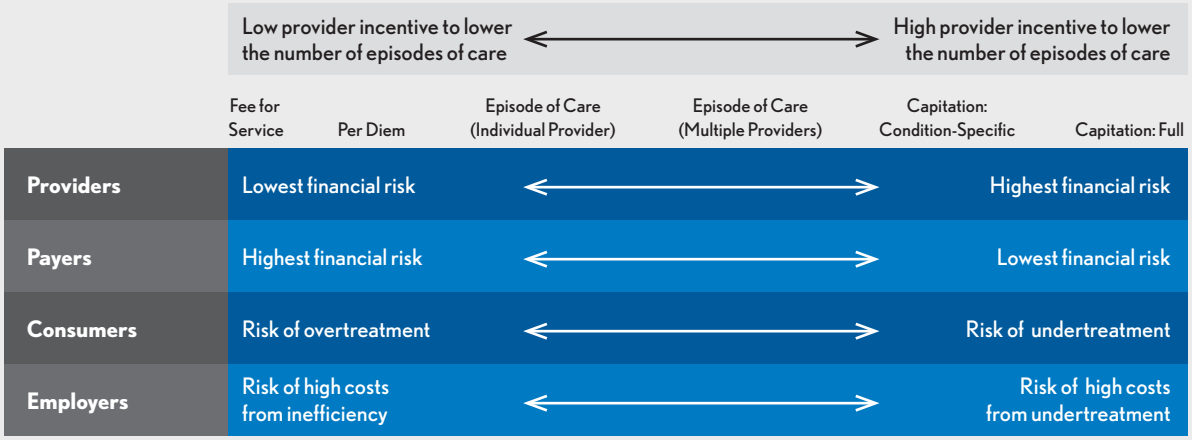
- Pay for performance relative to quality, utilization, or efficiency benchmarks
- Bundled payments based on episode of care
- Shared saving and loss programs
- Capitation or global payment

The need for flexibility in provider contract negotiations, based on providers' structure, ability to manage population risk, and other factors, also was cited by payers and purchasers. Although payers are attempting to use various payment mechanisms to push providers toward greater integration and assumption of financial risk, this can be a difficult process. As one executive stated, "Payment policy is best used in support of care redesign, but it's not necessarily simple."

The fact that geographic market variation also affects payment models is another reason to experiment with a variety of value-based payment mechanisms, carriers and employer organizations say. As one employer organization leader suggested, "You can do very different things in California, where capitation is more common."

In terms of which specific payment methodologies might become most prevalent, several interviewees commented

UNDERSTANDING PAYMENT REFORMS IN THE CONTEXT OF STAKEHOLDER RISK



Source: HFMA, *Healthcare Payment Reform: From Principles to Actions* (2008).

that a fee-for-service "chassis" could still be used, provided that gainsharing issues could be resolved. One interviewee commented that claims systems are not configured for bundled payment, while another stated that capitation is insufficient because it does not allow for containment of trend.

Shared savings and loss programs are expected to gain traction. As one interviewee noted, "Whoever can figure out how to own the patient, the patient's data, and patient management will be the successful entity." In this leader's view, this could be the employer, a payer, or, in some markets, a provider.

COMMITMENT TO PURSUING VALUE-BASED PAYMENT

All payers interviewed expressed a commitment to pushing value-based payment. CMS has communicated its schedule for increasing the percentage of hospital payment at risk for performance, and in 2015, will introduce value modifiers for professional services. Both cost and quality data are to be included in calculating payments for physicians. MedPAC leaders have expressed openness to experimenting with value-based payment methods. One commercial carrier's goal is to have 75 percent of commercial, nonmanaged care members in a plan that utilizes value-based contracting by 2015; currently, fewer than 5 percent of its members are in such a plan. Another carrier estimates that 20 percent of its providers will experience some form of financial risk sharing within five years.

Business leaders generally expressed optimism that employers are increasingly becoming more willing to take stronger positions on value-based payment, especially where there is a clear quality argument. As better provider-specific quality and price data emerge, these leaders expect that employers will be more willing to tier, if not eliminate, providers from their networks. In anticipation of this, a carrier interviewed by HFMA is building capabilities for products that offer highly modular network configurations.

Other levers to drive value include the following.

Consumer engagement. Viewpoints on the potential for patient engagement to improve value ranged from skeptical to strongly supportive. Some indicated little optimism that consumers will drive value in any meaningful way, since this has not been demonstrated to date. One interviewee noted that achieving transparency is more difficult than one might expect. "If I find out that Hospital X is best at outpatient care, but my orthopedist doesn't practice there, what do I do, fire my doctor?" one interviewee commented. And concerns about provider-specific data reliability led one commercial carrier leader to state, "We're not big fans of consumer transparency."

On the other hand, some interviewees view consumer transparency as a vital complement to value-based payment mechanisms. For example, a CMS representative described it as "incredibly important;" he sees consumer engagement as an outcome of CMS's efforts to drive improved reporting. Meanwhile, a commercial carrier described consumer transparency as a "key ingredient" for driving improved value.

All interviewees agreed that the quality and price data available to healthcare consumers today are insufficient. Many commented on the need for a simple rating system of providers, although one CMS leader stressed the need to have population-specific ratings (e.g., for the elderly, lower-income mothers and children). A CMS leader stated that developing data useful to consumers will require "a dialogue among CMS, patients, medical boards, private payers, and the private sector."

Several interviewees noted that consumer engagement today may be inhibited not only because of lack of transparency and understandable metrics, but also for other reasons. One issue that surfaced pertains to benefit design, and the sense that today's benefit structures don't necessarily make it easy for the patient to "do the right thing." Others mentioned that fragmented care delivery can also impede the patient's ability to engage appropriately in his or her care.

CHAPTER 11

Delivering Value

Interviews and surveys conducted with hospital and health system leaders indicate that they are beginning to invest and organize in preparation for the emerging payment environment. This section reveals areas of synergy between external stakeholders and providers. Most notably, external stakeholders and providers:

- Recognize that the future requires them to focus on cost containment
- Anticipate a real commitment to pursuing value-based payment methodologies over the next three to five years
- Believe the path forward is largely one of experimentation with payment methods
- View care delivery as the key to improving value in health care

This section examines these topics from the perspective of the provider and also discusses findings related to:

- Approaches providers are taking toward experimentation with care delivery and payment methodologies
- Plans for investment in costing and business intelligence capabilities
- How organizational leaders are developing more change-oriented cultures and workforces
- Outcomes providers anticipate from these efforts

FOCUS ON COST CONTAINMENT

Regardless of the emergence of value-based payment or state or federal healthcare legislation, interviewees predict a future of reduced revenue and noted that their organizations are working toward improved efficiency.

"We'll get paid less for each unit of service," says Dominic Nakis, CFO of Oak Brook, Ill.-based Advocate Health Care, "We need to become more cost-efficient." Cost containment initiatives at Advocate include (but are not limited to) labor productivity, supply cost management in physician preference items, logistics and commodity purchases, and clinical effectiveness initiatives such as length of stay variability analysis, cardiac order sets, blood and radiology utilization, and management of ventilation days for ICU patients.

Dean Health in Madison, Wis., recognizes that the employer community cannot withstand the double-digit premium increases of the past. Dean Health's goal for 2012 is to wring out $20 million in costs, having already successfully cut a similar amount from last year's budget.

Longmont United Hospital, based in Longmont, Colo., has maintained a focus on cost containment. For example, the hospital put case managers in the emergency department, which accounts for 70 percent of the hospital's inpatient admissions, to more appropriately triage what route (inpatient or other) these patients take for care. Neil Bertrand, Longmont's CFO, estimates this practice costs the organization $10 million in revenue annually, but stated, "It is the right way to deliver care."

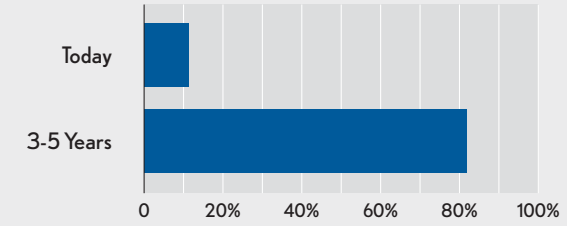
UAB Hospital of Birmingham, Ala., has already tackled key initiatives, including productivity analyses and supply cost containment. The hospital's overall goal is to reduce cost while maintaining or improving quality.

PROVIDERS' EXPECTATIONS OF VALUE-BASED PAYMENT METHODOLOGIES

The HFMA value metrics survey revealed that respondents anticipate a substantial increase in the prevalence of value-based payment. Roughly 80 percent of providers surveyed expect that 5 percent or more of their commercial payments will be based on value-based mechanisms within three to five

ANTICIPATED GROWTH IN USE OF VALUE-BASED PAYMENT MECHANISMS

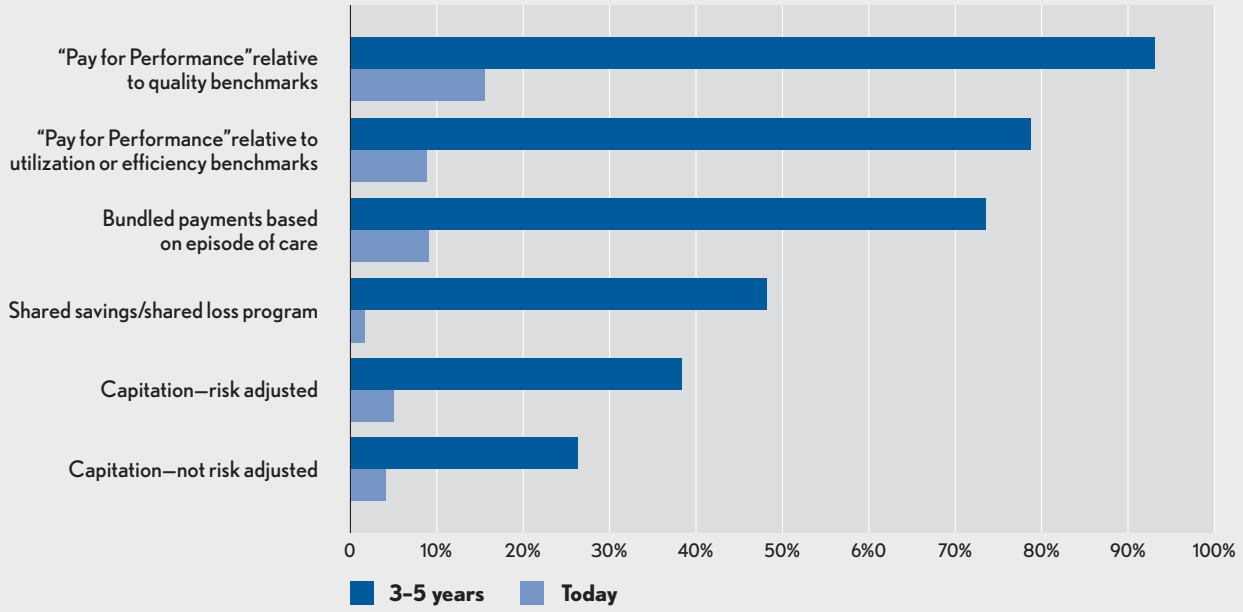
Percentage of survey respondents indicating that 5 percent or more of their commercial payments are (today) and will be (within 3 to 5 years) based on value-based mechanisms.



Source: HFMA Value Project Survey, December 2011.

ANTICIPATED GROWTH IN VALUE-BASED PAYMENT, BY PAYMENT MECHANISM

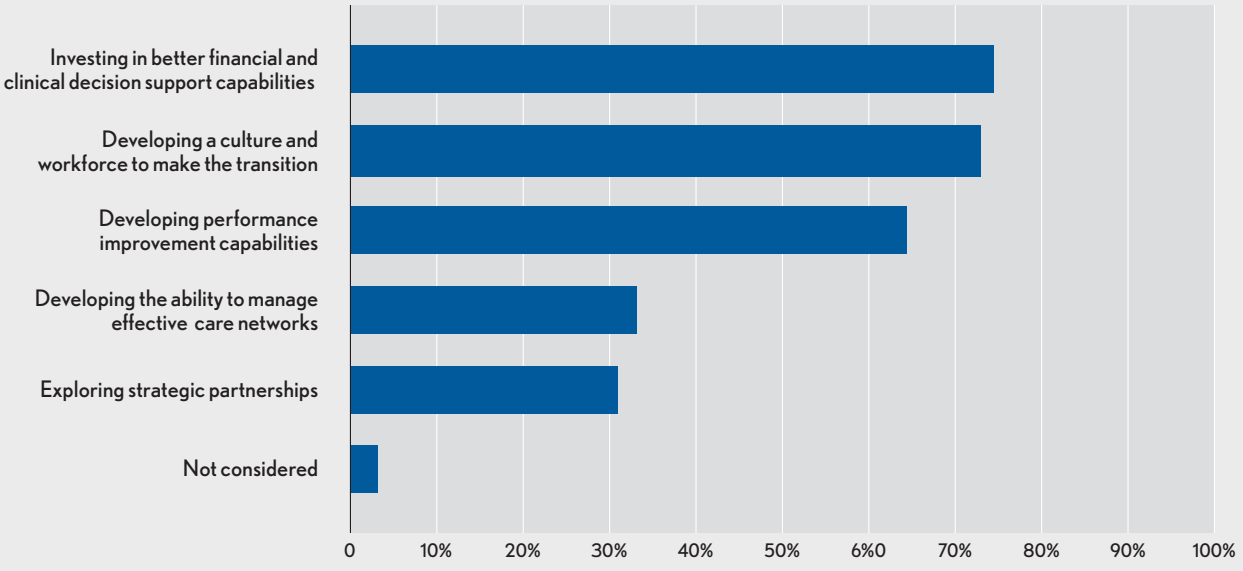
Percentage of survey respondents indicating that mechanisms will account for 5 percent or more of payment from commercial carriers.



Source: HFMA Value Project Survey, December 2011.

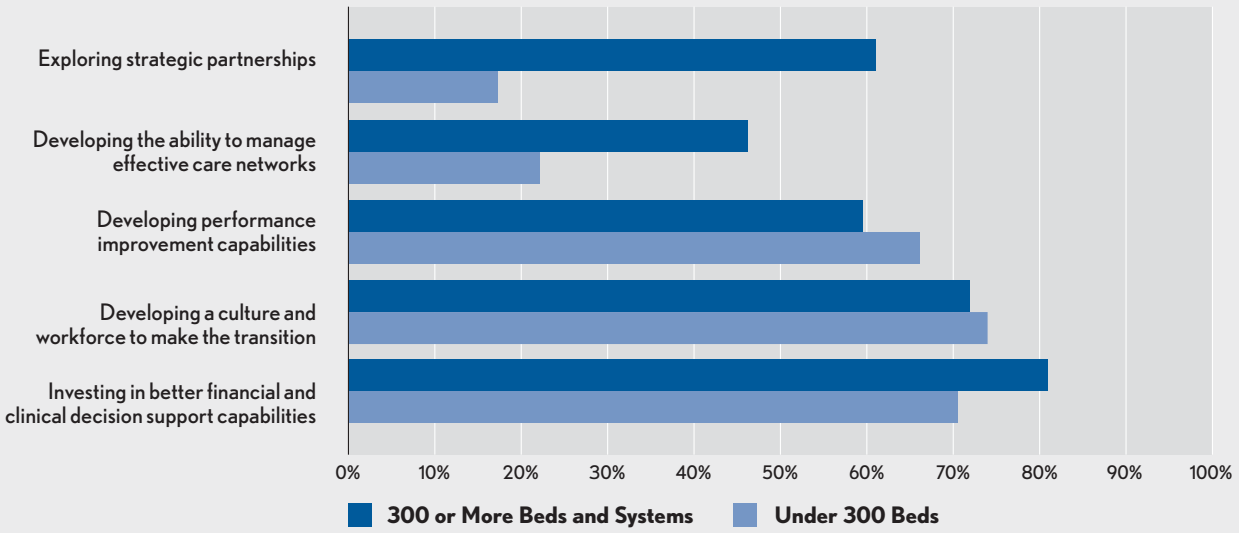
STRATEGIES TO PREPARE FOR VALUE-BASED PAYMENT

Almost 9 in 10 hospitals and health systems responding to the survey have initiated more than one of the strategies below.



Source: HFMA Value Project Survey, December 2011.

LARGER ORGANIZATIONS MORE LIKELY TO EXPLORE STRATEGIC PARTNERSHIPS OR NETWORK DEVELOPMENT



Source: HFMA Value Project Survey, December 2011.

years, up from slightly more than 10 percent of providers today. Hospital and health system interviews validated that at most organizations, executive leaders have created awareness among board members of this emerging payment shift and its potential implications.

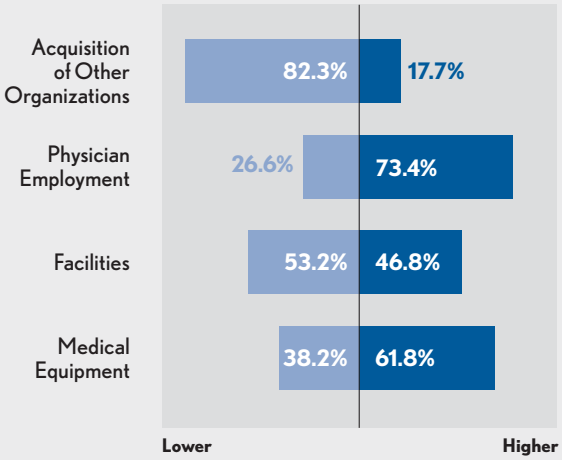
Although the use of value-based payment mechanisms today is generally limited, respondents anticipate growth in all of them, particularly pay-for-performance benchmarks and bundled payment arrangements.

Most providers are actively preparing for value-based payment by investing in better financial and clinical decision support capabilities and focusing on developing a culture and workforce to make the transition to a different payment environment (see the exhibit above).

When these data are split by size, hospitals or systems of 300 or more beds are substantially more involved in exploring strategic partnerships than smaller hospitals. Interviews with larger organizations confirmed that many of them are proactively pursuing customized arrangements with carriers and purchasers. Advocate, for example, has a unique shared savings arrangement with Blue Cross Blue Shield of Illinois. Dean Health is working directly with an alliance of self-funded employers to pursue a unique risk-based payment arrangement. And Fairview Health Services in Minneapolis, Minn., has unique payment arrangements established with all major commercial carriers in Minnesota.

BUSINESS INTELLIGENCE COMPETES WITH OTHER STRATEGIC PRIORITIES

Investments in physician employment and medical equipment are higher strategic priorities for survey respondents.



Source: HFMA Value Project Survey, February2012.

The emerging payment environment is not the only driver of organizational strategy. Other strategic priorities compete with investment in business intelligence capabilities required for value-based payment. For a majority of survey respondents, employment of physicians and investments in medical equipment are a higher strategic priority than investments made in business intelligence capabilities.

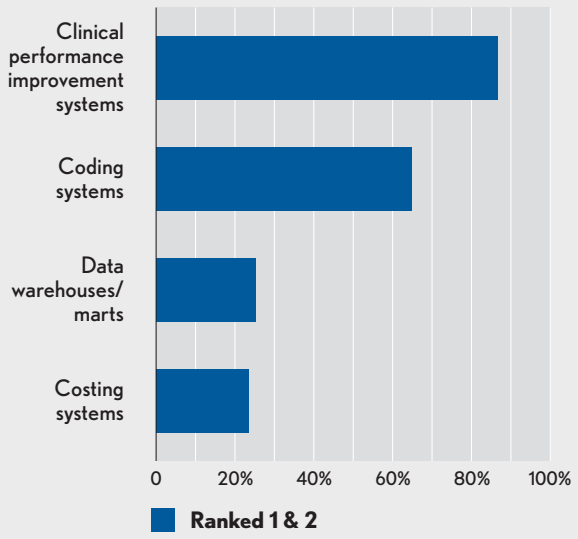
Business intelligence is not the only place organizations are investing as they prepare for value-based payment. Organizations are also shaping their care delivery structures, processes, culture, and alliances and are creating new internal relationships and forums to prepare for a new payment environment. In fact, this research confirms that leading organizations are developing each of the four value-building capabilities described in a previous section: people and culture; business intelligence; performance improvement; and contract and risk management.

CARE DELIVERY AS THE PRIMARY MECHANISM TO IMPROVE VALUE

Like external stakeholders, provider organizations interviewed see care delivery as the primary mechanism to maintain or improve quality while driving out cost. As noted by Fred Hargett, CFO of Novant Health in Winston-Salem, N.C., "The key to improving cost structure will be through changes in care delivery." Melinda Hancock, CFO of Richmond-based Bon Secours Virginia Health System, was more specific, saying, "The only way to manage business is through primary care physicians. They are critical for population health and disease management." This emphasis on clinical care management resulted in numerous care delivery-focused investments and experiments.

PLANNED ALLOCATION OF BUSINESS INTELLIGENCE INVESTMENTS

Percentage of survey respondents ranking each area as first- or second-highest priority.



Source: HFMA Value Project Survey, February 2012.

Investment in clinical systems. HFMA's costing and business intelligence survey revealed that most respondents are investing primarily in clinical performance improvement systems, followed by coding systems. Interviews confirmed that this was generally true in terms of the sequencing of activities as well as the amount of dollars allocated.

University of Iowa Healthcare prioritized clinical performance improvement highest among its investments in business intelligence. Mark Henrichs, assistant CFO at the University of Iowa, explains that the organization sees opportunity in expanding their existing clinical decision support capabilities to do better clinical performance improvement, utilizing functionality related to best practices and protocols. This functionality will help them reduce clinical variation. At Bothwell Regional Health Center in Sedalia, Mo., CFO David Halsell explains, "We are underperforming on coding accuracy. We must step up quickly; it will help with revenue." Halsell also indicates that investment in coding systems will help the organization "get more focused on clinical quality improvement." Novant Health is in the midst of its electronic medical record (EMR) implementation, and is de-prioritizing costing system improvements until the EMR is in place.

Forums to identify and execute care delivery initiatives. In addition to investing in clinical and coding capabilities, many of the organizations interviewed are leveraging or building new forums to identify opportunities to improve value through care delivery. Typically, the establishment of these forums requires strong change management that encourages a culture of physician partnership and front-line engagement.

In 2008, Dean Health, based in Madison, Wis., established a Medical Value Program (MVP) to identify and follow through on opportunities to reduce variation in care delivery. The work of this group is central to the organization's strategic planning and budgeting process. Its efforts resulted in initiatives that saved Dean Health $20 million in 2011.

This forum consists primarily of clinical leaders from the hospital, health plan, and medical group. Today, the team is proactively proposing a pipeline of projects to affect future annual budget cycles. Each initiative has an estimated budget impact associated with it, to help with prioritizing. The organization has mechanisms in place to financially align employed physicians to these goals.

Bon Secours of Richmond, Va., also has an established approach for identifying care delivery initiatives, such as reduction in pressure ulcers and reduction in hospital-acquired infections. Unlike most organizations surveyed, Bon Secours has processes and structures to quantify the financial impacts of each initiative. These projects result from collaboration among the CFO, CMO, and CIO. In 2009, this work resulted in $12 million in savings, and in 2010, $19 million. In 2011, 80 percent of the initiatives undertaken met financial performance goals. The organization today is focusing on initiatives that favorably affect cost per case, with a particular focus on those that affect fixed versus variable cost.

Novant Health, serving North Carolina, Virginia, South Carolina, and Georgia, recently established an Innovation Group, a "bottoms up" forum to share ideas for improving or maintaining quality while reducing cost in clinically oriented areas as well as in support departments. So far, the ideas submitted have been small in scale, but creative. The organization is not yet measuring the cost impacts of ideas generated by the Innovation Group: At this early stage, CFO Fred Hargett notes, "You have to go on faith that there's a favorable cost impact."

As described in a previous chapter, some leading organizations are augmenting their care delivery improvements by involving patients directly in the process. At Spectrum Health, leaders established patient and family advisory councils to help prioritize and design improvement activities. Similarly, the Cleveland Clinic created an Office of Patient Experience to involve patients and caregivers directly in care improvement initiatives.

Experimentation with care delivery approaches. A number of interviewees indicated that they are experimenting with different approaches to care delivery. For instance, one multihospital system is forging a new relationship with community long-term care facilities to collaboratively improve management of readmissions from those settings.

Longmont United Hospital, Longmont, Colo., is pursuing innovative arrangements with other providers. The hospital recently organized a co-management agreement forming a limited liability company (LLC) with all orthopedic surgeons and neurosurgeons in the area.[36] Immediate goals of the LLC are to establish and manage to quality and efficiency measures. Ultimately, the goals of this organization are to:

- Create aligned incentives
- Prepare for bundled payment
- Foster behavior modification on the part of all parties

Additionally, Longmont United is participating in the Boulder Valley Care Network (BVCN). BVCN was created at the urging of the Boulder Valley School District, which sought help from area providers to manage costs and care in its self-funded plan. BVCN is a provider consortium including Boulder Community Hospital and Avista Hospital and their related medical staffs. Including the hospitals' medical staffs, a total of seven provider entities are involved in the BVCN.

In collaboration with the community school district, BVCN medical leaders are starting to analyze chronic disease in the district's population. BVCN and the school district have designed incentives for savings, to be distributed among the providers. BVCN is also discussing the possibility of applying for ACO status. BVCN providers are not linked electronically, but hope to leverage the Colorado Regional Health Information Organization (CORHIO) for that capability.

Some organizations indicated they are beginning to focus on their own self-funded population of employees as a means of gaining experience with population care management. Longmont United Hospital intends to contract with the BVCN and utilize the care management approaches there as a means of better analyzing, identifying, and executing opportunities to improve care management for the Longmont United Hospital insured population.

Contracted networks. Many interviewees commented that their organizations are working to align their contracted physicians with their cost and quality efforts. Whether they are successful could impact their ability to manage outcomes-based payment arrangements.

Most interviewees are working to ensure that network physicians are on EHRs. One organization is considering a carrot-and-stick approach to this issue, offering subsidies, but with a deadline to implement or risk contract termination.

Dean Health is well along the path toward aligning its contracted network. Over time, Dean has developed the "Dean Value Contract," which CFO Steve Caldwell described as a process of aligning physicians to value in contractual terms that are "as sophisticated as possible." The Dean Value Contract has migrated contracted physicians to be accountable for key metrics of importance to Dean Health, including patient satisfaction, total cost of care, clinical quality, and generic drug metrics.

[36] This model is consistent with an HFMA co-management case study from Iowa Health-Des Moines, available at hfma.org/IowaHealthCaseStudy.

CHAPTER 12

Purposeful Experimentation with Value-Based Payment Methodologies

To prepare for value-based payment, some hospitals and health systems are pursuing a path of experimentation (e.g., with bundled payments), while others are pushing commercial carriers to move directly to shared savings arrangements. Experience with financial risk management and market environment appear to influence which path organizations take. The organizations pursuing shared savings arrangements tend to have more experience with financial risk management, with greater leverage in markets moving more aggressively toward value-based payment methods.

Experimentation. Many organizations interviewed are proactively positioning to experiment with different value-based payment methodologies, as a strategy to learn what is required to be successful in these different arrangements. This approach is emerging regardless of the current degree of market pressure to include value-based payment mechanisms in contracts. For example, UAB Hospital is proactively pursuing bundled payment arrangements. UAB pulled together a cross-functional team that used data from disparate sources to identify opportunities. The organization packaged a chronic obstructive pulmonary disease (COPD) proposal for CMS. Additionally, leaders for the organization are meeting with UAB's major commercial carrier, Blue Cross, to push for a unique payment arrangement related to the COPD bundle.

At Longmont United, the BVCN will participate in CMS's bundled payment initiative with PROMETHEUS. The hospital will be one of just two providers in Colorado participating in this initiative. Longmont is now sending data to PROMETHEUS so that the vendor can help identify bundled payment opportunities, with a goal of finding three to five high-volume or high-cost areas with variation in care.

Novant Health's strategy is to approach value-based payment through experimentation, Hargett says. He noted that Novant is open to trying different types of value-based arrangements. The organization has negotiated numerous pay-for-performance arrangements already with commercial carriers while continuing to evaluate shared savings or episode-of-care payment arrangements.

Shared savings. Because of its long history in running its own health plan, Dean has tremendous experience in population risk management. The organization's goal is to pursue population-based payment methodologies. Its efforts to contract on a shared savings basis with a major local self-funded consortium has had some success through pay for performance, and the parties are discussing moving to gainsharing in the future. Dean has applied for the Medicare Shared Savings program. The organization is less interested in bundled payment or pay for performance, and is very willing to take full risk with payers.

Fairview Health Services, based in Minneapolis, has shared savings agreements in place with all four major commercial health plans in its market. Altogether, Fairview has roughly 300,000 patients in commercial shared savings arrangements. Additionally, Fairview has been approved as a Pioneer ACO, and anticipates that about 19,000 Medicare patients will be involved. Fairview is also considering methods of bundled payment; however, its primary focus related to value-based payment is population health management.

Effective Jan. 1, 2011, Advocate Health Care, based near Chicago, initiated a commercial shared savings

arrangement with Blue Cross. Advocate CFO Dominic Nakis describes this as a deliberate move on Advocate's part to pursue population-based risk arrangements and to gain experience with this particular payment methodology. Additionally, Advocate has had capitated payments "for quite some time," through Medicare Advantage plans and other commercial HMO contracts, Nakis says. He estimates that about 275,000 lives are covered under these capitated arrangements. Advocate is not pursuing bundled payments.

Fairview and Advocate shared some common first experiences as they embarked on population risk management. Notably, each invested in care coordinators. Both are also learning how to analyze and act upon longitudinal claims data.

Daniel Fromm, Fairview's CFO, notes, "We want to receive patient-level claims data as frequently as we can get it." Some commercial carriers have been willing to provide Fairview with longitudinal data, and others have provided aggregated statistics. Fairview created an analytics function within the finance department to work with these data; however, both finance and clinical staff review and use the data to assess aspects of care and cost (such as per-member, per-month costs for pharmaceuticals, total cost of care, and high claims management) and to find opportunities to manage patients well in lower-cost settings. They also try to use the data to manage capacity at a particular location.

Blue Cross sends Advocate complete longitudinal patient data for the patients attributed to Advocate in the shared services arrangement. Advocate invested in a population health management system in early 2011, which allows for the aggregation of total spend for each attributed patient across all healthcare providers, whether they are within or outside of the Advocate network. This in turn allows for data mining to find opportunities to deliver care across venues in more cost-effective ways, and identify higher-cost situations that can be managed by case managers. Advocate hired an actuary to work with the data, whose analyses are then shared with case managers.

A few organizations interviewed expressed reservations about shared savings arrangements and ACOs in particular because of the lack of accountability required of the patient. Leading organizations such as Advocate and Fairview are mitigating this concern by obtaining and analyzing as much longitudinal data as possible, and by experimenting with care coordinators to best meet the clinical service needs of patients participating in these shared savings arrangements.

Interviewees noted that tackling emerging payment methodologies created some stronger relationships within their organizations. Specifically, partnerships among contracting, finance and physician leaders were beginning to emerge. At UAB, efforts at defining episodes of care for bundled payment are tightening these relationships. At Longmont, some commercial carriers are proposing specific areas of focus, with associated payment arrangements; in these cases, contracting staff work with the quality improvement department to determine what is feasible.

CHAPTER 13

Costing and Business Intelligence Investments

As provider organizations grapple with a future of reduced payment, a key issue is where to focus attention. Effective business intelligence and costing systems can help to identify internal trends of cost growth as well as facilitate comparisons to evidence-based standards of care.

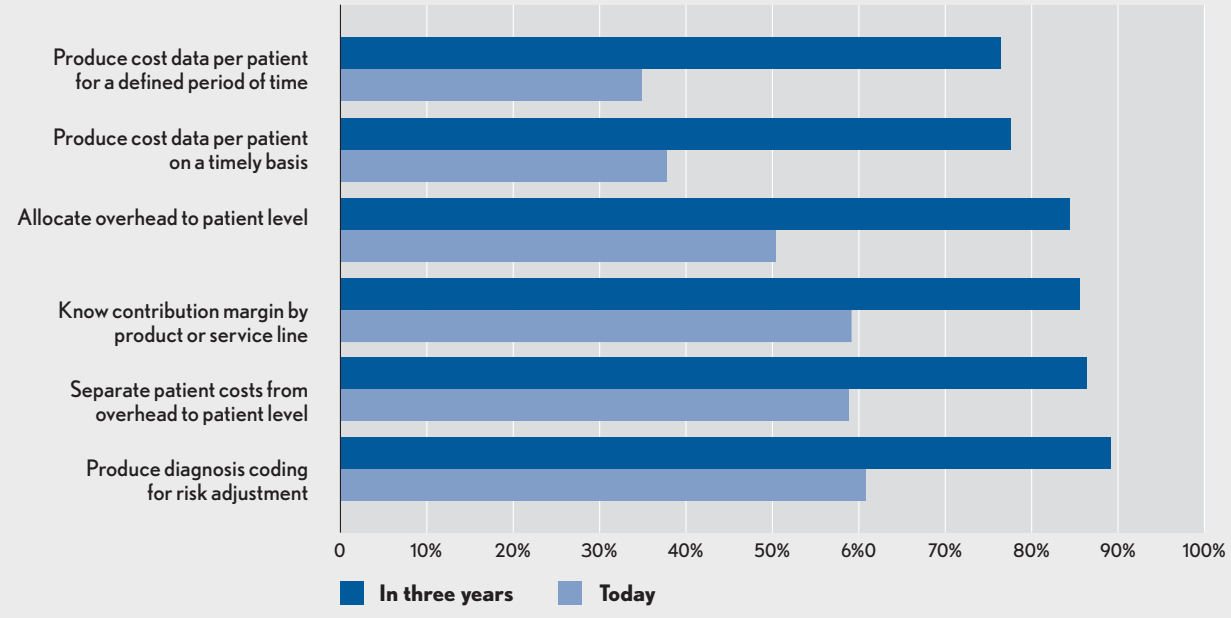
Many organizations interviewed acknowledge that they require improved costing and decision support capabilities to be successful in a value-based payment environment. As noted previously, organizations surveyed are prioritizing clinical system investments, but they also anticipate dramatic improvements, particularly in their inpatient costing capabilities.

HFMA's costing and business intelligence survey revealed that most hospitals lack significant capabilities, particularly with respect to producing cost data per patient on a timely basis and over a defined period of time in an inpatient setting. Hospitals today have stronger capabilities to understand contribution margin by inpatient product or service line and to separate inpatient costs from overhead down to the patient level. Significant improvements are expected in these capabilities.

Those surveyed also anticipate dramatic improvements in their costing capabilities across care settings. The greatest degree of improvement is expected in outpatient costing. Several interviewees explained the lack of emphasis on

ANTICIPATED IMPROVEMENTS IN INPATIENT COSTING-RELATED CAPABILITIES

Percentage of survey respondents indicating moderate or significant capabilities today and in three years.



Source: HFMA Value Project Survey, February 2012.

costing capabilities in post-acute settings by noting that often, post-acute care is outside the walls of the organization.

Organizations interviewed clarified that improving costing systems with relatively less investment should be possible because the price of costing systems pales in comparison to clinical systems. Some hospitals are focusing on better leveraging the systems they already have in place through improved data mining.

Survey responses indicated that few organizations currently have capabilities that will be important for success in a value-based payment environment. Very small percentages of respondents today have significant ability to attribute per patient costs across the care continuum and few organizations are able to quantify the financial impact of quality improvements. This skill will be important as organizations determine how to reduce their cost structure over time to remain market-competitive. Fewer than 10 percent have significant capabilities to assess profitability per physician, which is another capability required to understand organizational cost structure and network effectiveness. Survey respondents anticipate significant improvement in these capabilities in the next three to five years.

Range of approaches. The organizations interviewed represent a spectrum of approaches to costing and decision support capabilities. A general theme is that organizations working to improve costing capabilities are trying to move from "directional" data to more precise, granular costing data.

Fairview is trying to mine more from its current costing system. The organization's costing system has been in place for many years, and it provides a rich hospital data set.

TOWARD GREATER PRECISION IN COSTING

Costing inquiries are driven by the question of what needs to be answered with cost data—the cost objective. If the cost objective is determining whether payment for a unit of service (e.g., procedure, encounter, RVU) will be adequate, costing information must be developed related to that payment unit. If the objective is determining the impact of specific performance improvement activities, costing information needs to be developed around the process of care under study.

Other industries have developed sophisticated approaches to answer these questions because of increasing price pressure driven by purchasers. In health care, this pressure is intensifying. As University of Iowa Healthcare assistant CFO Mark Henrichs notes, "Budget decisions are becoming much more consequential. In the past, cost accounting systems were directional. As budgets get tighter, the precision has to increase."

From Directional to Precise

Narrowing the definition of the cost objective adds granularity to the cost information presented, but it also increases the time and expense of collecting the data. Provider organizations need to consider the costs and benefits of moving along the costing precision continuum.

Directional	← →	Precise
Ratio of Cost to Charges	RVUs	Activity-Based Costing

Key components of precise costing systems include a clear delineation of direct and indirect costs. Direct costs are unambiguously associated with the cost objective. Indirect costs are everything that is not direct and are usually allocated to the cost objective in some general fashion. As an example of how costing can produce less directional, more precise data, consider how greater precision might be defined for the three major cost categories below.

Cost Category	More Precise Definition
Indirect and Overhead	Rationally allocated based on actual usage (e.g., an OR uses far more electricity per square foot than a standard patient room)
Direct Labor	Applied at a cost objective level using, for example, a time-driven activity based costing approach
Direct Supply	Through the requisition system, accurately charging for all items consumed at the cost objective level

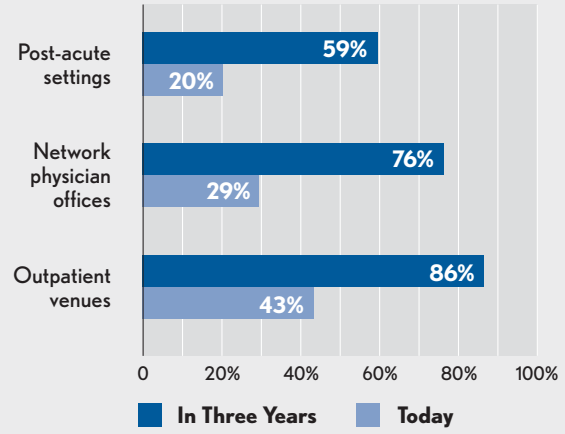
WHY PRECISION MATTERS

Below are some examples of decisions that more precise costing data will help support as organizations work to improve the quality and cost-effectiveness of care.

Costing Object	Purpose	Why Precision Matters	When Used?	Considerations
Service line analysis	Determine contribution to margin/profitability per service line	Need to understand which services lines generate actual profits or losses	Evaluating organization's cost structure or service line strategy	Precise data on all three major costing categories is essential to determine true profits or losses
Physician practice pattern variations	Identify performance improvement opportunities Quantify financial impacts of performance improvement initiatives	Costs of actual supplies used can vary significantly among physicians—need actual costs on a per-case basis Must know if expenses involved in improving performance are matched or surpassed by cost savings	Under any payment method—from DRG to capitation—to optimize margin or profitability	A focus on direct costs will be most useful in this analysis
Profitability per physician	Determine resource allocations	Get physician alignment strategy and compensation structure right	DRG or bundled payment systems	Indirect cost and overhead allocation can greatly impact findings
Bundled episode of care or DRG (commercial carrier) margin analysis	Pricing payment for the bundle/DRG	More precisely calculate average cost per case to ensure adequate margin/profit per episode or DRG	In a pricing-competitive marketplace	Allocation across episode may differ based on venues within bundle
Cost-effectiveness per provider	Determine care allocations	Make sure utilization is focused on most cost-effective providers	Shared savings, capitated, and global payment systems	Although computation of costs may differ by provider type or venue, computation should be consistent within a venue (e.g., all outpatient facilities)so valid costing comparisons can be made
Total cost of care per patient across the continuum	Identify patients who may need better coordinated care or additional services support Analyze the financial impact of treating chronic condition patients to develop strategies for managing utilization and minimizing costs.	Make timely interventions in patient care to improve outcomes and cost-effectiveness	Shared savings, capitated, and global payment systems.	Costs for contracted providers are not relevant, except to the extent they drive the price charged to the contracting organization. Organizations will want to determine per patient utilization of contracted providers to identify opportunities for better care management.

ANTICIPATED IMPROVEMENTS IN COSTING-RELATED CAPABILITIES ACROSS CARE SETTINGS

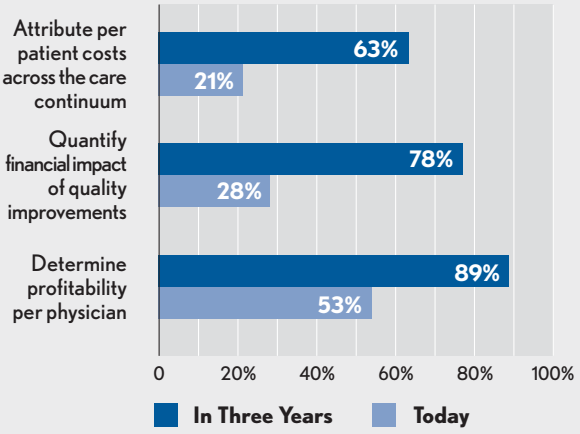
Percentage of survey respondents indicating moderate or significant capabilities today and in three years.



Source: HFMA Value Project Survey, February 2012.

ANTICIPATED CROSS-ORGANIZATIONAL STRATEGIC COSTING DATA USE CAPABILITIES

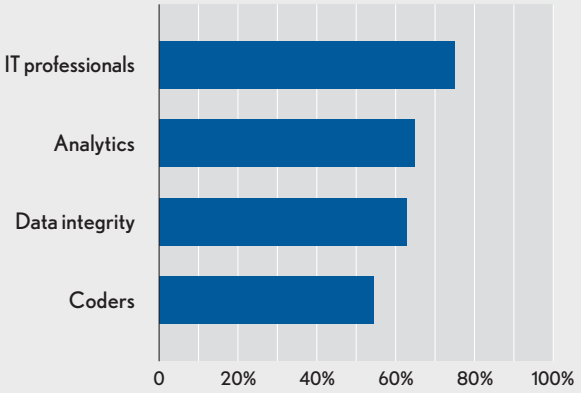
Percentage of survey respondents indicating moderate or significant capabilities today and in three years.



Source: HFMA Value Project Survey, February 2012.

ANTICIPATED ABILITY TO MEET BUSINESS INTELLIGENCE STAFFING NEEDS

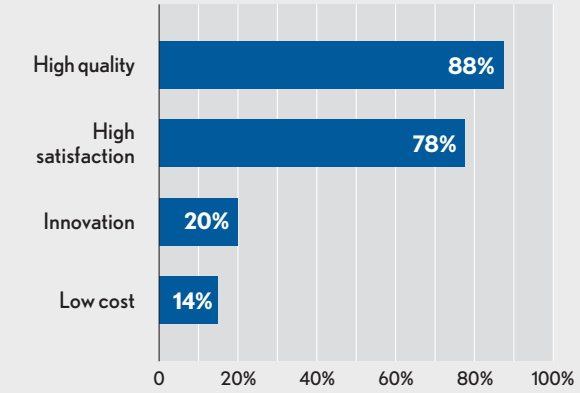
Percentage of survey respondents indicating confidence that they can recruit enough sufficiently trained and experienced staff in the following areas.



Source: HFMA Value Project Survey, February 2012.

PROVIDERS SEE MARKET POSITIONING AS HIGH QUALITY, NOT LOW COST

Percentage of survey respondents ranking each factor as first or second highest in terms of importance for establishing their organization's reputation in its market.



Source: HFMA Value Project Survey, February 2012.

Finance staff work with clinical managers on a regular basis to update RVUs. "This process has been in place for a long time. We'd miss it if it weren't available to us." They believe the costing data are both accurate and consistent. However, what Fairview lacks are costing capabilities related to physicians' practices, whose costing information is not as sophisticated or detailed as it needs to be to determine financial performance by physician. Improving costing capabilities for physician practices is an area of focus for the organization. The CFO's view is that the costing system can house the information; Fairview will focus on the processes, assumption sets, and allocation models needed to make improvements in this area. Additionally, Fairview is concentrating on building data warehouses and decision support capabilities that enable access to clinical, financial, and other data.

The University of Iowa has worked to update cost allocation tables in its existing costing system, with a goal of making the data more granular and accurate. For example, the University of Iowa has developed more specific allocations of utilities. Assistant CFO Mark Henrichs notes that the budget decisions they need to make using costing data are becoming much more consequential. "In the past, cost accounting systems were directional. As budgets get tighter, the precision has to increase."

UAB has aggressive plans to improve and maintain its costing and decision support capabilities. The organization invested $1.5 million in cost accounting systems and improved decision support. The new systems went live in late April. The cost accounting systems will house labor, supply, overhead, and "catchall" costing data to cover all aspects of UAB operations. For inpatient data, UAB is conducting time-motion studies to make the RVU estimates more specific to UAB, and is refining its supplies cost schedule and assumptions related to overhead allocation. Finance staff will audit these schedules on a regular basis to ensure the accuracy of the data. For physician office data, UAB uses a blend of general ledger allocation and more specific costing data. The decision support system contains cost, quality, and patient satisfaction data, with clinical data spanning pre-admission to post-admission. Analytical staff was trained to query the decision support system.

Differing views and approaches. A couple of the interviewees pointed out that their organizations are investing in costing capabilities not specifically because of transitioning payment methodologies, but rather because organizations will experience reduced revenues. One interviewee noted that his organization will invest in cost accounting capabilities "to get to the level of granularity in cost data that we'll eventually need to run our business."

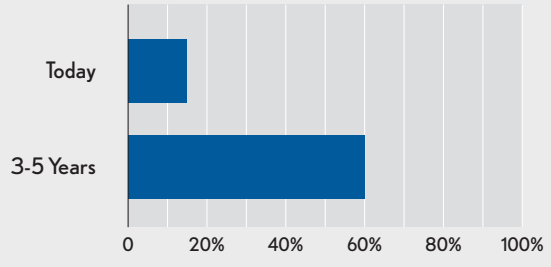
A few interviewees questioned the need for better cost accounting. One commented, "We are generally satisfied with our cost accounting systems. How is cost accounting going to help us?" Another stated, "Costing is not a pressing issue. I feel as if we know where we need to go."

Some organizations are deemphasizing investment in costing and business intelligence capabilities and instead putting more organizational energy now toward engagement of front-line staff and aligning with physicians. These change management efforts are geared toward creating a culture that embraces value improvement and is well-positioned to execute on improvements in care delivery. An example is Novant, which, as noted, is focusing on creating cross-functional forums to identify and execute on opportunities to improve care delivery and is deemphasizing investment in costing until some point in the future.

Staffing. To some degree, concerns about staffing—both in regard to volume and capabilities—varied by type of facility and market. For example, a rural hospital CFO in the Pacific Northwest indicated his facility is sufficiently staffed with coders and felt that this was a function that could be outsourced. However, a larger facility in Boston observed, "There are not enough coders to go around."

IMPACT OF COMMERCIAL CARRIERS' USE OF QUALITY AND COST DATA ON PATIENT UTILIZATION AT YOUR ORGANIZATION TODAY AND IN 3 TO 5 YEARS

Percentage of survey respondents anticipating a positive impact from commercial carriers' use of quality and cost data to encourage patient utilization of certain providers.



Source: HFMA Value Project Survey, February 2012.

Of greater concern to rural hospitals is their ability to recruit an appropriate number of skilled data analysts. Across provider types and markets, survey respondents and interviewees expressed the greatest degree of confidence in finding the IT staff necessary for future operations.

ANTICIPATED OUTCOMES

Although the future of health care will be defined by reduced revenue and investments in capabilities to improve cost structure, survey respondents overwhelmingly aim for their organizations' reputation to be based on high quality, not low cost.

Those who participated in interviews following HFMA's value metrics survey clarified why they believe a reputation of quality is paramount.

"Nothing trumps quality," says Mark Henrichs, assistant CFO at the University of Iowa. "If you say you are the low-cost provider, you scare people away." In three to five years, Henrichs believes healthcare organizations will see more customers purchasing on the basis of cost, but "This is not happening today."

One CFO of a multi-hospital system noted that being "low cost" is not a good marketing point for hospitals and health systems. "It doesn't draw patients," she says. "Patients want to hear about quality." She indicated it will be about five years before there is a sufficient level of transparency and cost pressures at the patient level for patients to use that kind of information in their decision making. The CFO of a rural facility agreed: "If our hospital doesn't have a reputation for quality and satisfaction, we will not get return business; it would go instead to a hospital 20 miles away."

One rural hospital CFO indicated that affordability is second on his list, behind quality, as cost "is a significant concern for our patients." During a series of interviews, HFMA encountered examples of hospitals that are purposefully aiming for a lower-cost position in the market with respect to contracts negotiated with payers. Most, however, aim to be at price parity with the market. As one CFO explained, "We charge what the market will bear."

Survey respondents expressed confidence about the future of their organizations. Sixty percent predict an increase in market share in a three- to five-year period. This finding appears incongruent with external stakeholders' efforts to reduce inpatient utilization. As one interviewee noted, "There will always be a need for bricks and mortar, but I would not expect more patient utilization in the future."

CHAPTER 14

Recommendations for Driving Value

This research reveals a marketplace environment in transition, with myriad quality metrics and a strong desire on the part of purchasers and payers for more efficiency and functional outcomes metrics. Payers intend to purposefully experiment with value-based payment methodologies over the next several years, developing an array of approaches to encourage providers to accept greater financial risk over time. New payment approaches and performance measures are geared toward facilitating provider-led efforts to streamline care delivery.

Although initial value-based payment arrangements offer providers opportunities to share or retain savings or earn incentives, the ultimate goal of these approaches is for savings to accrue to healthcare purchasers, thereby creating value for the customer. It is expected that these payment models will evolve over time, and that, to be successful, providers will need to demonstrate their ability to deliver quality care at a lower price to the purchaser.

In simultaneously managing today's dynamic environment and preparing for a future of risk-based payment, providers are utilizing technical and change leadership skills to transform care delivery while investing in capabilities to drive performance improvement. Moving forward, we recommend that provider organizations take the following steps to position for success in this emerging payment environment:

Recommendation No. 1: Do not delay in developing the four value-driving capabilities required to adapt in a new payment environment. The Value Project identified four key capabilities required for success in the emerging payment environment (see the sidebar at right). Organizations are preparing for payment changes by developing these capabilities. Particular steps that leading organizations are taking now include the following:

- Developing change management capabilities to prepare an agile workforce and organizational culture (people and culture)
- Establishing strategic plans with incentives to align organizations to the most important goals (people and culture)
- Cultivating physician leadership (people and culture)
- Implementing clinical decision support systems/EHRs (business intelligence)
- Refining costing capabilities to move from a directional to a more precise view of costing data (business intelligence)
- Identifying variations and work on standardization (performance improvement)
- Developing the ability to mitigate risk by understanding population-specific drivers of utilization and cost under risk-based contracts and identifying actionable leverage points for influencing these drivers (contract and risk management)

HFMA's research indicates that, although value-based payment is just emerging in most markets today, the majority

THE FOUR VALUE-DRIVING CAPABILITIES

- **People and culture:** The ability to instill a culture of collaboration, creativity, and accountability
- **Business intelligence:** The ability to collect, analyze, and connect accurate quality and financial data to support organizational decision making
- **Performance improvement:** The ability to use data to reduce variability in clinical processes and improve the delivery, cost-effectiveness, and outcomes of care
- **Contract and risk management:** The ability to develop and manage effective care networks and predict and manage different forms of patient-related risk

of organizations are taking proactive steps to ready for this new future. Some are articulating organizational goals aligned with value improvement, and determining mechanisms to incentivize focus on the most critical initiatives. Most are anticipating that improvements in care delivery processes and structures will be the primary vehicle by which they deliver greater value, and are investing in clinical and coding capabilities. Many organizations are establishing or leveraging internal forums to identify and act upon opportunities to improve clinical care. To be effective, these types of forums typically require physician leadership, alignment, and buy-in, as well as engagement by front-line staff. Developing staff capabilities to be involved in performance improvement is a priority in many organizations.

Most providers are assessing their costing and decision support capabilities and determining how best to ensure the breadth and depth of data they need to identify clinical improvement opportunities, ensure physician engagement in these improvement efforts, and measure results. Organizations are first ensuring the consistency of their costing data, and many are investing further to achieve the precision and appropriate granularity in these data that increasing price pressures and new payment methods might require. Organizations also are determining what analytical skills and resources are necessary to utilize the data to help drive decisions.

An organization that has not yet begun to assess the impacts of the shifting payment environment is at risk of lagging the market. Beginning the process through scenario analysis, financial planning, and board discussions are good initial steps. Additionally, assessing the current state of capabilities required, as described in a previous chapter, is important.

Leading organizations are not only assessing what capabilities they need, but also determining how best to balance and sequence them as they navigate the emerging payment environment. Some organizations are placing more emphasis on physician alignment and front-line engagement and development, for example, while others are more focused on technical capabilities such as decision-support. Although business intelligence, contracting and risk management, performance improvement, and emphasis on workforce are all important in the emerging payment environment, leaders should assess how best to organize these efforts based on the capabilities of their organizations and their markets.

Recommendation No. 2: Embrace strategic agility for your organization. Become comfortable with ambiguity and with learning from both successes and failures as your organization experiments with change. Simplify organizational structures and decision-making processes to empower front-line staff to seek solutions. Balance a culture of accountability with a culture of creativity (i.e., while managers should be held accountable for targets, they must also be encouraged to create/innovate).

In today's dynamic market environment, it is important for organizations to develop the ability to be strategically agile—that is, to lay the foundation to change course successfully, and sometimes quickly, as strategies evolve. Leading providers are developing strategic agility in different ways:

- Many providers are proactively readying for a variety of payment methodologies, intending to experiment as a way to gain knowledge about what it takes to be successful under these new payment arrangements. Providers purposefully embarking on a path of experimentation with payment models are determining what level of detail is required in their costing data and whether that level of detail can be obtained through improved data mining, better maintenance of costing data, or investments in new costing systems.
- Many organizations are pursuing ways to foster greater physician engagement in improvement efforts. Numerous provider organizations are creating internal cross-functional forums to identify initiatives, execute them and measure results. To ensure physician participation, some providers are paying physicians to participate in these forums, and discussing what kinds of incentive structures best align physicians to these efforts. Some organizations are determining how best to involve contracted physicians in improvement activities. For example, the Dean Value Contract utilized by Dean Health specifies that contracted providers must achieve performance on patient satisfaction, total cost of care, clinical quality, and generic drug metrics.
- Provider organizations are creating opportunities and environments in which front-line staff are empowered to identify and act on initiatives to improve and streamline care delivery. Key to fostering this engagement is leadership's acceptance that some performance improvement

initiatives will fail while others succeed; the emphasis is on failing fast, extracting key lessons, and using that knowledge in the next iteration of experiments. Chapter 1 offers examples of two health systems—Sharp HealthCare in San Diego, Calif., and Bellin Health in Green Bay, Wis.—that have developed processes for periodic evaluation of programs to identify successes and failures so resources can be redeployed to pursue more promising opportunities.

- Shifting care to lower-cost settings and other market dynamics create financial vulnerabilities for hospitals. The most successful organizations of the future are now beginning to create flexibilities in their operating structure (e.g., by concentrating on fixed as well as variable cost reductions and by designing facilities in purposefully modular fashions).

Organizations that are proactively experimenting with different payment methods, aligning with physicians, empowering staff, and discussing ways to create more nimble infrastructure are beginning to develop more agile cultures. As healthcare leaders know, it typically takes a long time to change cultures. These are important first steps to position healthcare organizations for success in a highly dynamic environment.

Recommendation No. 3: Seek stakeholder alignment around a common set of value metrics that are meaningful to their intended end users. Given widespread acknowledgment of CMS's leading role in developing value metrics, in the near term, provider organizations should use contract negotiations with commercial carriers to push for alignment of contract value-based metrics with CMS value-based metrics. Recognizing the limitations of current metrics, longer term, all stakeholders should embrace the refinement and adoption of value metrics consistent with the following guidelines for the development and use of value metrics suggested by this research:

- Work to replace process metrics with patient-centered functional outcomes.
- Align value metrics with the "triple aim" of improving care for individuals, improving the health of populations, and reducing the per capita costs of health care.
- Focus on a limited set of metrics to drive performance.
- Use payment incentives and penalties selectively, emphasizing performance on metrics that have been proven or stakeholders agree are most likely to drive the most desirable quality or cost outcomes.
- Report provider-specific performance to end users in a way that is understandable and actionable.

External stakeholders, including employer organizations, CMS, and commercial carriers, acknowledge that expecting providers to focus on too many performance metrics at one time can diffuse focus and effectiveness. Providers, too, emphasized this point.

Virtually all hospitals are now participating in CMS's value-based purchasing program. The performance standards required for incentives in this program can serve as a useful starting point for providers in their negotiations with health plans on what types of performance metrics to include in commercial contracts. Leveraging already-required metrics in this manner will help providers focus more effectively on fewer performance standards.

Longer term, value metrics will require refinement. HFMA advocates that value metrics be refined consistent with principles including working to replace process metrics with more outcomes-oriented performance indicators, aligning value metrics with the goals of IHI's "Triple Aim," and focusing on a limited set of influential performance drivers. The National Quality Strategy is an emerging framework of quality metrics that may, over time, serve to align stakeholder interests in performance improvement.

Recommendation No. 4: Explore strategic partnerships and opportunities with payers, employers and patients in your service area. For commercial carriers, action items could include:

- Partnering to identify opportunities to improve care and contain costs in employer-sponsored insurance, individual insurance, and Medicare Advantage plans
- Developing chronic disease management programs

For self-funded employers, action items could include:

- Working to understand/define employer goals for employee health (e.g., smoking cessation, weight reduction, exercise) and productivity (e.g., days absent for illness of employee or family member)
- Developing on-site workplace clinics
- Developing chronic disease management programs

For the benefit of patients, action items could include:

- Incorporating patient perspectives in operations and planning (e.g., patient advisory councils)
- Compiling data on patient expectations and actual outcomes for common procedures and using these to set patient expectations and track performance
- Establishing partnerships with other community health partners (e.g., physicians, social services agencies, etc.) to support desired patient outcomes

Depending on its market environment and internal capabilities and capacity, there may be an opportunity for a provider to improve care in partnership with commercial carriers, community health leaders, self-funded employer purchasers, and patients. For example, a provider could examine available clinical and financial data specific to its patient population to identify areas of concern, such as obesity, excessive use of the emergency department, or overuse of services within a clinical department. Community leaders or an influential area employer also could approach a commercial carrier with a proposal to jointly focus on improving care in a specific area; this could be an effective way to prepare for value-based payment while forging new strategic partnerships.

Many organizations contacted for this project are proactively finding ways to identify and act on strategic improvement opportunities of highest importance to their patient populations. For example, Longmont United Hospital of Longmont, Colo., is working with other local community providers to meet the healthcare needs of the area school district and other large employers. This arrangement better positions Longmont United to identify and act on opportunities to improve care in partnership with important purchasers.

Some providers are working directly with patients to obtain their input on and prioritize care delivery improvements. For example, as noted in a previous chapter, Spectrum Health has established a patient advisory council to engage patients directly in performance improvement.

Depending on an organization's internal capabilities and capacity as well as its external market environment, an opportunity may exist for a provider to be proactive in approaching local purchasers about outcomes measurement. Employers are particularly interested in outcomes as a measurement of value, and the market is lagging in providing these data, particularly on a severity-adjusted basis. A provider may have a unique opportunity to provide leadership and influence in this area by identifying, defining, and demonstrating performance on outcomes. Further, pursuing outcomes measurement creates a unique opportunity to involve patients in defining expectations related to return to functioning.

Recommendation No. 5: Prepare to differentiate the effectiveness of care provided by your organization within a value-driven, competitive marketplace. Be explicit about the value equation (quality in relation to total payment for care) that your organization intends to offer the market. Shift the organization's focus from procedure-based pricing to total payment for care. Ensure that the benefits of your delivery system are seen and enjoyed by purchasers (i.e., maintain focus on value through the purchaser's perspective).

Although the degree to which the insurance exchanges and other market dynamics will drive purely price-sensitive purchasing in health care is uncertain, research conducted through HFMA's Value Project confirms that the price of health insurance and health care is of escalating concern to purchasers. With the increasing availability of provider-specific quality and efficiency data, purchasers will be armed with the information necessary to determine provider networks and drive decisions at the point of care. As price sensitivity escalates, these decisions will likely be based more on price over time.

Given these market dynamics, provider organizations should be thoughtful about the value proposition they intend to offer purchasers. In many organizations, the optimal position will most likely involve the capability to demonstrate lower total cost on the array of services provided. Other providers may opt to maintain a higher price position while carefully defining the factors (e.g., better clinical outcomes or higher levels of patient satisfaction) that accompany the higher price. If much better quality comes at a slightly higher price, a purchaser can still enjoy value provided that the higher price position is acceptable.

Providers that heavily cross-subsidize across payers should bring a laser focus to this effort. Market dynamics such as escalating price sensitivity across payers, employers' increasing understanding of the impacts of cross subsidization, and regulators' authority to influence plans available

on insurance exchanges suggest that significant cross subsidization will not remain a viable financial strategy for long.

It is important that providers that heavily cross-subsidize across payers objectively analyze and segment each customer base to do the following:

- Understand what value equation is viable in each market segment
- Determine which patient segments should remain as part of the provider's patient base in the future
- Determine aggressive plans to accomplish that end state

Recognizing that it will take time to transition to the leaner cost structure that will likely be required to reduce cross subsidization, providers should work with state and federal regulators and representatives to explain the challenges, implications, and multi-year plan to minimize cross subsidization.

Providers have work to do internally and externally to ready for this future. As noted, providers should be explicit about the value equation (quality in relation to total payment for care) that they intend to offer purchaser segments, and should focus internal efforts toward that goal. As noted, decision support and analytical capabilities, an engaged workforce, improved contracting capabilities, and performance improvement skills are necessary to develop a more streamlined and flexible operation.

Providers also should begin to engage in internal discussions about the steps necessary to transition successfully from a "quality" reputation to one based on "value." Many providers already realize that higher cost to the purchaser often indicates lower quality due to overtreatment. Externally, provider organizations would be well served to begin discussions in their communities about how, in health care, there is little relationship between high quality and high cost of care.

SECTION 4

The Value Journey: Organizational Road Maps for Value-Driven Health Care

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.

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

COHORT-SPECIFIC ROAD MAPS

This section 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.

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.

ABOUT THIS SECTION

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		

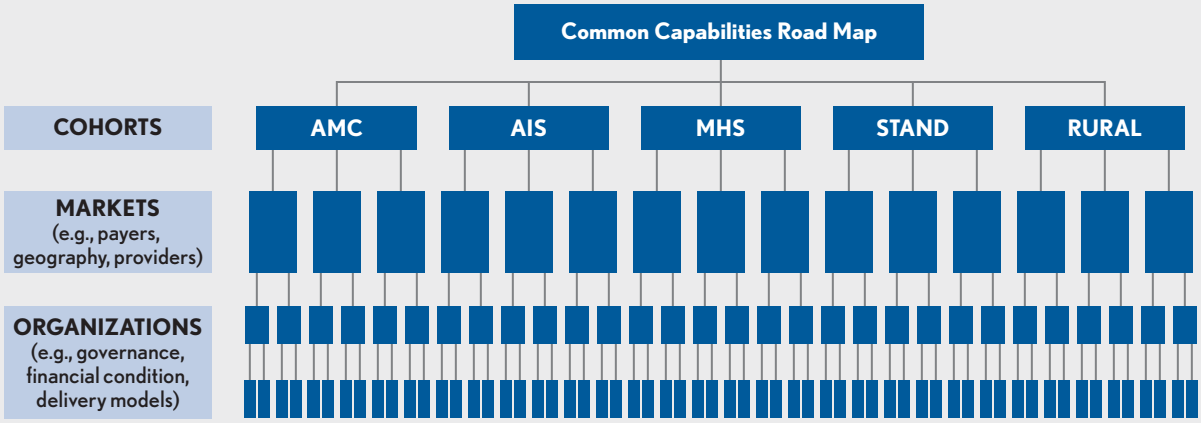
INTRODUCTION

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. 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?

FACTORS INFLUENCING AN ORGANIZATION'S ROAD MAP TOWARD VALUE



AMC: Academic medical centers
AIS: Aligned integrated systems
MHS: Multihospital systems
STAND: Stand-alone hospitals
RURAL: Rural hospitals

The following assumptions underpin the cohort-specific information in this section:

- Cohorts aim for financial sustainability and view delivery system transformation (improved care coordination, efficiency, and patient centricity) as paramount to success.
- Although not all organizations aim to provide population health management, some organizations in all cohorts will choose this path.
- The starting point for each cohort road map is the "common capabilities road map." Variances from the common road map at the cohort level are highlighted in the cohort-specific road maps and accompanying text.
- The cohort-specific road maps are market- and organization-agnostic. In other words, specific market and organizational characteristics were not considered in these road maps.

HFMA's Value Project, together with the support of 35 healthcare organizations and representatives from McManis Consulting, 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 indepth 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 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 section as well as their unique marketplace and organizational characteristics, hospital and health system leaders can better chart their course on the road toward value.

CHAPTER 15

Value Commonalities for All Healthcare Providers

There are four common 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

Over the course of its 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.

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

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

their performance would be positioned in the beginning, middle, or advanced stages of the continuum shown.

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

HFMA'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 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 a previous chapter, 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 chapters 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 this research, 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 a previous chapter, 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 centricity 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 research 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 a previous chapter, 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.

CHAPTER 16

Academic Medical Centers: A Value Road Map

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 130). 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 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.

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.**

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

UNIQUE CHALLENGES AND OPPORTUNITIES FOR ACADEMIC MEDICAL CENTERS

Challenges	Opportunities
• 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)	• 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.

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.
- 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

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

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
- 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

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

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 research 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.

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, 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 AMCs 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

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/Commerical 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.

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 AMCs, 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 AMCs 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 AMCs and will benefit from their transformation. Because they are a vital part of the overall healthcare system, it is important that AMCs make the transition from volume to value effectively.

CHAPTER 17

Aligned Integrated Systems: A Value Road Map

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 research. 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.

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.**

The two site visit organizations selected to represent this cohort were Billings Clinic in eastern Montana and 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 a previous chapter, 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 section. 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

UNIQUE CHALLENGES AND OPPORTUNITIES FOR ALIGNED INTEGRATED SYSTEMS

Challenges	Opportunities
• 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	• 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

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.

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 section. 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 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 care at a lower total price while providing superior clinical quality. For example, Geisinger Health System 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

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

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 research acknowledged that, within their organizations, opportunities exist to better integrate

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

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, 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. 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.

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.

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.

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 a previous section, 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.

CHAPTER 18

Multihospital Systems: A Value Road Map

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.

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.

CHALLENGES AND OPPORTUNITIES

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

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.

UNIQUE CHALLENGES AND OPPORTUNITIES FOR MULTIHOSPITAL SYSTEMS

Challenges	Opportunities
• Optimizing the system's combination of centralized and decentralized governance	• Leveraging economies of scale to optimize investments and achieve cost reduction
• Relatively decentralized physician leadership	• Sustaining and leveraging favorable terms for access capital
• Integrating physician and nonphysician management and leadership approaches	• Utilizing joint learning opportunities/multiple "labs" for experimentation
• Varying degrees of financial alignment with physicians	• Forming strategic partnerships
• Working with nonstandardized approaches to clinical and financial information systems	• Taking advantage of favorable payer relationships
• Working toward a common culture among widespread locations	• Managing the multihospital system's diversified portfolio of activities

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.

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

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

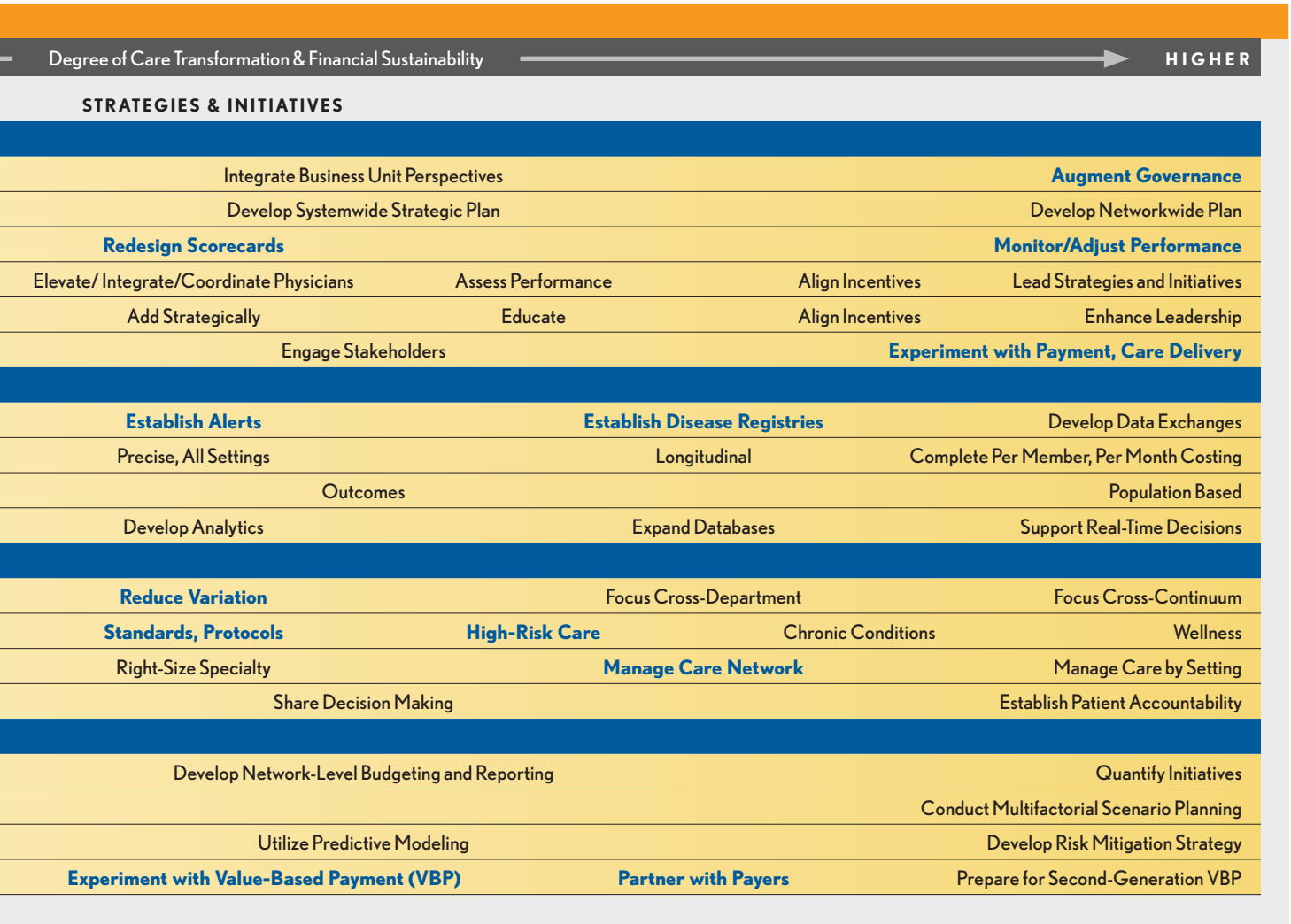
payment, volume, or revenue changes that might affect one component of the system, but not others.

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 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 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.

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.

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.

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 a previous section, 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.

CHAPTER 19

Rural Hospitals: A Value Road Map

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.

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.**

CHALLENGES AND OPPORTUNITIES

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

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

UNIQUE CHALLENGES AND OPPORTUNITIES FOR RURAL HOSPITALS

Challenges	Opportunities
• 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	• 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.

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
- 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 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

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,

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		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 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

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 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 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 research 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 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 research 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 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.

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.

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 opthamology. 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.

CHAPTER 20

Stand-Alone Hospitals: A Value Road Map

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.

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.**

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 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

UNIQUE CHALLENGES AND OPPORTUNITIES FOR STAND-ALONE HOSPITALS

Challenges	Opportunities
• 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	• 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

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 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.
- 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.

STAND-ALONE HOSPITAL ROAD MAP TO VALUE

LOWER

ORGANIZATIONAL CAPABILITIES

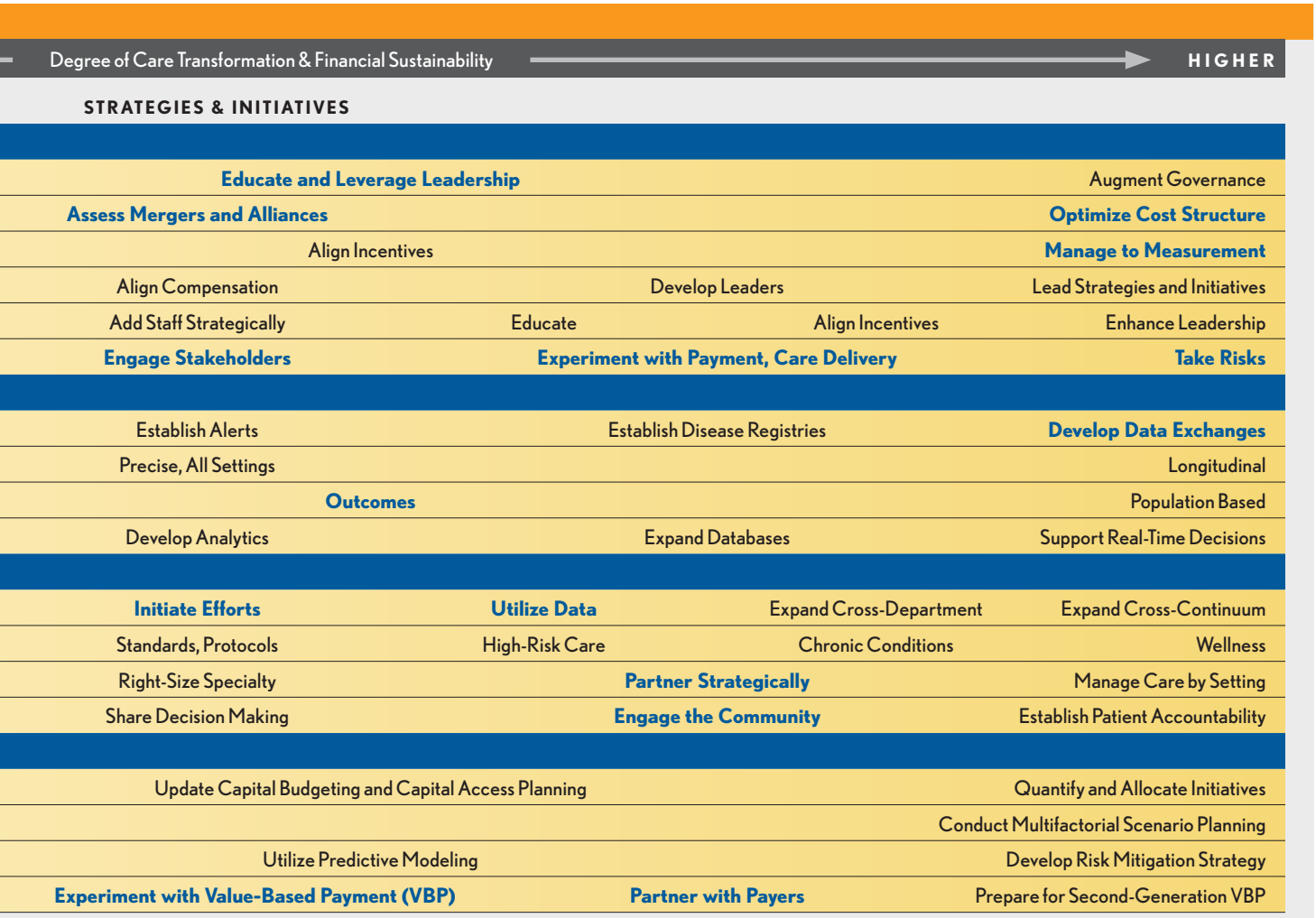
People/Culture		
Governance	Review Governance	**Adjust Board Composition**
Strategy and Structure	Review Strategy by Segment	
Management	Align Executive Leadership	**Develop Common Plans, Goals**
Physicians	Educate	Assess Performance
Staffing and Skills	Assess Needs	Plan Attritions
Communication and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

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 (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 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

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.

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.

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 Schreibert, 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 section 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 this section highlight many areas of potential collaboration between hospitals and health systems and other industry stakeholders. HFMA encourages readers 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.

SECTION 5

Strategies for Delivering Value

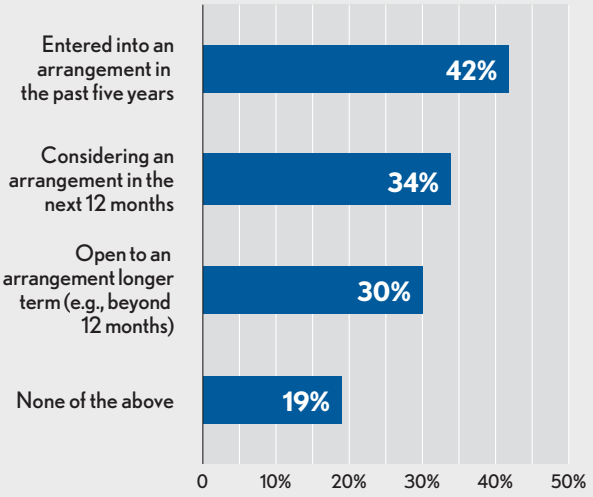
EXECUTIVE SUMMARY

The demands of today's healthcare marketplace are spurring a new wave of acquisitions and affiliations among healthcare organizations. Facing pressure to reduce the cost of care, improve the coordination of care delivery, and assume financial risk for the health outcomes of patient populations, organizations are seeking partners who can help them add new capabilities, achieve economies of scale, enrich data on clinical outcomes, or widen access to services.

A survey of HFMA's senior financial executive members, conducted in the fall of 2013, indicates the extent of interest in acquisition and affiliation activity. More than 80 percent of respondents had entered into an arrangement or were actively considering or open to the idea.

Although the acquisition and affiliation strategies discussed in this chapter are part of a wider trend toward consolidation, our emphasis will be squarely on *value-focused* acquisition and affiliation strategies. Consolidation efforts that are focused primarily on gaining market dominance are less likely to increase the value of care for patients and other care purchasers, and are more likely to attract unfavorable scrutiny from employers, health plans, other competitors, the media, and potentially state and federal antitrust authorities. On the other hand, acquisition and affiliation strategies designed to improve the quality or cost-effectiveness of care are more likely to deliver value to care purchasers, demonstrate an organization's superior value proposition in a competitive marketplace, and accordingly improve that organization's market share.

INTEREST IN ACQUISITION AND AFFILIATION ACTIVITY



Note: Respondents could choose more than one answer.

RESEARCH HIGHLIGHTS

Several key themes emerged over the course of our research on acquisition and affiliation strategies.

An emphasis on value-focused strategies. The healthcare organizations interviewed understand that the best way to gain market share is by meeting care purchasers' demand for high quality, convenient access, and competitive prices. They are seeking acquisition and affiliation partners that will help them achieve these goals.

An understanding that different needs require different approaches. Organizational needs vary greatly depending on local market conditions and the organization's mission, existing capabilities, and future goals. Organizations are considering a range of partners and partnership opportunities to meet these needs, often pursuing several options simultaneously.

The emergence of new organizational combinations. Healthcare organizations are growing both horizontally (e.g., hospital to hospital) and vertically (e.g., healthcare system to health plan), and different types of organizations are combining forces (e.g., academic medical centers and regional health systems).

A blurring of the lines between competition and collaboration. Market conditions and organizational needs are opening up collaborative possibilities for organizations that may have viewed one another as competitors.

The need to change governance and support structures as organizations change. As organizations grow and gain new capabilities, they are reevaluating and reshaping existing board and management structures, IT systems, financial systems and fund-flow models, and physician relationships to accommodate the changes.

CHAPTER 21

Acquisition and Affiliation Strategies

Traditional acquisition activity—in which a weaker system, typically seeking capital investment, is acquired by a stronger system—continues in the healthcare industry. However, many arrangements are being driven more by strategy than by financial need. "Around 2009, we saw the rationale for acquisition and affiliation activity change," says Kit Kamholz, managing director at Kaufman Hall. "Organizations became more interested in bolstering their physician platforms, driving quality initiatives, lowering costs, improving IT foundations, and enhancing their brand."

"A trend now is that mergers and acquisitions are occurring between organizations that are both financially strong," says Jullia Quazi, managing director at BMO Capital Markets. "This is different even from the recent past, when traditionally one party to the transaction had significant financial concerns."

Interviews with acquisition and affiliation consultants and provider organizations that are actively pursuing acquisition and affiliation strategies identified several key drivers of activity in today's marketplace.

OPERATIONAL EFFICIENCIES

Organizations recognize the need to achieve greater economies of scale in purchasing and to centralize and streamline operational functions such as revenue cycle or IT. AllSpire Health Partners, a collaborative partnership of seven independent health systems representing 25 hospitals in New Jersey and Pennsylvania, arose from conversations among CEOs of the participating systems, "each of whom was looking for as many ways as possible to add scale," says Marion McGowan, executive vice president and chief population health officer at Lancaster General Health, one of the systems in the alliance. "They were seeking a way to remain independent, yet achieve economies in partnership with others that they would be unable to achieve on their own."

CLINICALLY INTEGRATED CARE DELIVERY NETWORKS

Hospitals, health systems, physician practices, and other providers may seek to create clinically integrated care delivery networks that will provide convenient access to high-quality services at competitive prices and can be marketed to health plans, employers, and individual consumers. The 2013 combination of HealthPartners and Park Nicollet Health Services in the Minneapolis-St. Paul market, for example, "completes the geography for a combined entity with a 'shared DNA' of careful stewardship of community resources to compete across the entire metropolitan area with a system emphasizing primary and specialty care services in clinics and ambulatory settings," says Nance McClure, HealthPartners' COO.

POPULATION HEALTH MANAGEMENT

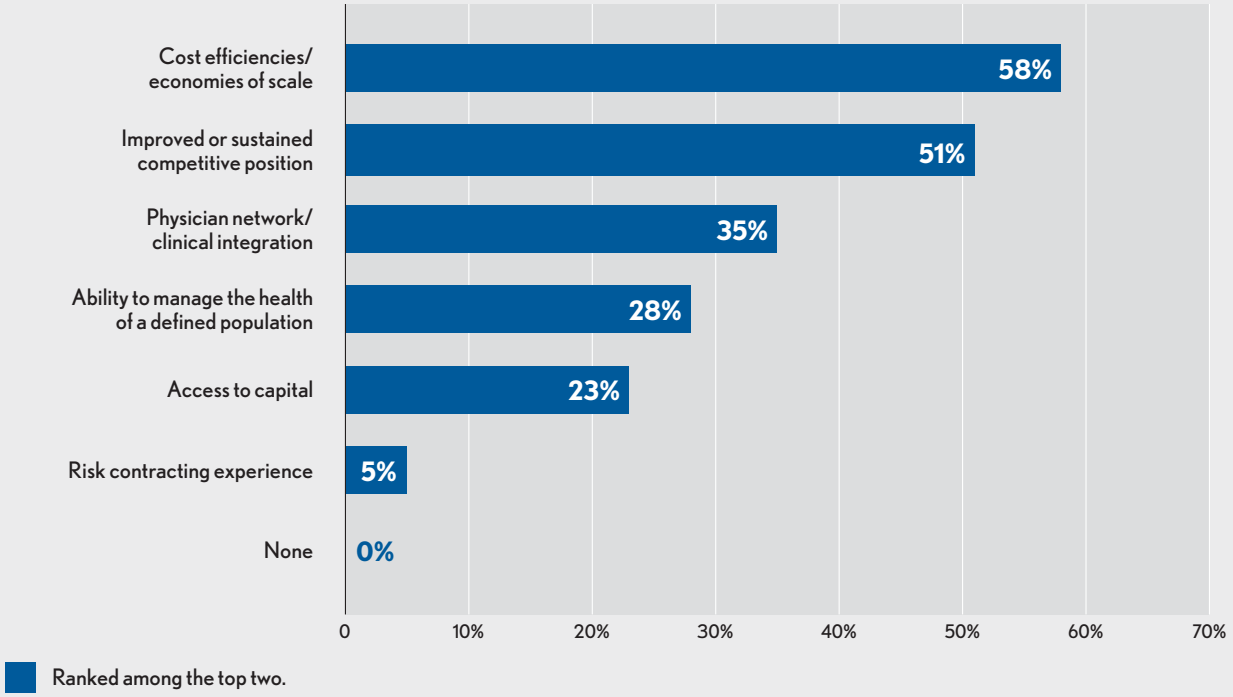
Many organizations see inevitable—and potentially rapid—movement toward a system in which providers will be asked to assume financial risk for managing the health of a defined population. They need access to data on populations of a sufficient size to help identify appropriate risk corridors and drivers of utilization and cost in various patient subpopulations.

NEW CAPABILITIES

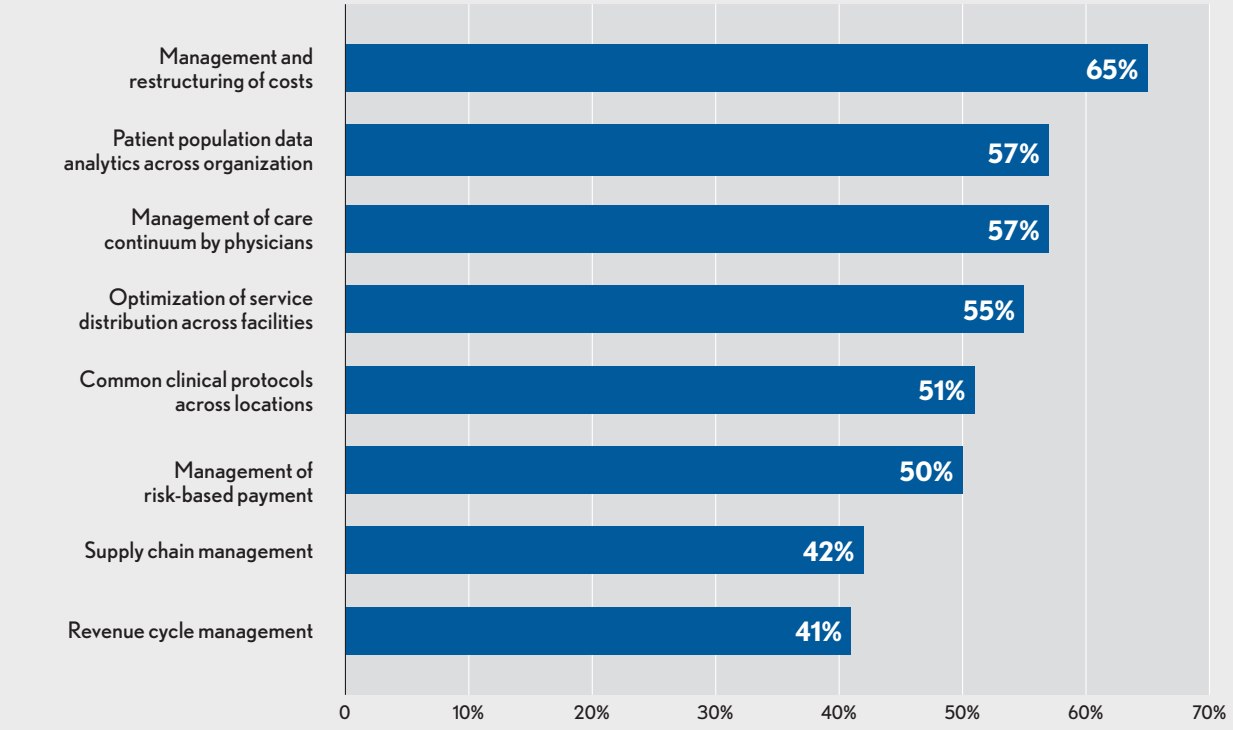
Although many capabilities can be developed internally, acquiring or affiliating with a partner that has developed key capabilities can be more efficient. For example, St. Louis-based SSM Health Care acquired Dean Health, a large, for-profit, multispecialty physician group that includes a health plan and is located in south-central Wisconsin. "When Dean put itself on the market, we saw a strategic opportunity to utilize Dean's capabilities in managing physicians and running a health plan to further SSM's transformation to an integrated, value-based organization," says Gaurov Dayal, MD, president of healthcare delivery, finance, and integration for SSM Health Care.

DRIVERS OF ACQUISITION AND AFFILIATION ACTIVITY

What are the most important reasons for an organization to consider a new organizational arrangement?



EXPECTED IMPROVEMENT IN CAPABILITIES BY ACQUISITION OR AFFILIATION



SERVICE LINE OR ASSET RATIONALIZATION

"The right care at the right time in the right place" has become a mantra in health care, but putting these words into action may cause significant disruptions to the existing infrastructure. Changes in utilization patterns and sites of care likely will require some level of coordination among health systems in the market to "right-size" the system in a way that maintains affordable access to care. "In markets with excess capacity, there will be a need to rationalize services and reduce beds," says David Johnson, former sector head and managing director at BMO Capital Markets. "There has to be a framework to tackle these types of questions."

HFMA's survey of senior financial executive members regarding their acquisition and affiliation activities reflected these concerns. Members identified the need to improve cost efficiencies and economies of scale as the strongest driver of acquisition and affiliation activity (see the exhibit at the top of page 182). Improved economies of scale were of particular importance for respondents in stand-alone facilities: 68 percent of respondents in such hospitals ranked this concern among their top two, compared with 58 percent of all respondents.

When asked what capabilities they would hope to improve through affiliation and acquisition activity, more than half the respondents identified:

- Restructuring of costs
- Improved access to patient population data analytics
- Cross-continuum management of care by physicians
- Optimization of service distribution across facilities
- Creation of common clinical protocols across locations
- Management of risk-based payment

As the responses suggest, the drivers of acquisition and affiliation activity today are multiple and diverse. These needs will be dictated by a variety of factors, including local market conditions, organization type, and existing and desired organizational capabilities. Few organizations should aspire to be all things to all sectors of their market. Some are well-situated as they are and have no immediate need to consider a change in structure, but many feel pressure from some or most of these drivers. As discussed in the following section, numerous acquisition and affiliation options are available to meet the varying needs of organizations.

ACQUISITION AND AFFILIATION OPTIONS

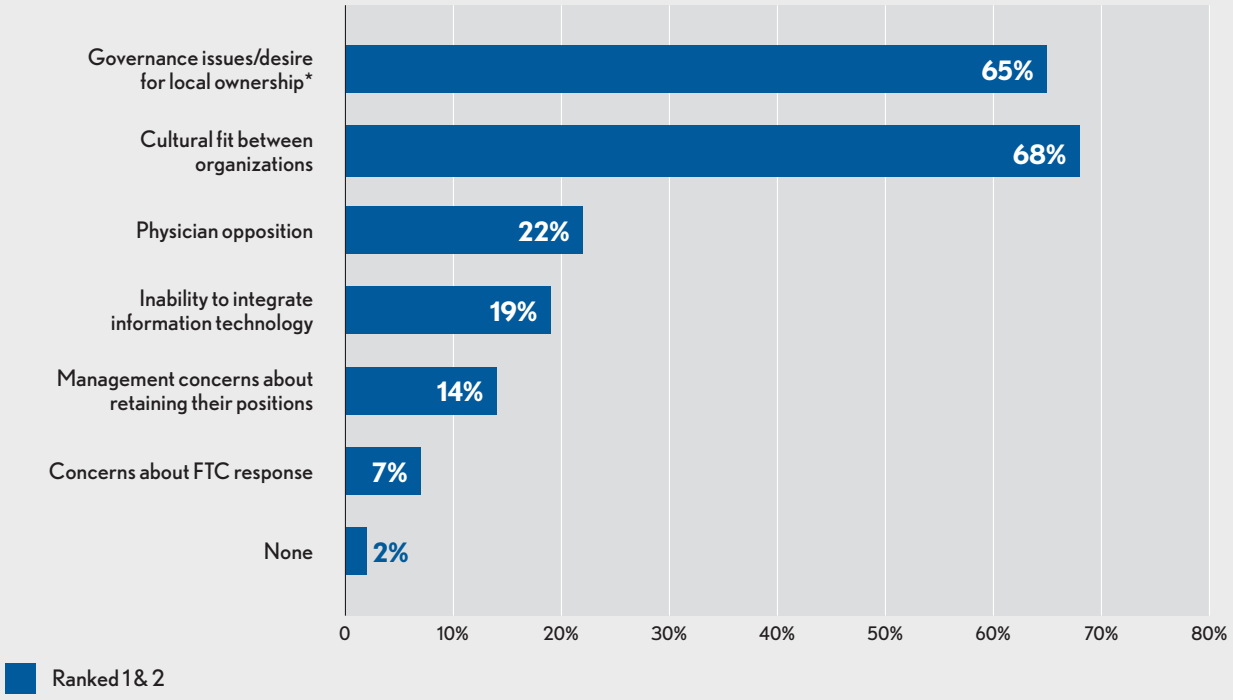
Almost 20 years ago, during the era of managed-care innovation, Robert Pitofsky, then chair of the Federal Trade Commission (FTC), suggested that as "pressures to control healthcare costs and assure quality continue, there is an increasing recognition of the efficiencies that can come about through cooperation and collaboration."[37]

Backlash against the managed-care movement slowed the new models of cooperation and collaboration that Pitofsky discussed in his 1997 speech, although merger-and-acquisition activity continued. But with a renewed emphasis on value—with "pressures to control healthcare costs and assure quality" only growing more acute—various acquisition and affiliation models to increase cooperation and collaboration have emerged and continue to develop.

Acquisition and affiliation models range from the full merger of two organizations into a single, combined entity to looser collaborative models in which organizations work together on certain initiatives but maintain freedom to pursue other opportunities individually or in partnership with other organizations. Organizations are looking for partners both horizontally (e.g., hospital to hospital) and vertically (e.g., health system to health plan). Some are pursuing multiple models simultaneously, depending on their organizational needs and the opportunities in their market.

Determining whether to pursue an acquisition or affiliation opportunity—and which model or models to pursue—should begin with an honest assessment of organizational position and anticipated future needs (see the accompanying sidebars). The HFMA survey of senior financial executives indicated areas that merit special consideration when conducting internal organizational assessments and evaluating potential partners.

CONSIDERATIONS BEFORE AGREEING TO ACQUISITION OR AFFILIATION



*Although combined top-two rankings placed governance issues/desire for local ownership slightly behind cultural fit between organizations, it is listed first on this graph because survey respondents who identified it as a consideration overwhelmingly ranked it as their No. 1 concern.

[37] Pitofsky, R., "Thoughts on 'Leveling the Playing Field' in Health Care Markets," The National Health Lawyers Association (now American Health Lawyers Association), 20th Annual Program on Antitrust in the Health Care Field, Washington, D.C., Feb. 13, 1997.

Internally, if the board or senior leadership team is firmly committed to maintaining local ownership, organizations can consider looser collaborative models in which the partners remain independent. At the same time, the board and leadership team should assess whether maintaining local ownership will best serve long-term organizational needs.

Externally, cultural fit is critical. In many markets, potential partners are familiar with each other and may have worked together already. Still, before finalizing an affiliation agreement, the organizations should have frank discussions about how each hopes to benefit from the relationship and what each would bring to it, and potential obstacles to reaching shared goals.

HORIZONTAL MERGERS, AFFILIATIONS, AND COMBINATIONS

Although traditional merger-and-acquisition activity continues among health systems, the focus of this activity is increasingly strategic. Many acquiring organizations are not interested in adding acute inpatient capacity. Leaders at Dignity Health, which has corporate headquarters in the San Francisco Bay Area, forecast as much as 40 percent excess inpatient capacity in their markets within the next five years. Accordingly, Dignity Health aims to scale back on inpatient beds while considering acquisitions where it has a need for growth or to complement the services it provides in a market. As Peggy Sanborn, Dignity Health's vice president of partnership integration, notes, "Most hospitals come with other assets, such as a physician network."

THREE KEY QUESTIONS

Is your hospital or health system wondering whether it should restructure through an acquisition or affiliation? Kit Kamholz, managing director at Kaufman Hall, suggests considering three key questions:

- Can my organization be successful in its current configuration?
- If not, what type of partnership makes the most sense based on critical success factors and organizational goals?
- What partner can best help my organization accomplish its goals?

Robert Shapiro, CFO of North Shore-LIJ Health System, based in Long Island, N.Y., observed that much of the hospital consolidation in the North Shore-LIJ system occurred in the 1990s. The system is preparing for a future in which core activity shifts from the hospitals to the physicians, and is focused on clear strategic opportunities when acquiring hospitals. For example, the acquisition of Lenox Hill Hospital gave North Shore–LIJ a presence in Manhattan.

If the potential acquisition is a hospital-based system, its other assets may be at least as important as the hospital itself. These assets might include affiliated physician networks, outpatient clinics, experience running a health plan, and, more intangibly, a favorable market position and payer mix. Financially troubled hospitals are becoming less attractive, even if they offer advantages such as a strong payer mix or location in a good market, unless opportunities to engineer a financial turnaround are apparent (for example, opportunities through the supply chain).

The distinction between not-for-profit and for-profit status has become less important in the context of acquisition or affiliation. Kaufman Hall's Kamholz states that hospitals should not focus too much on the tax status of a potential hospital partner. "In terms of forming new structures, the importance of this distinction has diminished over time. For-profit systems have become more experienced with recognizing and accommodating needs of not-for-profit partners, while larger not-for-profit health systems have become more business-focused and centralized in their decision making." Charlie Francis, chief strategy officer for Dignity Health, agrees: "There is a big difference between how you live out your mission and your tax status."

Religious affiliations of not-for-profit systems can pose roadblocks in some instances. The ethical and religious directives of Catholic hospitals and systems, for example, may reduce opportunities for partnerships with organizations that provide services in conflict with church teachings. Dignity Health addressed this issue by ending its governing board's affiliation with the church in January 2012, although the organization remained not-for-profit. The board of directors assumed governance duties for the organization as a whole, while a separate sponsorship council has responsibility for the system's Catholic facilities.

Case studies: Integrating without merging. Although integration through a merger is the most common type of horizontal transaction, some organizations have pursued models that achieve extensive integration without a full merger.

Froedtert Health and the Medical College of Wisconsin have affiliated to create a system in which they maintain separate boards but utilize an internal joint management structure. A key component is the clinical executive committee, which oversees joint planning, IT governance, and quality performance for the system. A 20-month planning effort also resulted in a new funds-flow model in which a percentage of the system's bottom line goes to the medical college to support academic programs, strategic reserves, joint investments, and a performance fund for the faculty practice.

This combination of an academic medical center with a regional health system provides opportunities to shift care, moving lower-acuity procedures to Milwaukee-based Froedtert's community hospitals and freeing capacity to treat higher-acuity cases at the Froedtert Hospital, the academic medical center. Froedtert Hospital runs at approximately 85 percent capacity, with delays of up to 30 days to get an appointment on the campus. "Most academic medical centers do a lot of 'commodity' care, which is good for both training programs and revenue," says Mark Lodes, MD, president of Community Physicians, a joint venture that combines Froedtert's employed and affiliated community physicians with faculty physicians who also practice in the community. "But we need to ensure that the right types of services are provided on the academic medical center campus and in the community hospitals."

Accordingly, Froedtert and the Medical College are moving elective joint surgeries off the main campus to Community Memorial Hospital, a facility located 14 miles away, using a "focused-factory" concept.

The decision was influenced by several factors. The community hospital had both capacity and high-quality outcomes. The procedure and population are well-defined, and the population is willing to travel for the procedure. And the cost of performing the procedures at Community Memorial will be significantly less than at Froedtert Hospital, allowing the system to promote Community Memorial as a lower-cost, high-quality center of excellence with which payers will want to contract. This frees up much-needed capacity at Froedtert Hospital for higher-acuity cases.

The effort also is forging closer relationships between community physicians and faculty physicians. "There was not much of a relationship between the community and academic physicians before this initiative," Lodes says. "This is changing that situation. The conversation today is about what it takes to run a center of excellence at Community Memorial."

HealthPartners and Park Nicollet Health Services came together in 2013 in what they describe as a combination, not a merger. Minnesota-based HealthPartners consistently has pursued a combination strategy in lieu of a buy-out model in its affiliations, limiting capital spending primarily to investments in new partners' electronic health record (EHR) systems or commitments to specific needs over a defined time frame.

In addition to Park Nicollet, Health Partners in recent years has combined with Lakeview Health, which includes the Stillwater Medical Group and Lakeview Hospital in Stillwater, Minn., approximately 20 miles east of St. Paul on the Minnesota/Wisconsin border; and several smaller hospitals—including Amery Regional Medical Center, Hudson Hospital & Clinics, and Westfields Hospital—that are part of the Twin Cities metropolitan area in western Wisconsin. HealthPartners also owns Regions Hospital, formerly Ramsey County Hospital, which it acquired in 1994.

SETTING A FUTURE COURSE

Jullia Quazi, BMO Capital Market's managing director, and David Johnson, BMO's former sector head and managing director, suggest organizations use the following questions to assess their position and chart a course toward possible acquisition or affiliation:

- **What business or businesses am I in?**
- **What is the growth trajectory for my business, and how can I best invest in areas with the highest growth potential?**
- **Do I have the right executive team and governance structure in place to effectively position my organization for the future? If not, what types of people do I need?**
- **What forms of affiliation should we consider?**
- **What can we stop owning and instead obtain through partnership or outsourcing?**

The organizations are under the oversight of a 19-member, consumer-governed board of directors (the Wisconsin hospitals still maintain local boards, with reserve powers for the organization board). They remain distinct corporate entities, however, with separate budgetary and margin goals. HealthPartners and Park Nicollet also maintain separate contracting relationships with payers, including different fee schedules and different relationships with payers in the market. In interviews, HealthPartners leaders describe the combined organization's corporate structure as "a unifying culture working for results driven by the Triple Aim [of improving care experiences, improving the health of populations, and lowering costs], with variations in the care delivery structure." The organization is highly matrixed across its component parts: McClure, the HealthPartners COO, noted that a traditional organizational chart "would be largely irrelevant."

Because the combined organizations within HealthPartners are separate entities, an emphasis on streamlining operational efficiencies has been less emphasized than in many horizontal combinations. The combined system has achieved economies of scale in its supply chain and has merged legal-and-compliance and marketing-and-communications functions on the operational side. (As separate employers, the entities maintain separate human resource departments.)

Much more significant is HealthPartners' blueprint on the clinical side, particularly its use of data analytics to increase value (by improving quality and managing the total cost of care) across the combined system. Park Nicollet and HealthPartners purchased an EHR system from the same vendor but have been on different instances of that system. An immediate emphasis is on getting all entities on the same instance of the EHR, as well as on the same financial management system.

The combination of HealthPartners and Park Nicollet has the potential to be a "game changer" because the combined entity is able to compete across the entire Twin Cities metropolitan area and has access to clinical data on a combined patient population of approximately 1 million. Among other factors working in its favor: It brings together key specialty focuses, with the ability to develop deeper subspecialization across the larger patient base. And it creates a system that is relatively light on hospital beds, with an emphasis instead on primary and specialty care services in clinics and ambulatory settings.

HealthPartners' ability to utilize data analytics to achieve Triple Aim goals has been demonstrated by tools the system has developed to reduce total cost of care within its own care delivery network and, as a health plan, with other providers across the state. In 2007, for example, HealthPartners developed a point-of-order decision support tool that could be embedded in EHR systems and offered the tool for use to all healthcare systems in the state (part of a multi-payer initiative to reduce the use and cost of high-tech diagnostic imaging). The decision support tool collects information submitted by a clinician during the ordering process and, based on indications from the patient assessment, feeds back a utility score for imaging ranging from 1 (low) to 9 (high). The clinician can still order imaging when the utility score is low, but the tool also provides alternatives of higher utility (such as ultrasound, plain x-ray, or no imaging at all). The tool can also be used with patients to facilitate shared decision making. Upon introduction of the tool in a pilot test, imaging utilization hit a plateau. HealthPartners estimates that within its own care delivery network, diagnostic imaging costs are now 10 percent below the state average in what has become a "lean cost" state for imaging.

HealthPartners' health informatics department has developed Total Cost of Care and Total Resource Use measurement tools, which have been endorsed by the National Quality Forum (the tools are available free of charge at www.healthpartners.com/tcoc). Within the HealthPartners health plan, the measurement tools are used to shape benefit design (including reference pricing), offer price and resource utilization transparency to plan members, and work with network provider members (both within and outside of the HealthPartners care delivery system) to manage payment and incentive goals in shared savings programs with the health plan.

On the care delivery side, the tools are used to identify utilization and price patterns affecting the affordability of care that HealthPartners' care delivery units provide. Park Nicollet, which has engaged significantly in risk-based contracting, has since its combination with HealthPartners established a total cost of care committee including vice

presidents and chiefs of service lines (both HealthPartners and Park Nicollet use a "dyad" leadership model), HealthPartners COO Nance McClure, and HealthPartners vice president of health informatics Sue Knudson. The committee meets monthly to report progress and identify issues and manage a broad portfolio of projects. Park Nicollet has also hired a director of total cost of care who has been paired with a data analyst to work with service lines and move the needle on cost.

VERTICAL ACQUISITIONS, AFFILIATIONS, AND COMBINATIONS

Whereas horizontal combinations involve similar organizations within an industry, vertical combinations bring together organizations that supply different components of a service or product within an industry. In health care, a vertical combination might include a multispecialty clinic and a hospital, or a health system and a health plan.

Some combinations can comprise both horizontal and vertical components. An example is HealthPartners, which had both a health plan and care delivery components—i.e., hospitals and clinics—before its 2013 combination with Park Nicollet, which was composed of a multispecialty clinic and a hospital. For HealthPartners, the combination was essentially horizontal, expanding its existing care delivery network into the west-suburban portion of the Twin Cities metropolitan area. For Park Nicollet, the combination included significant "vertical" components, giving the organization access to HealthPartners' health plan capabilities and data analytics.

FACTORING IN ORGANIZATIONAL TYPE

In Phase 2 of the Value Project, HFMA researched the impact of the transition to value on five organizational types: aligned integrated systems, academic medical centers, multihospital systems, rural hospitals, and stand-alone hospitals. Although acquisition and affiliation strategy will be driven by multiple factors, here are specific considerations for each type:

ALIGNED INTEGRATED SYSTEMS

Many of these organizations developed from a multispecialty clinic and include a health plan. They face unique challenges in adapting their tightly integrated models—which in many instances have evolved over the course of decades—to new partners.

The culture of a potential affiliate is important regardless of organizational type but particularly is significant for aligned integrated systems. Is the potential partner open to cultural change? How well-aligned are the partner's physician practices to overall organizational goals? Have the partner's physicians, either independent or employed, demonstrated an ability to collaborate effectively on clinical improvement initiatives?

ACADEMIC MEDICAL CENTERS

To fully support their threefold mission of teaching, research, and specialized clinical care, academic medical centers need access to larger populations than do other hospitals. At the same time, most centers have strong reputations and brands that they understandably want to maintain.

Academic medical centers are pursuing a variety of acquisition and affiliation strategies to gain access to a population large enough to support their mission, with a target population of 3 million cited by representatives of various academic medical centers during interviews. Some have affiliated with a regional health system in their market, strengthening community hospitals in the system through improved access to the expertise of the medical faculty while bolstering the academic medical center through referral networks for tertiary and quaternary care. Others are using telehealth strategies to reach suburban and rural populations, potentially allowing the partner organization to stabilize and retain the patient onsite, and making the academic medical center a logical destination for a referral if a patient needs to be transferred.

With respect to their brand, academic medical centers have a keen interest in the reputation and quality of potential partners. For example, as NewYork-Presbyterian Hospital considers tightening its affiliations with nonacademic partners, "Our aim is coverage in the market, not size for size's sake," says Phyllis Lantos, the hospital's CFO. "We want the best in each community."

MULTIHOSPITAL SYSTEMS

Many multihospital systems interviewed for this research noted the importance of ranking among the top two systems in their market to offer the most attractive and competitive network products to care purchasers.

Accountable care organizations (ACOs) are often vertically integrated structures, albeit less formal versions in many cases. One of the earliest and best-known is the affiliation between Blue Shield of California, Dignity Health, and Hill Physicians Medical Group to coordinate care for members of the California Public Employees' Retirement System. It since has expanded to other markets and employers, with Blue Shield's health plan, Dignity Health's hospitals, and Hill's physician practices sharing risk for managing to a budgeted cost of care for the population. The partners share claims data, pharmacy data, twice-daily hospital censuses, and information on admissions and discharges to enable predictive modeling and, in turn, proactive identification of candidates for case management, as well as active management of patients who are ill or in need of treatment.

Case study: Diversifying capabilities. The acquisition of Dean Health, based in central Wisconsin, by St. Louis-based SSM Health Care solidified a longstanding relationship between the organizations while enabling the vertical integration of Dean's advantageous capabilities into the SSM system. Dean Health was a large, for-profit, multispecialty physician group with expertise in managing practices and running a health plan. Dean physicians had practiced at St. Mary's Hospital, a facility in Madison, Wis., that is owned by SSM, and Dean and St. Mary's shared an integrated EHR system and were participating in a Medicare ACO pilot. The level of familiarity between the organizations before the combination significantly eased issues related to integration.

Larger systems also should consider seeking scale through geographic breadth or by gaining economies within more regional or local markets. "Large systems can achieve great national economies in such areas as revenue-cycle management, IT, and supply chain," says Kit Kamholz, managing director at Kaufman Hall. "The question is whether they can also generate regional economies, such as the ability to work effectively with physicians, optimize and rationalize services across locations within a regional market, or share nursing staff to adjust to fluctuations in volume."

As systems grow, "They can also face a tension between economies of scale and diseconomies of growing complexity in certain relationships," says David Johnson, former sector head and managing director at BMO Capital Markets. "Some organizations are getting bigger by doing more of what they've always done, adding size without increasing complexity. Other organizations are diversifying their organizations as they grow, which increases complexity."

RURAL HOSPITALS

Rural hospitals in geographically isolated communities face a variety of challenges, including physician recruitment, managing cost structure—sometimes in an environment of declining revenues—and implementing new IT systems. At the same time, the close connection between a rural hospital and its community can make board members reluctant to cede local control.

Affiliations can help rural facilities support specialty services within their community, gain financial support and technical expertise for implementation of electronic health record systems and data analytics, and share in economies of scale to produce better cost-efficiencies. Looser affiliation strategies, such as participation in a telehealth network with a larger system or academic medical center, can support local physicians and keep the care of lower-acuity patients close to home. Tighter affiliation strategies, such as a merger with a larger system, typically provide greater support for operational and IT needs.

STAND-ALONE HOSPITALS

Stand-alone hospitals in competitive markets probably are aware of acquisition and affiliation activity drivers that involve issues of size and scale. Some degree of affiliation activity likely will be necessary for these hospitals to remain competitive.

The primary question is the extent to which stand-alone hospitals want to remain independent. The collaborative partnership models that are emerging in markets around the country are among the affiliation options that offer opportunities to achieve the benefits of greater size and scale without yielding organizational independence. Whether a stand-alone hospital wishes to remain independent or join a larger system, considerations such as the hospital's market position, financial strength, and physician relationships will have a significant effect on its options.

The acquisition of Dean in September 2013 came as SSM's revenues were shifting rapidly to non-hospital-driven sources. Within the newly merged organization, which includes markets in Missouri, Illinois, and Oklahoma, as well as Wisconsin, the high degree of integration in Wisconsin has led to decreased costs and improved outcomes. While sensitive to the differences in its various markets, SSM is beginning to export aspects of the Dean model to other physician practices in building its consolidated medical group. SSM also immediately put health plan experts from Dean in charge of its self-funded employee plan and has realized immediate cost savings through steps such as switching to Navitus, a free-standing pharmacy benefit-management organization that was jointly owned by Dean and SSM and is now part of the SSM system.

The vertical combination of Dean Health and SSM "has given SSM the capabilities needed to transform to an integrated, value-based organization," says Dayal, the president of healthcare delivery, finance, and integration for SSM Health Care. "The value of this acquisition will ultimately lie in our ability to continue to lower the total cost of care and improve clinical outcomes. We are very confident in accomplishing both of these objectives as an integrated organization."

MULTISYSTEM COLLABORATIVE MODELS

These models, in which hospitals or health systems come together to work on operational or clinical initiatives while remaining independent, have emerged in several markets. Examples include the BJC Collaborative in Missouri and Illinois, the Granite Health Network in New Hampshire, Stratus Healthcare in central and south Georgia, Integrated Health Network of Wisconsin, and AllSpire Health Partners in New Jersey and Pennsylvania.

Many of these partners came together as recently as 12 to 18 months before this chapter was written. "Hospital board and executive teams are interested in participating in these arrangements because they offer the possibility of adding scale without ceding control over the organization," says Kaufman Hall managing director Mark Grube.

Whether such collaboratives will have a meaningful impact on the market is unclear. "We will not know for several years whether these newer arrangements have achieved their goals," says Quazi, managing director for BMO Capital Markets. Some goals will be harder to achieve than others, says Johnson, the former sector head and managing director at BMO: "For example, decisions regarding rationalization of services and reductions in beds in markets with excess capacity are more difficult to make in a more loosely affiliated arrangement."

Grube says many collaborative partnerships are focusing their attention initially on:

- Group purchasing activity
- Back-office functions
- Sharing of best practices, both operational and clinical
- Forming accountable care structures for risk sharing of managed-care activities

Not yet on the agenda for these partnerships are:

- Decisions on which services should be provided by which organization, an issue that could raise antitrust concerns regarding market allocation
- Control over clinical decision-making processes
- An integrated bottom line for the partnership

Case study: An innovation company. AllSpire Health Partners is a collaborative partnership of seven systems of similar size: Lancaster General Health, Lehigh Valley Health Network, Reading Health System, and Wellspan Health in eastern Pennsylvania; and Atlantic Health System, Hackensack University Health Network, and Meridian Health in New Jersey. The markets for the seven systems are geographically contiguous, but with relatively little competitive overlap. Combined, the member organizations represent approximately $10.5 billion in revenue and a service area of more than 6 million people.

AllSpire does not have a dedicated infrastructure and staff; instead, staff from the member organizations contribute time to the governing board, councils, and committees that oversee development and management of the partnership and identify opportunities to pursue. Each membership organization contributes funding to support legal, branding, and outside consulting costs.

Governance and management of the partnership runs through three entities:

- The board of managers, which includes up to four members from each partner system, typically including the board chair and CEO. Leadership rotates among the partner systems alphabetically. Each member organization has one vote.

- The management council, which includes the seven CEOs of the member organizations. The council reviews initiatives proposed by the development committee and recommends approved initiatives to the board of managers for ratification.
- The development committee, which includes two C-suite-level executives from each member organization, representing legal, population health, finance, clinical, and operations to provide a balance of expertise.

The AllSpire partnership is intended to run as an innovation company. The development committee is the partnership's research and development arm, running ideas through a structured process of review and prioritization for consideration by the management council. The development committee meets for 90 minutes weekly, with additional meetings for co-leaders of committee subgroups. The subgroups are assigned selected initiatives, with a project manager assigned from a partner system and two subgroup leaders, one from a New Jersey system and one from a Pennsylvania system.

The development committee is taking a disciplined approach to identifying initiatives, recognizing the benefit of building momentum through early successes and of not taking on too much at once. Its efforts are focused on five initial areas:

- Population health, beginning with self-funded employee plans
- Laboratory and imaging services, focusing on opportunities for efficiencies of scale among the seven partner systems and implementation of recommendations from the "Choosing Wisely" campaign
- IT, with initial discussions focused on health information exchange, disaster data recovery, and common HIPAA strategies
- Group purchasing, especially novel relationships in which the partnership could share risk with vendors
- Clinical initiatives, focusing on those that create transformation in care delivery such as emergency department throughput and end-of-life and palliative-care strategies

After the management council and the board of managers approve an initiative, the partnership determines whether it needs to be structured as a separate joint-venture organization and whether any additional partners should be added. Joint ventures are funded separately from the AllSpire partnership, based on analysis of capital funding needs and financial potential. Necessary funding is contributed by joint-venture partners, which may include all or some of the seven member organizations.

Case study: Bolstering care management. The Integrated Health Network (IHN) partnership in Wisconsin has taken a different approach than AllSpire, using a model in which member organizations fund full-time staff for the partnership. Among the primary goals is creation of a broad-based, clinically integrated regional network to provide a continuum of care management options, with single-signature authority to contract on a nonexclusive basis with employers and other payers. Accordingly, the member organizations have invested in a clinical IT infrastructure that includes a tool with risk-stratification and patient registry-creation capabilities. Among the staff funded by the IHN member organizations are care transitions personnel, who use the data and risk-stratification information from the IT infrastructure to identify the most critical patients and oversee their care.

IHN is a partnership of five health systems—Froedtert Health, Agnesian HealthCare, Ministry Health Care, Columbia St. Mary's, and Wheaton Franciscan Healthcare—and the Medical College of Wisconsin; Froedtert and the Medical College together form one of two academic medical centers in the state. The inclusion of the Medical College is considered an important asset in the partnership's effort to develop a clinically integrated network that can offer a full range of services to payers, employers, and patients.

Combined, the system comprises 34 hospitals, more than 450 clinic locations, 4,300 contracted providers, and more than $7 billion in net revenue. The recent addition of Ministry Health Care has expanded the geographic territory well into northern and west-central Wisconsin, but most of the partners operate within the Milwaukee metropolitan area. Although the distance between many of the member organizations is not great, Milwaukee historically has been divided into small, contiguous markets with limited competition among them.

The three most important committees for IHN, each chaired by a CEO from one of the member organizations,

are market strategy and product development, finance, and clinical integration. With the partnership focused on creation of a clinically integrated network that can engage in risk-based contracting with commercial payers, the clinical integration committee has been the most active to date, engaged in developing common care protocols. Its initial focus has been on management of complex conditions such as diabetes, chronic obstructive pulmonary disease, asthma, coronary artery disease, hypertension, and heart failure. As IHN has begun to contract with payers, the finance committee has become actively engaged in reviewing terms.

IHN and United HealthCare entered into a shared-savings agreement that covered a population of about 53,000 as of January 2014. Within a year, the number is expected to increase to 100,000 and will include the self-funded populations of Froedtert Health, Medical College of Wisconsin, and Wheaton Franciscan employees. United initially is contracting with a subset of the IHN members, but the contract likely will expand to include the full network.

The ultimate goals of IHN are to:

- Develop differentiated core competencies in population health and risk management among the member organizations
- Develop new mechanisms for delivering services to populations
- Contract together efficiently under single-signature authority
- Develop long-term relationships with health plan partners to maximize the number of lives under management and reach a critical mass of risk-based revenue that will enable member organizations to focus more exclusively on managing healthcare expenditures

OTHER ACQUISITION AND AFFILIATION OPTIONS

As the HFMA member survey indicates, traditional hospital-to-hospital or system-to-system mergers remain most popular, but nearly half the respondents are pursuing an alternative form of acquisition and affiliation activity. Along with vertical integration and collaborative partnership models, these include joint ventures and operating agreements, management-service agreements, and numerous other options.

Hospitals and health systems also are looking at a wider field of potential partners. "We are seeing new types of companies emerge out of the more creative arrangements," Quazi says. "There is more strategic diversity in the business models than ever before."

Many organizations are pursuing different models for different markets, goals, or growth opportunities. Dignity Health, which operates hospital-based systems in markets in California, Nevada, and Arizona, recently acquired a 22-state chain of occupational medicine and urgent care centers and is considering investment opportunities in healthcare-related startup companies. "We don't want to

LESSONS ON BUILDING A COLLABORATIVE PARTNERSHIP

Leaders from systems participating in the AllSpire Health Partners and Integrated Health Network (IHN) collaborative partnerships shared several lessons on collaboration.

Strive to obtain financial contributions from all collaborative partners. There will be expenses associated with legal, branding, and communication needs, and potentially IT infrastructure and staff funding. A financial contribution also demonstrates commitment to the partnership. Contributions may be split equally or variably among member organizations, perhaps depending on the size of the organization or its level of participation in partnership activities.

Stay disciplined in defining the partnership's initial efforts. Try for some quick accomplishments to build momentum for the partnership, and don't take on too much at once. Both AllSpire and IHN have worked to clearly define areas of focus.

Make sure key staff members from the participating organizations have the necessary time and energy to build the partnership. Even in a staffed model such as IHN, leaders from each organization will need to devote significant time to the partnership.

Define clear leadership roles on the various boards and committees to ensure accountability and develop a structured decision-making process. In particular, CEOs of the member organizations should take on active leadership roles to move decision making forward.

do everything ourselves; we like to partner," says Dignity Health CFO Michael Blaszyk. "But you have to be capable of partnering well. So much of health care is about control, and some of that must be ceded in a partnership."

One of the five items on Dignity Health's transformation agenda is innovative and diversified business lines, and the system is pursuing a multipronged strategy to achieve this goal. "Our strategic question when contemplating a partnership is, 'How do we build this into something that is economically fruitful?'" Blaszyk says.

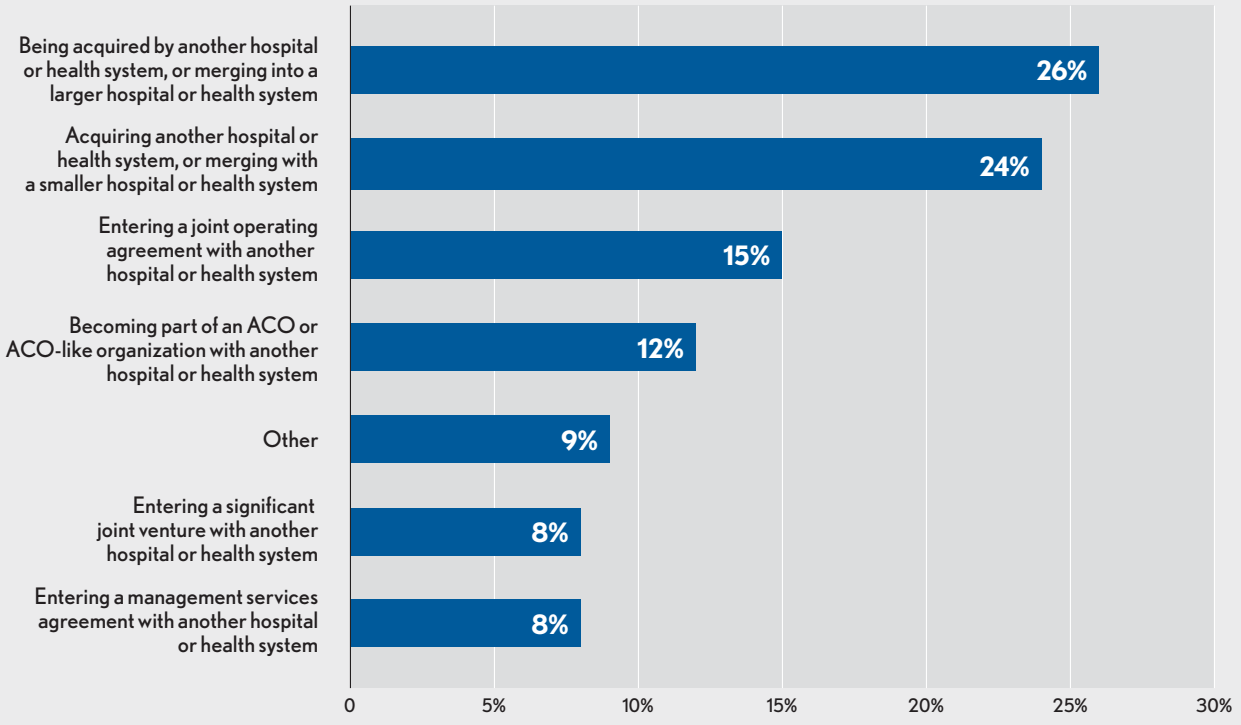
Case study: Joint ventures. As described earlier, Dignity Health—through a joint venture with Blue Shield of California and Hill Physicians Medical Group—was among the first healthcare organizations to form a commercial ACO in an effort to contain costs of care for a defined patient population. Since then, Dignity Health has continued to pursue joint-venture opportunities with a range of "nontraditional" partners.

In one of its markets, Dignity Health and a for-profit system formed a joint venture that merged their local physician networks under a limited liability corporation co-owned by the two systems. The joint venture has created a marketwide network that allows both partners to compete more effectively against the biggest system in the market.

Dignity Health also has entered into joint ventures with United Health Group and its subsidiary, Optum. A venture called Shared Clarity combines Dignity Health's clinical data with United's claims data to assess the efficacy and cost of physician-preference items. Other systems can buy into the joint venture to expand the pool of clinical data and the volume of purchases that can be offered in negotiations with vendors that offer higher-value products.

PREFERRED ACQUISITION AND AFFILIATION ARRANGEMENTS

Which of the following options best describes the most significant type of arrangement your organization has pursued or is pursuing?



In another joint venture, Dignity Health and Optum teamed to create Optum 360, a national company designed to help healthcare organizations strengthen revenue-cycle processes. Dignity Health brings provider expertise regarding the revenue cycle, while Optum brings expertise in technological systems on the payer side.

Case study: Diversifying for national growth. In July 2012, Dignity Health announced its intention to acquire U.S. HealthWorks, the largest independent operator of occupational medicine and urgent care centers in the country. The acquisition gives Dignity Health a national footprint and provides a foundation on which to build additional population health capabilities. As a specialist in occupational medicine, U.S. HealthWorks has relationships with employers that could enhance Dignity Health's opportunities to directly contract with self-insured employers.

The acquisition is consistent with Dignity Health's interest in diversifying beyond acute care. Charlie Francis, chief strategy officer for Dignity Health, notes predictions that some strong regional systems are in position to grow into national systems. As opposed to a strategy of national growth based upon the acquisition of acute-care providers that may need to be downsized as site-of-practice and utilization patterns change, the acquisition of U.S. HealthWorks provides a national platform on which services can be added while avoiding the higher cost structure of acute-care providers. "The acquisition of U.S. HealthWorks was a diversification opportunity that offers a higher profitability profile," says Lisa Zuckerman, vice president of treasury services for Dignity Health.

Case study: Investing in innovation. Dignity Health is taking advantage of its headquarters location in the San Francisco Bay Area to explore affiliations through equity investments with new healthcare-technology startup companies, another aspect of the system's focus on innovative and diversified business lines.

Investments in these companies serve several purposes. A health system offers sites for piloting new technologies with patients. Some of the technologies Dignity Health has invested in could significantly reduce the cost of certain services. Of course, if the technology is successful and finds a wide market, Dignity Health could realize a strong return on its equity investment.

LEGAL AND REGULATORY ISSUES

The primary legal and regulatory issues affecting acquisition and affiliation strategy concern antitrust law. The position of the FTC and Department of Justice (DOJ)—the agencies that enforce federal antitrust law—is consistent with a value-focused acquisition and affiliation strategy.[38] Acquisitions or affiliations intended to produce pro-competitive effects, including improvements in quality, cost efficiency, or access to care, are less likely to be challenged if these pro-competitive effects outweigh any potential anticompetitive effects (for example, a more dominant position in the market resulting from the acquisition or affiliation activity). Generally, the greater the potential antitrust concerns, the greater the pro-competitive efficiencies must be. "An organization can gain dominant market power simply by being really good," says Doug Hastings, chair emeritus of Epstein Becker Green in Washington, D.C. "Antitrust concerns are raised when that position is gained instead through acquisitions."

Although the FTC and DOJ have defined "safety zones" for many types of acquisition and affiliation activity in health care,[38] antitrust analysis is highly fact-specific. However, certain considerations provide insight as to whether antitrust issues might arise for the various acquisition and affiliation options described in this chapter.

COLLABORATION, CLINICAL DATA, AND HIPAA

In addition to antitrust issues, healthcare organizations should be aware of changes to the HIPAA, made in subtitle D of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The HITECH Act strengthened both civil and criminal enforcement of the HIPAA privacy and security rules. The revisions define four "penalty tiers" with increasing levels of culpability, establishing a minimum to maximum range of monetary penalties for each tier, with the maximum penalty for violations of identical provisions of HIPAA within each tier in a given calendar year set at $1.5 million. The HITECH Act also struck a limitation on liability when an entity covered by HIPAA was able to establish that "it did not know, and by exercising reasonable diligence would not have known" of a HIPAA violation. A covered entity in such a situation now must be able to establish that it corrected the violation within 30 days of becoming aware of it to claim an affirmative defense.

Although these provisions are of concern to all healthcare organizations, they should be of particular concern to organizations in looser collaborative partnerships that are sharing clinical data among partners to improve patient care. Organizations should carefully review their HIPAA compliance programs to ensure that shared data are adequately "scrubbed" to conform to HIPAA privacy requirements and that strong measures are in place to ensure the security of shared data.

HORIZONTAL MERGERS, AFFILIATIONS, AND COMBINATIONS

An initial question for horizontal activities is whether a change of ownership or control will be involved. If so, the activity could constitute a merger that requires pre-merger notification to the enforcement agencies.

A merger involving change of ownership or control is less likely to attract substantive antitrust scrutiny if the hospital being acquired operates in a separate geography and market from the acquiring organization and its subsidiaries or other affiliates or if the merger will not significantly increase providers' market share or the concentration of providers in a given market.

Antitrust issues with respect to other transactions are less clear-cut. These include debt transactions where, for example, one organization provides capital to another and takes a minority position on that organization's board. Management-agreement models may also be in a gray zone, although concerns are fewer if the managed organization maintains its own fiduciary board, no sharing of competitive information takes place, and no pre-established "triggers" would move the entities closer together.

[38] States also enforce their own antitrust laws, typically but not always hewing closely to federal approaches.

"Transactions that do not involve acquisition of assets, but rather involve forming a joint venture, creating a contractual arrangement, or making changes in management, typically do not constitute a merger, and are unlikely to trigger the need for a Hart-Scott-Rodino filing," says Hastings. "Such arrangements are less likely to be challenged, even where there may be market share concerns, so long as there are indicia of financial and clinical integration."

VERTICAL ACQUISITIONS, AFFILIATIONS, AND COMBINATIONS

A U.S. district court decision early in 2014 to order a breakup of the affiliation between St. Luke's Health System and Saltzer Medical Group has drawn new attention to antitrust issues related to vertical integration.

The case included allegations involving both horizontal and vertical integration, but was decided on the horizontal integration issues "because horizontal acquisitions are easier to challenge than vertical acquisitions," says Bob Leibenluft, a partner at Hogan Lovells in Washington, D.C. "But the vertical integration issues are why the case happened. Those were the basis of an initial, private antitrust lawsuit by one of St. Luke's competitors, which the FTC decided to join."

The horizontal integration issues in the case involved a classic market-concentration analysis. Combined, primary care physicians in the Saltzer Medical Group and physicians already affiliated with St. Luke's would have had 80 percent of their market in Idaho, enabling the combined group, in the court's opinion, "to negotiate higher reimbursement rates from health insurance plans that will be passed on to the consumer."

The vertical integration issues—not part of the court's decision—dealt with referrals. Specifically, "buying up" referrals through acquisition of physician practices can help solidify or maintain the system's dominant position in the market.

Although the FTC has focused primarily on horizontal integration issues, vertical integration is emerging as a new issue in health system acquisitions of medical groups, often introduced in private lawsuits. A key consideration is whether the vertical integration will reduce horizontal competition among medical groups in a market. This is highly fact-specific, but the chances of attracting FTC attention increase considerably if there is horizontal market overlap between acquired practices. A second consideration is whether there is an appearance that a dominant system is "buying up" physician practices in a market. This can trigger private antitrust lawsuits from competitors, as in the St. Luke's case.

Leibenluft offers these guidelines when considering a vertical transaction:

- Look at the transaction from the perspective of your competitors. Might it be perceived as an effort to foreclose referrals?
- Make sure your internal team is clear about the goal of the transaction and focuses its communications accordingly. If the goal is to create an integrated network to improve quality and cost-efficiency, speculation about the transaction's impact on market power could bring that goal into question.
- Seek the advice of antitrust counsel early in the process if, as a general rule, your system commands 40 percent or more of the market and is looking to acquire or affiliate with a significant percentage of physicians in a given specialty or a significant percentage of primary care physicians in the market.

The accountable care movement has increased vertical integration in different configurations among health plans, hospitals, and physician groups. The FTC and DOJ have defined "safety zones" for ACOs that involve physicians, hospitals, and outpatient facilities and were created pursuant to the Medicare Shared Savings Program.[39] The analysis of

CONVERSATIONS WITH FTC STAFF

HFMA thanks Christopher Garmon, Christine White, and Stephanie Wilkinson, all members of the FTC's staff, for discussing issues related to federal antitrust law with us. These discussions reflected their personal opinions. Nothing in this chapter should be construed as representing official agency policy or guidance.

[39] "Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program," Federal Trade Commission and Antitrust Division of the Department of Justice, Oct. 20, 2011 (www.justice.gov/atr/public/health_care/aco.html).

other ACOs—including commercial ACOs formed between provider organizations and health plans—would be similar to the analysis for joint ventures in which clinically integrated organizations are formed, as discussed below.

JOINT VENTURES, COLLABORATIVE PARTNERSHIPS, AND OTHER ACTIVITIES

Joint ventures between hospitals to create clinically integrated organizations are increasingly common. "These ventures typically use one of two basic integration models," says John Marren, a partner with Hogan Marren in Chicago. "In the 'best care' model, a tertiary hospital forms a joint venture with one or more community hospitals. The tertiary hospital is able to upgrade the level of services provided at the community hospital, enabling it to manage lower-acuity cases, while higher-acuity care shifts from the community hospital to the tertiary hospital. In the 'clinical integration' model, hospitals work with physician networks to improve the quality and cost-effectiveness of care across the network."

Hospital partners in both models typically have joint ownership of the clinically integrated organization, but designate a physician-led board with key committees such as performance, initiatives, infrastructure, and payer relations. The joint-venture agreement among the hospital and physician partners specifies an overall plan to create efficiency and improve quality through integration of hospital and physician efforts.

Marren identifies several key considerations in assembling these organizations. Regarding data gathering, the organization needs to make sure there is one platform and one set of protocols from the various partners. "Data is the game-changer today," Marren says. "Consistency of data gathering among the partners is critical to the joint venture's success."

There must be an economic benefit to participation—e.g., an opportunity to participate in shared savings—for physicians in a clinically integrated network. Money for physician payments within a hospital-owned clinically integrated organization should not end up back at the hospital, except for what is needed to fund the integrated organization's infrastructure.

Antitrust enforcement policy for joint ventures involving a clinically integrated organization is fairly well-settled, Marren notes. Key questions include:

- Is the clinical integration program real? In other words, does the program contain authentic initiatives, actually undertaken and requiring the active involvement of all participants in the network (described in a 1996 statement by the FTC and DOJ as an active and ongoing program to evaluate and modify practice patterns by the venture's providers)?
- Are the program's initiatives designed to achieve likely improvements in healthcare quality and efficiency?
- Is joint contracting with a health plan reasonably necessary to achieve the efficiencies of the clinical integration program?

Organizations should note, however, that clinically integrated networks that meet these descriptions could still raise antitrust questions if they have a high market share and could exercise market power.

Collaborative partnerships among independent hospitals and systems typically pose fewer antitrust concerns than more tightly integrated models, especially if market overlap between member organizations is limited. If the collaborative partnership is developing a network product, much of the discussion regarding clinically integrated networks applies.

If the collaborative partnership is developing a network product, much of the discussion regarding clinically integrated networks applies. Additional considerations include:

- Will the member organizations remain open to contract independently beyond the product that the partnership is offering? The risk of anti-competitive harm is mitigated if the member organizations remain non-exclusive in fact, as is the risk of having a complaining party, such as a health plan, initiate a private antitrust lawsuit.
- Are the member organizations carefully tailoring the information they share to their needs in developing the network product? Some information sharing is permissible; the key is to tailor and stage the information sharing. For example, what information is needed to make an initial "go/no go" decision on development of the product? If it is a "go," what level of information

sharing is necessary to progress to the next stage in developing the product? Organizations should avoid substantial information sharing until they are confident that the product they are developing will likely move forward and should remain mindful of the guidelines on information sharing set forth in the DOJ and FTC's 1996 *Statements of Antitrust Enforcement Policy in Health Care*.[40]

- Is the partnership reaching out to the payer community to keep it apprised of the partnership's legitimate goals and progress? Again, communicating with payers about how the partnership will achieve quality goals and cost savings can help to diminish any concerns that the member organizations are engaging in anti-competitive behavior.

With respect to other activities by collaborative partnerships, member organizations should be careful to avoid market-allocation concerns if they take up the issue of service-line rationalization. If members appear to be dividing the market for services among themselves, potentially allowing each to dominate the market in a certain group of services, they could attract serious antitrust scrutiny.

Although antitrust enforcement typically focuses on monopoly power (i.e., the ability of a seller to control the market), it also can address monopsony power (i.e., the ability of a buyer to drive sellers' price below a competitive level). For example, if a collaborative partnership is engaged in group-purchasing activities and member organizations constitute a dominant block of buyers in the market for a specialized healthcare service (e.g., temporary nursing staff), they could be accused of exerting monopsony power. Such actions by organizations are rare, however.

Partners should seek the advice of experienced counsel whenever they suspect antitrust concerns may apply. But the general rule is relatively simple: If the goal and effect of acquisition or affiliation activity truly are to create value for patients and other care purchasers, the activity is far less likely to run afoul of legal and regulatory concerns.

[40] "Statements of Antitrust Enforcement Policy in Health Care," U.S. Department of Justice and Federal Trade Commission, August 1996 (ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care).

CONCLUSION

From the beginning, HFMA's Value Project has emphasized the need to focus on the care purchaser's perspective. Value is created when the purchaser experiences an improvement in the relationship between the quality and the cost of care. As healthcare organizations contemplate acquisition and affiliation strategies, they must keep the purchaser's perspective clearly in sight.

The examples of acquisition and affiliation activity highlighted in this chapter have the potential to significantly increase value:

- AllSpire Health Partners' emphases on operational efficiencies and the sharing of clinical best practices aim to both enhance quality and offer more cost-effective care delivery.
- Dignity Health's multipronged strategy is engaging a wide range of partners in reducing total cost of care, forming networks that can offer competitive products to health plans and their beneficiaries, and investing in technologies and facilities that could significantly alter care delivery with improved access at a lower cost.
- Froedtert Health and the Medical College of Wisconsin are working to move lower-acuity cases to lower-cost care settings, while collaborating with their Integrated Health Network partners on development of a clinically integrated network that is capable of risk-based contracting.
- HealthPartners and Park Nicollet Health Services have combined to provide access to their care delivery services across the Twin Cities metropolitan area, while maintaining their focus on total-cost-of-care and resource-utilization metrics.
- SSM Health Care's acquisition of Dean Health brings Dean's sophisticated provider-integration and managed-care capabilities into its system, accelerating its transformation into an integrated, value-based healthcare system.

Few doubt that the forces transforming health care today will lead to further consolidation within the industry. The difference is significant, however, between consolidation that seeks only to increase market power and an acquisition and affiliation strategy that seeks partners who can help produce the cost-efficiencies, gains in clinical quality, and access that care purchasers both need and demand. By taking the latter approach, healthcare organizations will be best-positioned to compete in their markets and win market share by offering patients, employers, and other purchasers a superior value proposition.

ABOUT THIS CHAPTER

The findings in this chapter are based on:

- Responses (145 total) to an HFMA survey sent to a random selection of senior financial executive HFMA members in October 2013. Fifty percent of respondents represented stand-alone hospitals, and 50 percent represented systems (20 percent at the system head-quarters level and 30 percent at the system facility level).
- Site visits and interviews with the following hospitals and health systems:
  - AllSpire Health Partners member organizations (Pennsylvania and New Jersey)
  - Dignity Health (multistate, California headquarters)
  - Froedtert Health (Milwaukee metropolitan area)
  - HealthPartners (Minneapolis-St. Paul metropolitan area and western Wisconsin)
  - NewYork – Presbyterian Hospital (New York metropolitan area)
  - North Shore – LIJ Health System (New York metropolitan area)
  - SSM Health Care (Illinois, Missouri, Oklahoma, and Wisconsin)
- Interviews with strategic consultants, finance executives, and legal and regulatory experts

CHAPTER 22

Physician Engagement and Alignment Strategies

"What's wrong with medicine today? You can't make money seeing patients."

This sentiment, expressed during one of the interviews HFMA conducted in researching this chapter, gets to the heart of a profound transformation in the business of health care that is reshaping the role of physicians. Put simply, revenues generated under the traditional fee-for-service model, whether in a physician's office or a hospital operating room, are flat or falling. New payment models are rewarding providers that can keep patients healthy and reduce their need for more expensive healthcare services. More broadly, this transformation is prompting healthcare organizations—health systems and medical groups alike—to ask many questions (some old and some new) about their physician strategies: Should health systems be acquiring physician practices and directly employing physicians? Should medical groups be asking their members to give up some of their independence in favor of team-based care delivery models? How should physician compensation be adjusted to account for factors such as quality and cost efficiency? What is the right blend of primary care and specialty physicians to meet current and future demand? And when is the right time to answer these questions and move forward?

One of the great difficulties in answering these questions is the fact that physicians are practicing in an environment that is part fee-for-service and part something else that falls beneath the broad umbrella of value-based payment and care delivery (e.g., bundled payment, shared savings, population health management). What precisely the "something else" will look like is still taking shape, but the fee-for-service part almost certainly will continue to diminish. Michael Kasper, CEO of the DuPage Medical Group, describes the issue as a question of pacing: "Move too quickly, and you can lose the confidence of your physicians. Move too slowly, and you will be lapped by the competition."

The pace of change and the opportunities available to physicians, health systems, and medical groups differ dramatically from market to market, as was evident in the survey results, site visits, and interviews HFMA conducted for this chapter. It is clear, however, that standing still is not a viable option.

This chapter will focus on how the transition to value affects physician strategy in the following areas:

- Alignment and employment options
- Compensation and incentives
- Financial support of physicians
- Leadership and governance
- Population health management capabilities

PHYSICIAN STRATEGIES: HIGHLIGHTS FROM HFMA'S VALUE PROJECT RESEARCH

Regarding strategies for physician engagement and alignment, a number of themes emerged in our conversations with leaders at the organizations visited during the course of our research.

The gap between what is possible and what is paid for today. The dilemma of "one foot on the dock, one foot in the canoe" is commonly cited in discussions of the transition to value, but it seemed particularly acute in our research on physician strategies. This dilemma is reflected in part in the description of today's ideal physician recruit: one who balances independence and entrepreneurial drive with a willingness to help evolve new team-based models of care delivery.

A continuing focus on multiple approaches to physician alignment. The right alignment model is the product of market dynamics and health system and physician group organizational needs and preferences, and can vary significantly across physician specialties. Moreover, no model guarantees alignment—physician employment, for example, will not bring alignment absent a culture that respects physician input and leadership.

The need to better understand and quantify the contributions and expenses related to physician employment. The continuing use of "loss per physician" as a metric in hospital and health system finance departments can obscure the value that employed physicians bring to the organization and call into question the goals of a physician employment strategy. A clearer understanding, quantification, and description of the relationship between financial support of employed physicians and the contributions they make to the system can provide a more objective view of physician employment and help organizations define and manage to an appropriate and sustainable level of financial support.

The relationship between physician strategy and consumer needs. The consumer marketplace in health care is changing rapidly. A significant focus of physician strategy should be on how consumer needs can best be met by improving convenience and accessibility to physician services. What are the locations and hours of primary care clinics? Are specialists grouped together in ways that can best serve the needs of important patient populations? What investments in physician engagement strategies and tools might be required to support improved physician effectiveness in meeting consumer needs?

The need to achieve scale in the physician enterprise. Greater scale in the physician enterprise is important in many areas. Sufficient scale in the primary care physician network helps to ensure the referrals needed to support specialty services. Greater scale can help spread the costs of physician practice management and support across the enterprise. Scale of the physician network and the patient population it supports is also an important element of population management and access to data on population health.

ALIGNMENT AND EMPLOYMENT OPTIONS

Issues of physician engagement and alignment have been a topic of conversation for many years, but these issues have grown in significance as the demands of healthcare reform and value-based payment intensify the need for a better-coordinated, more cost-effective approach to care delivery.

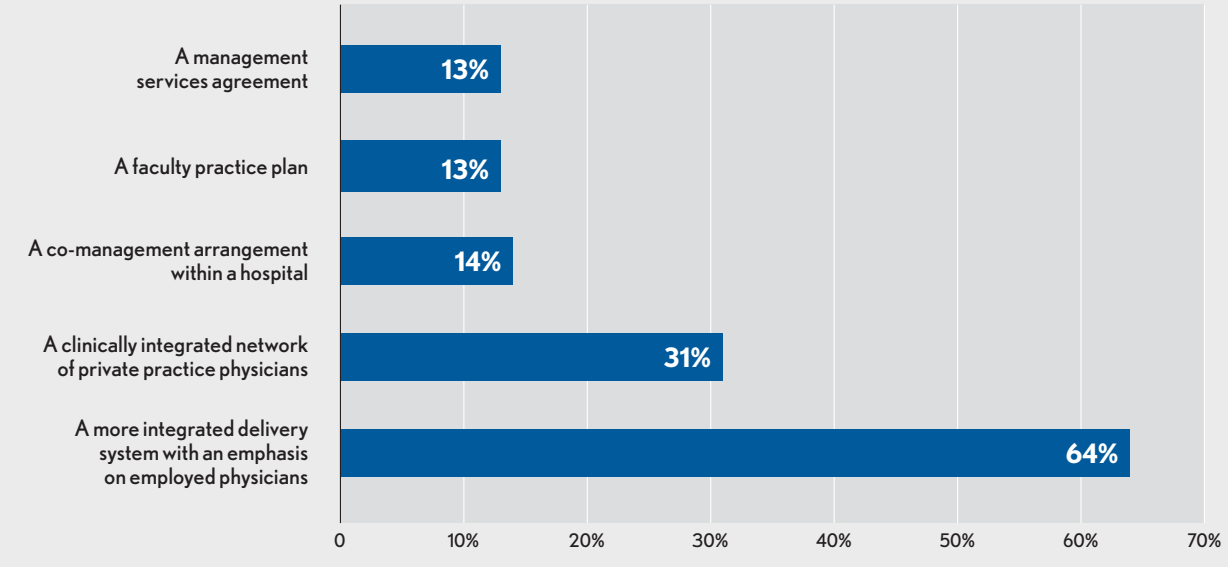
Demands to decrease utilization of specialty and acute care services by focusing on preventive care, to avoid readmissions following inpatient hospitalizations, and to increase the quality and cost efficiency of services across settings can be met only with the close cooperation of clinicians across primary, specialty, inpatient, and post-acute settings. New health plan products for both employer-sponsored insurance and for individuals purchasing health plans in the state and federal exchanges are offering "narrow" or "preferred" networks; their appeal to consumers is driven in part by their ability to offer convenient access to a full range of primary, specialty, and acute care services within the network. Hospitals, health systems, and multi-specialty practices need access to a sufficient referral base to maintain service lines, even as utilization rates for many services are declining. Physicians are facing new economic pressures, from flat or declining payment rates to the need for investments in electronic health records (EHRs) and IT infrastructure.

In response to these new dynamics, individual physicians, independent medical groups, and hospitals and health systems are taking a fresh look at alignment opportunities. From a hospital and health system perspective, direct employment of physicians is back on the agenda. Nearly two-thirds of respondents to an HFMA survey of senior financial executive members indicated that they have been pursuing a more integrated delivery system with an emphasis on employed physicians (see the exhibit below).

Organizations that are pursuing an employment model are trying to avoid mistakes made during the 1990s by ensuring that compensation agreements encourage sustained productivity and by creating forums that give physicians a meaningful voice in organizational decisions that affect clinical practice. They are also trying to be strategic in their

MOST RESPONDENTS REPORT PURSUING A MORE INTEGRATED DELIVERY SYSTEM WITH AN EMPHASIS ON EMPLOYED PHYSICIANS

Which of the following arrangements most closely resembles the model you have been pursuing recently with physicians? Exclude emergency department, pathology, and radiology specialists. Please check all that apply.



Source: HFMA Value Project Survey, March 2014.

approach to physician employment, based on anticipated needs for primary care and specialty services.

At the same time, there is an impression in some markets of a physician "land grab" mentality that may not best serve the interests of either health systems or physicians in the long run. One interviewee noted that there are three primary motivators for physician employment: community need, playing offense, or playing defense. Community need is, of course, the soundest basis for a physician employment strategy, but competitive forces require organizations to play offense or defense in many markets.

From a hospital or health system perspective, physician employment offers the tightest alignment model but may not always be the best strategic option. Accordingly, alternative alignment options—including co-management agreements, management services agreements, and clinically integrated networks of independent physicians—are also being pursued. A critical factor in the success of these options is the ability to identify sufficient economic linkages between the parties to ensure that everyone involved is pursuing the same objectives. Technology is becoming an increasingly significant factor in these alternative arrangements as well, as parties combine to pursue risk-based contracting that requires sophisticated tracking and understanding of patient data across settings of care.

Physician alignment is, of course, a two-way street. From the physician's point of view, a decision on whether to seek employment at a hospital or health system (either through direct employment or employment by a system-owned medical group), join an independent medical group, or pursue other alignment opportunities involves careful consideration of personal and professional goals. Although health systems and independent medical groups have many similar goals, they are not always the same (see the sidebar below). Some options may offer greater independence, others greater financial and administrative support. This chapter aims to account for both organizational and individual physician perspectives in discussing employment and alignment options.

A COMPARISON OF PERSPECTIVES

Health System Goals

- Growing/sustaining the primary care base
- Right-sized specialists
- Team-based culture
- Evidence-based practices
- Shifting from fee-for-service to value-based payments as a group
- Reaching a sustainable benefit/cost ratio over time

Medical Group Goals

- Maintaining/enhancing quality of care
- Meeting/exceeding physician financial goals
- Maintaining/enhancing quality of practice
- Maintaining/enhancing physician practice governance and management
- Reducing unproductive costs and efforts

Source: HFMA Physician Strategies Toolkit, hfma.org/valuephysiciantoolkit.

PHYSICIAN EMPLOYMENT

There has been a clear trend toward physician employment in recent years, although there is significant variation in employment trends across specialties and by physician age and gender. A 2012 survey of physicians by the American Medical Association (AMA) found that "while there has been a shift toward hospital employment, 53.2 percent of physicians were self-employed and a full 60 percent worked in practices that were wholly owned by physicians."[41] Looking at single-specialty groups, the AMA survey found that over 45 percent of internal medicine single-specialty groups had at least some hospital ownership, compared with less than 8 percent of surgical subspecialty, radiology, and anesthesiology groups. Of physicians younger than 40, 43.3 percent had an ownership stake in a practice, compared with 60 percent of physicians ages 55 and up. Less than 39 percent of female physicians had an ownership stake, compared with just under 60 percent of male physicians.

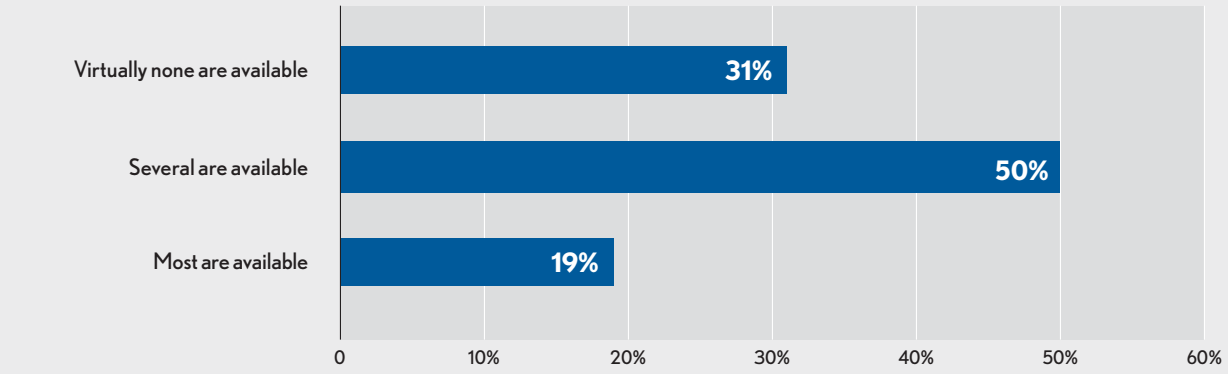
Data from HFMA's 2014 survey of senior financial executives also found wide variation among markets in the availability of physician practices for acquisition or alignment. While 50 percent of the respondents indicated that several independent practices or medical groups remained available in their markets, nearly a third indicated that "virtually none" were available; less than 20 percent indicated that "most are available" (see the exhibit on page 204).

With respect to the current mix of employed and non-employed physicians, the HFMA survey respondents indicated a wide range of situations. Just under a third of the respondents indicated that most (i.e., more than 75 percent) of their physicians are employed. At the other end of the

[41] Kane, C.K., and Emmons, D.W., *Policy Perspective: New Data on Physician Practice Arrangements: Private Practice Remains Strong Despite Shifts Toward Hospital Employment*, American Medical Association, 2013.

AVAILABILITY OF INDEPENDENT PHYSICIAN PRACTICES/GROUPS FOR ACQUISITION OR ALIGNMENT

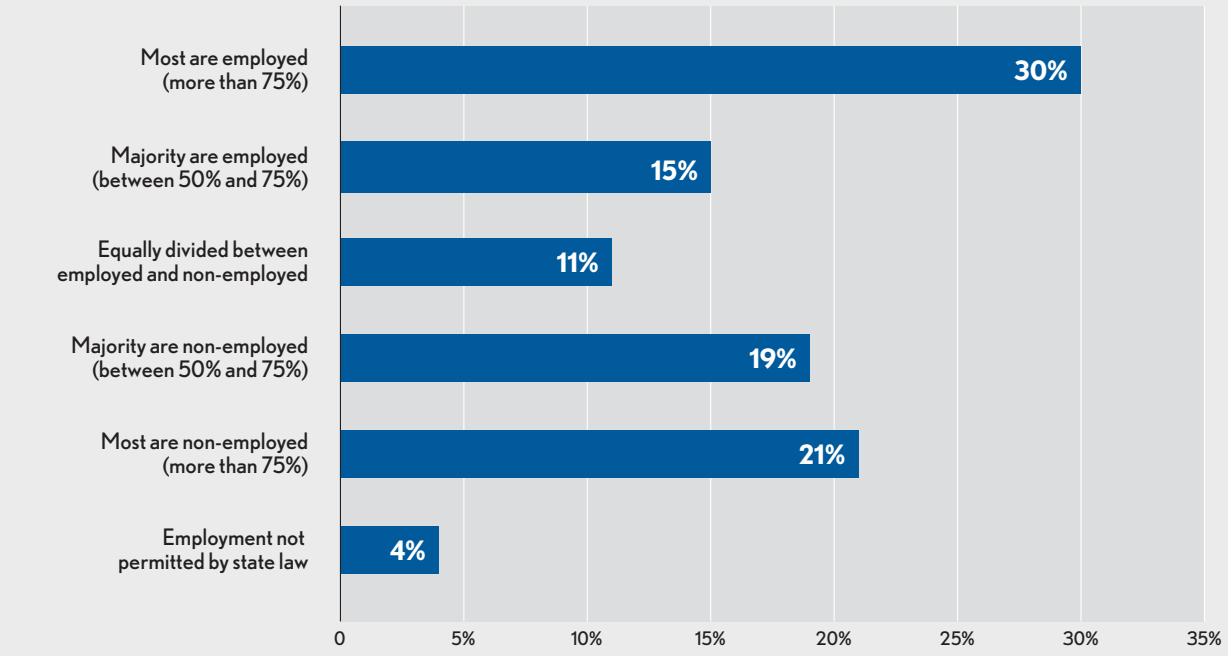
Please describe the extent to which independent physicians or medical groups are available within your community for acquisition or alignment.



Source: HFMA Value Project Survey, March 2014.

MIX OF EMPLOYED AND NON-EMPLOYED PHYSICIANS IN HOSPITAL AND HEALTH SYSTEM NETWORKS

Which of the following options most closely approximates the composition of your network, in terms of the mix of employed and non-employed physicians?



Source: HFMA Value Project Survey, March 2014.

scale, a little more than 20 percent of the respondents indicated that most (again, more than 75 percent) are non-employed (see the exhibit on page 204).

Almost 80 percent of the HFMA survey respondents are looking to expand primary care, while just over 40 percent are looking to expand specialty services (see the exhibit top of page 206). More than 50 percent of smaller (i.e., fewer than 200 beds) and stand-alone facilities are interested in expanding specialty services, but fewer than a third of multihospital systems and larger facilities (more than 1,000 beds) wish to do so. Indeed, about a third of multihospital systems and larger facilities are seeking to reduce or control utilization of specialty services; virtually no smaller facilities or stand-alone facilities are seeking to do so. Orthopedics is the specialty that organizations are most likely to seek to expand (chosen by 60 percent of respondents), followed by cardiology (48 percent), oncology (41 percent), and neurology (34 percent). Neonatology ranked lowest, at 7 percent.

Matt Ullum of Healthcare Strategy Group, a Louisville, Ky.-based consulting group focused on physician alignment strategy, confirms that primary care is the biggest focus among clients as they work to lay the foundations of population health management. "We're also seeing fewer management services organizations and professional services agreements and more employment and co-management agreements, particularly for such specialties as orthopedics and general surgery, but the emphasis is clearly on primary care and employment," Ullum says.

Most of the hospitals and health systems interviewed have traditionally been conservative in their approach to physician employment, but have expanded the number of physicians they employ in recent years. At the Denver-based HealthONE healthcare system, part of HCA's Continental Division, a disciplined approach to physician employment has its roots in the fact that "physician investment is expensive," according to a hospital finance executive. "As a for-profit company with accountability to shareholders, this is an issue of key concern." Another HealthONE leader noted that although employment might create a stronger economic bond between hospital and physician, "it is not equivalent to alignment." Part of HealthONE's physician employment strategy is driven by market dynamics.

Michelle Conger, chief strategy officer for Peoria, Ill.-based OSF HealthCare, notes that "The focus of OSF right now is development of the primary care physician base in all of its markets, combined with a strategy to partner with particular specialties." Dan Baker, OSF HealthCare CFO, dates employment of physicians, beginning with primary care, back to the 1990s, but adds, "OSF has not traditionally placed a heavy emphasis on employment of specialty physicians. The physicians we do employ have typically had a relationship with OSF for a number of years." As OSF HealthCare has begun to develop accountable care organizations (ACOs)—it is participating in Medicare's Pioneer ACO program—Illinois state insurance law,

LESSONS LEARNED FROM PHYSICIAN EMPLOYMENT

Respondents to HFMA's member survey on physician strategies were asked to share their experiences with physician employment. The most important—and frequently cited—lessons were the following.

Employment does not equal alignment. Physician employment is not a shortcut around the hard work and investments of time and resources required of both health systems and their physicians to align themselves around common organizational goals.

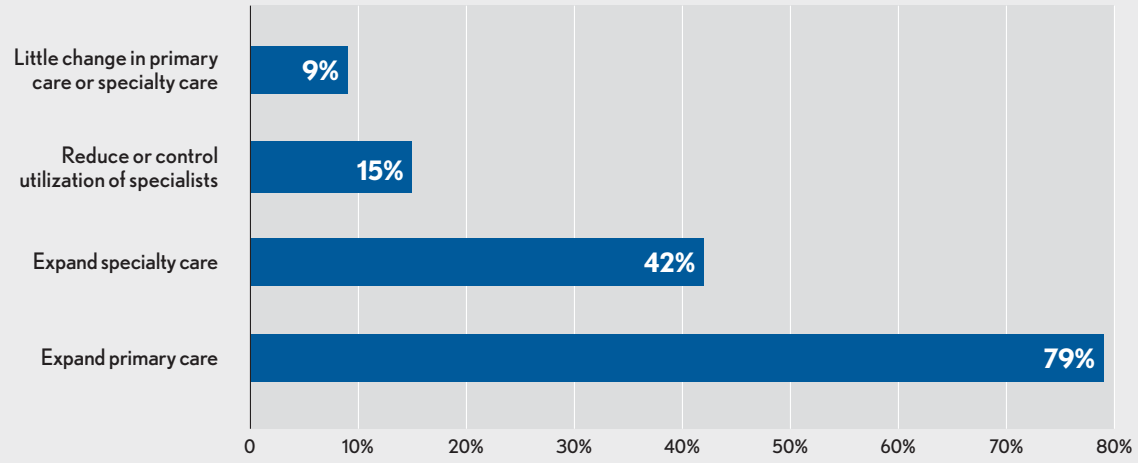
Clear and consistent communication on expectations is critical. "It is extremely important to set expectations from the beginning and then follow up on a regular basis," says one respondent. Another notes, "Standard business practices should be developed prior to any practice acquisitions or employment strategy" to ensure expectations are clear.

Know your organization's needs and have a strategy in place before you start. "It is far better to determine needs, identify positive attributes, and recruit physicians than to simply employ any physician who shows up at your door," a respondent says.

Consider employment needs beyond physicians. If acquiring a practice, consider who beyond the physicians has been important to the practice's success: "It is a good idea to evaluate the staff to determine who else should be included in the employment," according to a survey respondent.

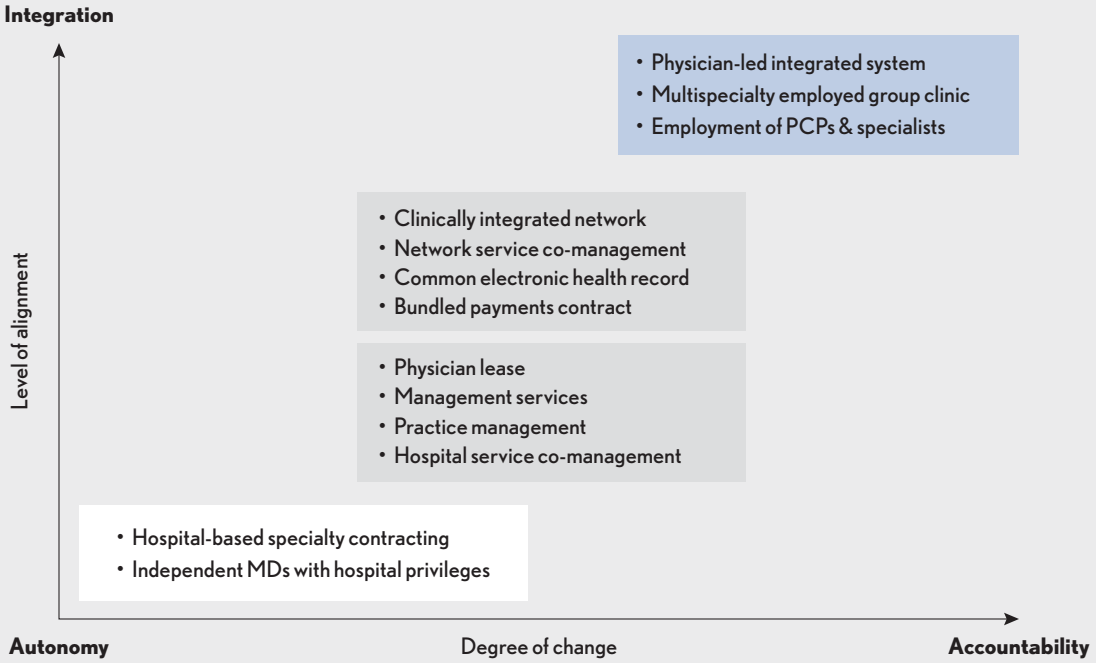
STRATEGY REGARDING PRIMARY CARE AND SPECIALTY PHYSICIANS

Looking forward over the next three years, which of the following best describes your organization's physician affiliation strategy, in terms of emphasis on primary care versus specialty services? Please check all that apply.



Source: HFMA Value Project Survey, March 2014.

PHYSICIAN/HEALTH SYSTEM ALIGNMENT OPTIONS TO BALANCE AUTONOMY, INTEGRATION, AND ACCOUNTABILITY



Source: HFMA Physician Strategies Toolkit, hfma.org/valuephysiciantoolkit.

which prohibits the system from having full-risk contracts with non-employed physicians, has also created incentives to pursue an employment strategy.

At Floyd Memorial Hospital and Health Services, based in New Albany, Ind. (part of the Louisville metropolitan area), growth in physician employment initially was fueled by physician interest. "In 2008, what is now Floyd Memorial Medical Group agreed to employ a group of four primary care physicians who were running a deficit but were important to the hospital," says Joy Whistine, vice president of physician services at Floyd Memorial Hospital and Health Services. "Although we were not intent on employing physicians, other community physicians came forward to inquire about employment possibilities." Floyd Memorial Medical Group has since developed a board-approved structure for assessing practices and determining return value and opportunity for the medical group and hospital, and has implemented standard guidelines for proposing growth in physician employment to the board.

As HFMA's interviews with these organizations suggest, the increase in physician employment by hospitals and health systems is the product of several factors. Systems that are actively pursuing or already engaged in risk-based contracting see a need to build their base of primary care physicians to better manage the health of their patient populations. Competition for physicians with other health systems can trigger an offense/defense dynamic in a local market. And physicians are increasingly seeing employment by a hospital or health system as a means of gaining the administrative and financial support needed to run a practice today.

Leaders at HealthONE, for example, identified their ability to alleviate the burden of managing a physician practice as a key factor in physicians' decisions to become system employees. As part of HCA, HealthONE uses HCA Physician Services (HCAPS) to manage and support its employed physicians and their practices. HCAPS offers operational and administrative management of the practices, employment of office staff, financial services (including credentialing, billing, and collections), and human resources.

Large, independent multispecialty practices offer an alternative to employment by a hospital or health system. DuPage Medical Group, a multispecialty group of approximately 425 primary care and specialty physicians in west-suburban Chicago, notes that newly hired physicians are typically on a two-year track to shareholder status in the group. Most of the group's physicians are thus both shareholders and employees. DuPage Medical Group is 100 percent physician-owned, with a 10-member governing board that includes five primary care and five specialty physicians. Michael Kasper, CEO of the medical group, sees the physician ownership component as a critical distinction between DuPage Medical Group and hospital employment, enabling physicians to maintain a sense of independence that sometimes comes under strain in a

COMPARING CLINICAL INTEGRATION AND ACCOUNTABLE CARE

Although clinically integrated networks (CINs) and accountable care organizations (ACOs) both seek to improve healthcare quality and efficiency, there are some significant differences between the two.

CINs

- Typically organized by a hospital or health system, which takes on the expense of developing infrastructure for the CIN
- Allow joint contracting with commercial health plans
- First developed in the 1990s; created and operated pursuant to guidance by federal antitrust agencies issued in 1996

ACOs

- May be organized by a hospital, physician group, or integrated delivery system
- May have payment relationships with both government and private payers (public ACO programs include the Medicare Shared Savings Program [MSSP] and the Pioneer ACO program)
- Are rewarded for success in improving quality and efficiency for an attributed population
- Federal antitrust authorities have defined "safe harbors" for ACOs formed pursuant to the MSSP

hospital employment situation. At the same time, DMG employs a management team that alleviates the burdens of practice management that a physician would experience in a solo or small practice setting.

OTHER ALIGNMENT OPTIONS

Despite the trend toward employment, many physicians and medical groups still prefer to remain independent. Possibilities in these cases range from clinically integrated networks (CINs) designed to offer a comprehensive range of medical services to co-management agreements focused on quality and cost-efficiency improvements in a select set of procedures or a specific service line.

CINs and ACOs. These arrangements are both designed to improve the efficiency and quality of health care. Although they share similar goals, there are important distinctions between the two.

CINs are typically organized by a hospital or health system and bring both independent and employed physicians together into an integrated network designed to improve the quality and efficiency of healthcare services. A 1996 statement from the federal antitrust enforcement agencies—the Federal Trade Commission (FTC) and Department of Justice (DOJ)—allowed parties to a CIN to jointly contract with payers, provided that:

- The CIN features clinical integration involving authentic initiatives that require the active participation of all network participants in an ongoing program to evaluate and modify practice patterns
- The program is designed to achieve likely improvements in healthcare quality and efficiency
- Joint contracting with a health plan is reasonably necessary to achieve the efficiencies of the clinical integration program

Contracts with the CIN will typically involve some form of value-based incentive (e.g., pay for performance, shared savings) that rewards the network for success in achieving its efficiency goals.

CINs first appeared in the 1990s and thus predate ACOs by about two decades. Clinical integration is a necessity for an ACO, but a CIN does not have to become an ACO. There are both "public" and "private" forms of ACOs. Public ACOs include those formed pursuant to provisions in the Affordable Care Act (ACA) that authorized the Medicare Shared Savings Program (MSSP) and the Center for Medicare & Medicaid Innovation's Pioneer ACO Program. On the private side, many commercial health plans are working with physicians, hospitals, and other providers to form ACOs. There is significant overlap between the two; an ACO that was formed to participate in the MSSP may also seek a commercial ACO contract with a health plan, for example.

A key distinction between ACOs and CINs is that ACOs are closer to a population management model in that they are designed to improve the quality and reduce the cost of care for an *attributed population*. They are typically rewarded with a share of the savings if they can reduce the cost of care

ACOs TAKE MANY FORMS

Drawing on a database of more than 600 accountable care organizations (ACOs), Salt Lake City-based healthcare intelligence firm Leavitt Partners has developed a taxonomy that outlines six different types of ACOs.

Full-spectrum integrated ACOs. Directly provide all aspects of health care to their patients and are often dominated by a large integrated delivery network (although other providers may be included)

Independent physician group ACOs. Owned by a single physician group and do not contract with other providers to offer additional services

Physician group alliance ACOs. May have multiple physician group owners (often including multispecialty groups), but do not contract with other providers to offer additional services

Expanded physician group ACOs: Regardless of the number of owners, these ACOs directly offer outpatient services only but contract with other providers to offer hospital or subspecialty services

Independent hospital ACOs: Have a single owner that directly provides inpatient services; outpatient services may also be provided directly by the ACO if the owner is an integrated health system, or they may be offered by a contracted provider

Hospital alliance ACOs: Have multiple owners, with at least one of the owners directly providing inpatient services

Source: Muhlestein, D., et al., *A Taxonomy of Accountable Care Organizations: Different Approaches to Achieve the Triple Aim*. Leavitt Partners, 2014.

for the attributed population below a historical benchmark while maintaining or improving the quality of outcomes for that population. Depending on the payment model, they might also be asked to share in the loss if costs of care exceed the historical benchmark.

To promote the formation of ACOs and the required collaboration among providers, the FTC and DOJ have created "safe harbors" from antitrust scrutiny for ACOs that fall below defined market share percentage thresholds.[42] The ACA authorized waivers of fraud and abuse laws to permit funding of an ACO's development (e.g., investment in a shared IT platform), distribution of shared savings among ACO participants, and the provision of nonmonetary preventive items or services (e.g., heart-rate monitors) to Medicare beneficiaries.

With respect to independent physician practices, both CINs and ACOs give hospitals and health systems a means of tightening their alignment with these practices while avoiding some of the potential financial costs of full employment. As the organizer of a CIN, the hospital or health system will still face significant costs to develop the necessary infrastructure for the network, including a common IT platform and care managers. Physicians in the market also have to be ready to integrate, which will typically include acceptance of quality metrics and care protocols designed to improve quality and efficiency.

Co-management agreements. These offer a means for hospitals to align with specialty practices that wish to remain independent. They are typically structured around a service line, such as orthopedics, with physicians receiving a base fee for managing the service line plus incentives if specified quality or operational targets are achieved.

To better align with independent physicians, OSF HealthCare has developed "accountable clinical management" models (ACMs), a twist on the classic co-management agreements that, in the system's experience, typically had a lifespan of three to five years. The ACMs have a formalized, physician-led governance structure focused on operational efficiency and clinical outcomes. Agendas and metrics are established in advance, and physicians receive training on the importance of the operational and clinical metrics that are being pursued. Predefined bonuses, tied to outcomes and fair-market-value parameters, are available to physicians who achieve their metrics. If metrics are not being met, system representatives and physicians hold in-depth conversations about the work needed to meet the metrics. Kathleen Forbes, MD, chief clinical officer for OSF HealthCare, notes that "the structure and training that bring physicians into the ACM's governance structure provide more 'glue' than with traditional co-management agreements."

Management service agreements. A precondition for a hospital or health system interested in pursuing management service agreements with physician practices is a proven track record in effectively managing practices. In this respect, large multispecialty medical groups focused on physician practice management may have an advantage over hospitals and health systems. For example, DuPage Medical Group has formed Midwest Physician Administrative Services as part of its revenue diversification efforts. The new entity provides back-office and billing and collection support to hospital-owned medical groups.

[42] An accountable care organization (ACO) falls within a "safe harbor" if independent ACO participants that provide the same service (a "common service") have a combined share of 30 percent or less of each common service in each participant's primary service area, wherever two or more of the ACO participants provide that service to patients from that primary service area. The statement by the Federal Trade Commission and Department of Justice also offers guidance for ACOs outside the safe harbor, including a summary of conduct to avoid and a process for expedited antitrust review of a proposed ACO ("Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program," *Federal Register*, Oct. 28, 2011.

COMPENSATION AND INCENTIVES

Physician compensation and incentives are at a crossroads. Although fee-for-service payment remains the dominant means by which most providers in most markets are paid, new value-based payment methodologies that reward quality and cost efficiency are gaining traction. Compensation and incentives remain subject to federal and state fraud and abuse laws that are premised on a volume-based market for healthcare services, even as the industry increasingly focuses on population management and improved care coordination to reduce utilization of high-cost specialty and acute-care services. Physicians want some sense of certainty regarding what their income will be, even as the system asks them—or their hospital employers—to assume greater risk.

Given the uneven pace of transition across markets, the organizations HFMA interviewed are at different places in their approaches to physician compensation and incentives. But they shared common issues and concerns:

- Productivity is and for the foreseeable future will remain part of compensation for employed physicians.
- Quality and efficiency metrics will be increasingly important. The challenge will be defining metrics that are sufficiently valid to support decisions affecting physician incomes.
- Efforts to develop team-based approaches to care may require compensation and incentives tied to organizational as well as individual goals.
- Financial incentives are not sufficient to ensure physician commitment to changes in practice patterns and care delivery.

Although this discussion will not go into detail on the Stark and related fraud and abuse laws that affect physician compensation and incentives, basic guidelines under the existing legal and regulatory framework require that, in all circumstances, volume or value of referrals should not be considered when developing a compensation and incentive framework.

PRODUCTIVITY

Physician productivity is a concern in any practice setting, but it is of particular importance to hospitals and health systems that are bringing formerly independent physicians into an employed setting. HFMA's survey of senior financial executive members in a hospital or health system setting found that a strong majority (85 percent) reported slight to substantial decreases in productivity when physicians moved into an employed setting; only 5 percent indicated that productivity improved, while 10 percent reported that productivity stayed the same (see the exhibit on page 211).

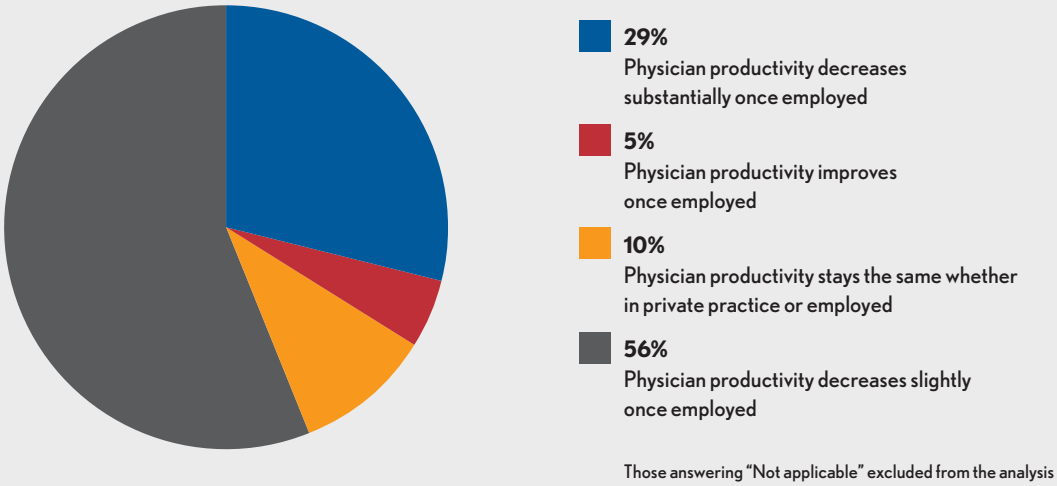
Productivity changes are by no means inevitable, however. Due diligence in negotiations leading to employment can establish benchmarks that promote sustained levels of productivity in an employed setting.

"Before employing a physician, Floyd Memorial Medical Group requests a three-year look back at the physician's billing records as well as his or her tax and income records," says Whistine, the vice president of physician services for Floyd Memorial Hospital and Health Services. "The average over this three-year history is then benchmarked against Floyd Memorial Medical Group's current experience with employed physicians in the same specialty to determine if the physician prospect meets the group's expectations. Base compensation plus the productivity incentive for the newly employed physician are then structured on the premise that compensation should match productivity (determined by work relative value units [RVUs]). If, for example, expected productivity for the employed physician is in the 73rd percentile, the physician will earn in the 73rd percentile of salary (based on Medical Group Management Association [MGMA] medians and other sources) if he or she achieves expected productivity levels." Only eight of 80 physicians who have been employed by the medical group experienced decreases in productivity, and they are no longer with the group.

For most specialties, HealthONE provides physicians with a productivity-based compensation plan along with a base-income guarantee for the first year. HealthONE also uses MGMA data to benchmark its physicians' productivity, establishing a threshold benchmark at a certain percentage of the MGMA scale that physicians are expected to achieve. Practice managers regularly review reports to see how their physicians are performing relative to the benchmark

CHANGES IN PRODUCTIVITY FOLLOWING PHYSICIAN EMPLOYMENT

What has been your experience, in terms of productivity, when physicians move from private practice to hospital or health system employment?



Source: HFMA Value Project Survey, 2014.

threshold and meet on a quarterly basis with physicians who are falling below the threshold.

The organizations interviewed strongly favor RVU-based productivity measures over compensation agreements linked to percentage of revenue. "I don't believe that it is fair to use a system based on charges or revenue," Whistine says. "Charges are meaningless and collection of revenue is not in the physician's control."

VALUE-BASED COMPENSATION INCENTIVES

Both OSF HealthCare and DuPage Medical Group have significant percentages of revenue tied to risk-based contracts: OSF HealthCare participates in the Pioneer ACO Program and DuPage Medical Group is a co-founder (with Edward Hospital and Health Services) of Illinois Health Partners, which has a commercial ACO arrangement with Blue Cross and Blue Shield of Illinois and, as of January 2014, became a participant in an MSSP ACO. Although both systems still use productivity as a significant factor in their compensation agreements, they have added incentives tied to quality, cost efficiency, and patient satisfaction to their physician compensation contracts.

Two years ago, OSF HealthCare began moving toward what it describes as a "transitional" compensation model, with 80 percent of compensation tied to productivity and 20 percent tied to incentive metrics. Incentive metrics are divided into four categories: access, quality, resource utilization, and system performance. Physicians under the transitional compensation model—currently about 40 percent of the system's employed physicians—will typically have metrics in all four categories, each worth 5 percent of their compensation. The system has also aligned physician incentives with team financial awards for staff in the physician offices to ensure that everyone in the office is aligned to drive desired outcomes.

The most significant issue OSF HealthCare has faced with its new model is complexity. "There are many metrics involved, and ensuring that they are all meaningful, accurate, and valid (especially from the perspective of the physicians), is a challenge," says Chuck Dennis, MD, vice president of the OSF Medical Group, Central Region. "Appropriate measures may not be readily available for all specialties. Also, as we move toward more team-based care delivery models, it can be difficult to attribute outcomes to any one physician. A big part of gaining physician acceptance of the new model is communication. We need to connect the dots with a simple message so physicians understand how the terms of their compensation agreements tie back to the key value equation factors of quality, patient experience, and cost."

The compensation model has been developed with the oversight of a physician compensation committee that includes four administration appointees and six physicians selected by the system's executive team based on their expertise and interest. Other individuals are brought in as needed—by specialty, for example—to help identify appropriate metrics. The physician compensation committee will be reviewing the new compensation model over the coming year and hopes to reduce the number of metrics involved. The system also is interested in adding a bonus component tied to the system's success in meeting its overall goals.

About 15 percent of physician compensation for primary care physicians at DuPage Medical Group is outside of productivity (the percentage is slightly lower for specialists). This percentage is tied to quality metrics, including team and organizational goals as well as individual goals hinging on factors such as utilization of generics or measures of asthma or diabetes control. Some efficiency dollars also are at stake in the care of professionally capitated lives among DuPage Medical Group's patient population.

KEY CONSIDERATIONS FOR PHYSICIAN COMPENSATION PLANS

John Hill, a partner in Healthcare Strategy Group, recommends these five key steps when building or changing physician compensation plans:

- Create mechanisms to engage and encourage physician leadership
- Incorporate quality metrics
- Build flexibility to allow for gradual increases in the amount of compensation tied to quality
- Refocus incentives to include group pools or team goals
- Understand the legal parameters of structuring these plans

Although payers in Floyd Memorial Hospital's market have not moved significantly toward value-based payment, the hospital and medical group are actively laying the groundwork for such a payment and care delivery system. They have begun to implement care management to reduce readmissions and recently assembled an employed hospitalist

ESSENTIAL ELEMENTS OF A HIGH-PERFORMING PHYSICIAN NETWORK

Source: Hill, J., and Ullum, M., *67 Tips for Developing a High-Performing Physician Network*, Healthcare Strategy Group, 2014. Available at www.healthcarestrategygroup.com/client-services/network-management-division/

group that has already produced significant drops in length of stay. Floyd Memorial Medical Group is also participating in the Physician Quality Reporting System with the Centers for Medicare & Medicaid Services. Up to 15 percent of compensation for physicians in the medical group is at risk based on performance against a set of quality and other performance indicators. All physicians are held to three standard indicators: patient satisfaction at the 75th percentile or higher, medical record auditing (85 percent or better in coding and documentation accuracy), and submission of complete charge reports and documentation within five days of service. Physicians are also held to two specialty-specific indicators, which may include diabetes control or Healthcare Effectiveness Data and Information Set measures for primary care physicians or on-time status or infection rates for surgeons (Daniel Eichenberger, MD, CMO for Floyd Memorial Hospital, notes that there can be difficulties in getting meaningful, respectable metrics for certain specialties).

ADDITIONAL COMPENSATION CONSIDERATIONS

Although compensation is important, it can be a blunt tool in efforts to drive change in behavior or performance. "Systems won't get physician engagement through financial incentives alone," says Steven Norris, MD, OSF Medical Group regional director, Peoria Primary Care, at OSF HealthCare. "Providers will just learn to play the game well. Instead, you need physician buy-in to your goals and strategy. Once you have that, you don't need to do much to encourage support."

Ullum, of Healthcare Strategy Group, agrees. "Aligned compensation is just one of many factors that help to create a high-performing physician network," he says. "Equally important are a coherent physician strategy, a common culture guided by a shared vision and behavioral norms, a continual focus on process improvement and outcomes, a strong brand identity for the group, physician leadership and governance that understands the need for change and guides physician behavior, an adequate investment in IT and other supporting infrastructure, and ensuring the financial stability of physician practices."

FINANCIAL SUPPORT AND SUSTAINABILITY

The costs of employing physicians go well beyond compensation. The costs of managing an acquired practice, paying salary and benefits for the practice's staff (often at a higher level as part of the hospital compensation plan than when the practice was independent), upgrading IT systems, paying for malpractice insurance, and other expenses add significantly to the financial impact of employment.

On the revenue side, ancillary revenues are often shifted from the practice to the hospital or health system, depriving the practice's business side of an important revenue stream on the ledger sheet. Employed physicians also shift from being essentially a small-business owner in an independent practice to a salaried employee of a large organization. As a result, systems will typically report financial support (often expressed as "loss per physician" on the hospital side or "investment per physician" on the practice management side) well in excess of $100,000 per physician, with potentially significant variations by specialty. Not surprisingly, a survey of HFMA senior financial executive members found that fewer than 25 percent expected to see a positive ROI from physician employment during the first two years of employment (see the exhibit below).

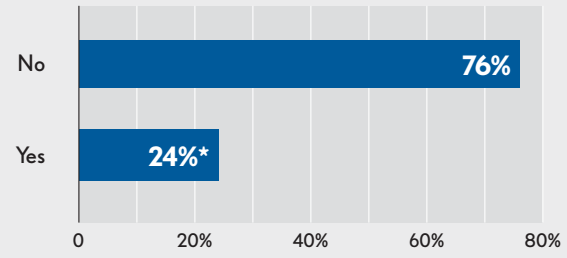
Financial support of physicians is not a fixed cost: Hospitals and health systems can adopt a number of strategies to reduce this figure significantly. A first step, says Ullum of Healthcare Strategy Group, is a focused effort on measurement and benchmarking of practice performance. "Working with the physicians, you need to define the key measures for the practice and manage them relentlessly," Ullum says. "If you are not measuring it, there will be no improvement. Benchmarking practices is also essential, as is close analysis of those that are not performing. For nonperforming practices, it is helpful to bring in an independent resource—whether another manager or a consultant—to help guide the improvement plan." Floyd Memorial Hospital had initially outsourced its practice management, but upon realizing its physician losses were reaching unsustainable levels, it hired an experienced practice manager and brought the function in-house in 2009. It has since reduced those losses by more than 50 percent and is currently holding them below budget.

Physicians also need to be held accountable for costs; they make decisions regarding staff resources, equipment, and supplies that have a major impact on a practice's financial performance. "Cost efficiencies can be created in the back office, but the local decisions that drive RVUs lie in the physicians' offices," says DuPage Medical Group CFO Michael Pacetti. The group computes costs at the organizational and departmental levels, as well as profit-and-loss per physician. Some costs are deemed general, and are spread across the physicians in the group, while others are deemed local. Local costs are those within the control of the individual physician or practice, and those for which the physicians are held accountable.

Most DuPage Medical Group physicians are, of course, shareholders as well as employees of the group, which provides added incentive to carefully manage costs. But effective cost management also will be a critical capability for hospitals and health systems as exposure to risk-based contracts grows, and as noted in the previous section, several of the systems interviewed are considering or actively implementing metrics tied to resource utilization in their physician compensation agreements. It is important for hospital administrators to work closely with physicians in defining appropriate resource utilization measures to help ensure that cost management decisions do not negatively affect the quality of patient care and to secure physician acceptance of the measures.

ROI EXPECTATION FOR PHYSICIAN EMPLOYMENT

Do you believe your organization will achieve a positive ROI after two years of physician employment?



* Further breakdown shows 21% of hospitals with >100 beds; 29% of hospitals with 500+ beds

Source: HFMA Executive Survey on Hospital and Physician Affiliation Strategies, 2013.

A smooth onboarding and credentialing process for newly hired physicians is also critical. "Many hospital executives don't understand this issue," Ullum says. "If the providers are not credentialed, you cannot collect from payers and face months of losses and cash flow challenges. Start the credentialing process the day you agree to hire the physician. No exceptions!"

Mary Passantino, development director for HealthONE Physician Care, agrees. "HealthONE's hospital CEOs are responsible for determining what recruiting efforts are necessary, but once they have identified a potential recruit, leaders from our team quickly get involved," she says. "The process from recruitment to onboarding takes from three to six months, and we have outlined a six-step process that takes the recruit through contractual terms, payer and hospital credentialing, state licensing (if needed), benefit changes, and human resources policies that will take effect upon employment."

Other factors that can help reduce physician financial support include the following.

Balancing employed specialists with an adequate primary care network. As health systems engage in more value-based contracting that seeks to reduce utilization of higher-cost specialist and acute care services, this balance should be regularly reviewed. Expansion of primary care practices and the patient panels they manage may be necessary to adequately support the system's specialists.

Investing in a physician practice-focused revenue cycle. There are significant differences between hospital and physician practice revenue cycles. Hiring the expertise and implementing the systems needed to manage physician practice revenue cycles is typically worth the investment.

Managing for economies of scale as the number of employed physicians grows. An OSF HealthCare cost containment initiative had an $8 million cost reduction goal for the physician enterprise, $5.5 million of which "came from efficiencies captured by capitalizing on the scale of the physician enterprise," says Mark Nafziger, chief administrative officer for OSF Medical Group.

RECOGNIZING VALUE

The health system's finance department should fully account for the value that employed physicians bring to the system. It is worth spending some time thinking about how financial support is described to the board and in conversations with employed physicians. "Loss per

ONBOARDING AN INDEPENDENT PHYSICIAN PRACTICE

Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Medical director and practice manager interviews	Preliminary collection of data	Offer extended with draft agreement; decision must be made within 10 days of offer.	Start date 90 days after executed agreement	Pre-employment screening (three weeks prior to start date)	Health benefits start on day 31 of employment—attend HR orientation
Confidentiality agreement	Pro forma preparation and analysis	Colorado license application—can take 90 days	FMV of assets if required	Payer and hospital credentialing (60 to 90 days)	One- and three-month review with practice manager, medical director, and hospital
		Collection of data (external FMV takes 60 days)			
		Employment Agreement Finalization			

Operational Planning (ongoing through the process)

FMV: Fair-market value analysis.

Source: HealthONE/HCA Continental Division. Available in the HFMA Physician Strategies Toolkit at hfma.org/valuephysiciantoolkit.

COMPENSATION AND FINANCIAL SUPPORT FOR HOSPITALISTS

The specialty of hospital medicine has grown dramatically in recent years as hospitals seek to better coordinate patient care within acute settings and ease transitions of care into and out of the hospital. Data published by the Society of Hospital Medicine (SHM) offer a glimpse into how compensation is changing for this specialty—representative of changes happening across specialties—as well as considerations regarding the financial support of physicians.

HOSPITALIST COMPENSATION

Median hospitalist compensation for 2014 is categorized by adult programs, pediatric programs, and academic programs. For both adult and pediatric program hospitalists, just over 80 percent of compensation is base pay (83 percent for adult programs and 84 percent for pediatric). The remaining percentage is incentive pay, with incentives divided between productivity (approximately two-thirds of incentive pay) and performance (approximately a third of incentive pay). In academic programs, the percentage of base pay is higher, as time spent on patient care is balanced with research and teaching activities.

Several factors are used by hospitalist groups to determine the performance portion of incentive pay. Patient satisfaction is the factor used by the highest percentage of groups with adult programs (79 percent, up from 71 percent in 2012), while good citizenship is the most commonly used factor in pediatric programs (80 percent). Core-measure performance is the second most commonly used factor for both adult and pediatric programs (74 percent of adult programs, 67 percent of pediatric). Both adult and pediatric programs are seeing rapid growth in the use of readmission rates as a factor in performance incentives. In 2014, 46 percent of adult programs and 40 percent of pediatric programs included readmission rates as a factor, up from 30 percent and 18 percent, respectively, in 2012.

FINANCIAL SUPPORT OF HOSPITALIST GROUPS

Median financial support in 2014 was $156,000 per full-time physician in an adult hospitalist program and $106,000 per full-time physician in a pediatric program. Ninety-four percent of adult programs and 87 percent of pediatric programs ran at a deficit.

Joe Miller, senior vice president and chief solutions officer for SHM, identified several factors contributing to the need for financial support of hospitalist groups:

- Many hospitalist groups (57 percent in 2014, up from 44 percent in 2012) are providing 24-7 services, including coverage for overnight admissions.
- Hospitalists are leading hospital initiatives on cost savings, readmission reductions, and quality.
- Additional roles for hospitalists that are not tied to additional patient revenue keep expanding. "Code blue" responsibilities are assumed by 42 percent of hospitalist groups, up from 31 percent in 2012; rapid-response team responsibilities are assumed by 45 percent of groups, also up from 31 percent in 2012; 90 percent of groups are involved in surgical or medical co-management of patients; and 25 percent take on responsibility for seeing patients in skilled nursing facilities and rehabilitation centers following hospital discharge.

As noted in this chapter's discussion of physician financial support, the value of the many roles assumed by hospitalists must be balanced against financial support to understand the true return on investment for the specialty.

Source: Society of Hospital Medicine, *2014 State of Hospital Medicine Report*. Available at www.hospitalmedicine.org/SurveyHFMA.

physician" is not necessarily the best descriptor. If ancillary services have been removed from the practice, understand—and be able to explain—the impact that has on the practice's margin. And consider the impact that a group of employed hospitalists, for example, are making on hospital readmission rates and the value to the system that avoidance of a financial penalty brings. It is certainly important to understand the costs associated with physician employment, but to some extent those are costs necessary to provide the services that generate the revenue on which the system's financial sustainability depends.

Looking at the system as a whole, the question should be: What is an acceptable level of expense to generate sufficient revenues to maintain the system's financial health? This is the level of physician financial support that the system should be managing.

LEADERSHIP AND GOVERNANCE

Physician leadership is essential to ensure physician alignment with the broader goals of an organization, be it a medical group, a hospital, or a multistate healthcare system.

Physicians have a professional obligation to make decisions that they believe are in the best interests of their patients; accordingly, physicians should have an active role in organizational decisions that will affect their ability to provide care. Not all physicians need be involved in every decision, of course, but they should have trust in the decision-making process because the active participation of all physicians will be needed to implement decisions and achieve corresponding goals. That trust is secured through the involvement of physician leaders.

John Hill, a partner in Healthcare Strategy Group, offers a simple warning about the consequences of failing to engage physicians—or worse, of alienating them: "Physician passivity *predicts* dysfunction. Physician antagonism *guarantees* dysfunction."

GOVERNANCE STRUCTURES AND ADVISORY COUNCILS

Physician leadership takes many forms, as demonstrated by the leadership structures at the organizations interviewed.

HealthONE, as part of HCA's Continental Division, has a physician leadership chain that extends from HCA's national headquarters to the local level. The national organization's CMO also serves as president of its clinical services division. Below corporate are three geographically defined physician service groups, each with its own medical director. And within the Continental Division, medical directors have been added to each hospital. Quality is a primary focus of the national organization, which has developed a list of approximately 100 initiatives from which local clinics can choose. Divisions will also define initiatives tied to quality metrics of importance among local markets and hospitals. At the local level, quarterly physician town halls provide a forum to introduce new initiatives and receive physician feedback.

At both OSF HealthCare, a multihospital, multistate system, and Floyd Memorial Hospital and Health Services, a stand-alone hospital system, physician advisory and governance councils help ensure the involvement of physician leadership in defining organizational priorities and initiatives. OSF Medical Group has an 18-member governance council, which includes 11 members elected by the members of the group to provide geographical representation. Although the governance council is advisory, not fiduciary, its members are asked to act in a fiduciary manner during their monthly meetings. Members can serve two consecutive three-year terms, and then must take at least one year off before serving again. Many operational issues are run through the governance council to obtain physician input, and the council also provides a forum for practicing physicians to connect with system CEO Kevin Schoeplein and other members of the executive team. The geographic diversity ensures representation from the four regions of OSF, but the system does not prescribe representation by primary care and specialist physicians. Dennis, the vice president for OSF Medical Group's Central Region, notes that "OSF believes that election by peers will produce the best people, and we have seen a good split between primary care and specialist representation on the council."

Floyd Memorial Hospital and Health Services has both an elected governance council for Floyd Memorial Medical Group and a medical staff advisory council, led by CEO Mark Shugarman, that includes both employed and independent members of the hospital's medical staff. The medical staff advisory council serves as a forum for sharing information on hospital initiatives and addressing physician concerns. Eichenberger, the Floyd Memorial CMO, links the high level of physician engagement with the medical group's governance council to the fact that the group, although owned by the hospital, is run independently; Whistine, the vice president of physician services, manages the group. "It's a very physician-driven group," Eichenberger observes. "Last year, for example, the physicians insisted on streamlining administrative processes with the system as a whole and it was done."

DuPage Medical Group is 100 percent physician-owned and led by a 10-physician board elected by the group's shareholders. The physician board hires the group's management team and has oversight of the group. The board president works closely with the management team in building a sense of trust and confidence with the other physicians.

PHYSICIAN LEADERSHIP DEVELOPMENT

Both OSF HealthCare and DuPage Medical Group have developed or are implementing formal physician leadership development programs. OSF HealthCare has developed a formalized academy that provides training to develop competencies at four levels of physician leader:

- Governing leaders (also described as "system visionaries")
- Executive leaders who serve in executive-level management roles
- Team leaders working on-site in medical group locations
- Foundational leaders, a group that includes all other providers interested in leadership development

An initial cohort has completed the two-year program, which focused primarily on team leaders. OSF HealthCare employs a dyad management model, which pairs physician team leaders with a site administrator, and physicians and administrators went through the training together. Team leader training includes both didactic learning and development of process improvement plans for the participants' individual site locations. "We had 170 providers go through the first team-leader training cohort and they are now operational and delivering on strategy," says Norris, the OSF Medical Group regional director, Peoria Primary Care. "We also identified several promising physician leaders in the first training cohort who might not have been identified without the academy."

DuPage Medical Group will be piloting a "mini-MBA" development program with the Loyola University Quinlan School of Business for physicians interested in board service. The six-month program will emphasize business knowledge and leadership skills, and will incorporate project-focused learning. Professors will come to DuPage Medical Group to make physician participation more convenient.

WHAT DO FINANCE LEADERS WANT FROM PHYSICIAN LEADERS?

HFMA's survey of senior financial executives found that collaborative decision making was the most important skill to develop in physician leaders. Respondents were asked to choose the two most important skills from a total of six, with the following results:

1. Collaborative decision making (selected by 46 percent)
2. Performance measurement (36 percent)
3. Quality improvement (35 percent)
4. Strategic thinking (31 percent)
5. Change management (30 percent)
6. Financial management (24 percent)

POPULATION MANAGEMENT CAPABILITIES

"Now that physicians are no longer being paid 'by the click,'" asks one interviewee, "what needs to change in patient care?" The answer to that question is quite frankly still taking shape, but it is clear that a significant factor will be an organization's ability to manage the health of the patient populations it serves. And that ability will largely be determined by the work of an organization's physicians and the clinicians who support them. Several of the organizations we interviewed have assumed sufficient risk—through the MSSP or Pioneer ACO program, commercial ACO structures, or both—to begin the transition to population management.

The very definition of *population health management* is still being debated. This chapter uses the Institute for Healthcare Improvement's definition of *population management*: reshaping payment and management of healthcare services for a defined population in pursuit of the Triple Aim of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care.[43]

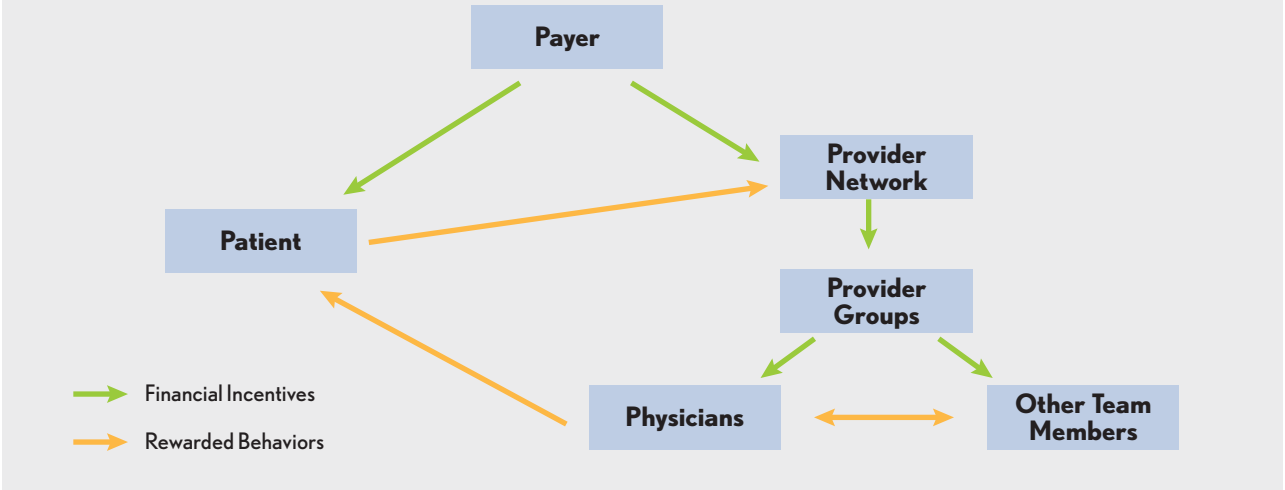
Beyond *population management* is *population health*, which seeks to affect broader determinants of health within a population. Although some organizations are beginning to move in this direction, the more basic concept of developing population management capabilities is still the focus for most organizations and will be the focus of this discussion.

PROVIDER/PAYER PARTNERSHIPS

A precondition for movement toward population management is the realignment of incentives within the healthcare system. Currently, the state of realignment varies significantly from market to market. Without the proper incentives to encourage desired behavior, it is difficult for the healthcare system to advance from fee-for-service payment to population management.

An effective incentive chain requires alignment of payment and incentives across many groups. For the payer, the key relationships are with the contracted provider network and the patient. The provider network should be rewarded for maintaining or improving the quality of patient outcomes at or below a historically benchmarked cost of care for an attributed patient population. At the same time, patients should have financial incentives to seek their care from the provider network that is being held responsible for the quality and cost-effectiveness of their care (e.g., different copayments based on choice of provider).

INCENTIVE AND BEHAVIOR FLOWS FOR POPULATION MANAGEMENT



[43] Lewis, N., "Populations, Population Health, and the Evolution of Population Management: Making Sense of the Terminology in U.S. Health Care Today," *IHI Leadership Blog*, March 19, 2014. The IHI distinguishes population management from population health in that the latter focuses on broader determinants of health.

Internally, the provider network should determine allocation of funds among the provider groups represented in the network, and the provider groups should determine allocation of funds to individual clinicians and other team members within a group. Allocation of funds will typically be based upon multiple factors, including the quality of patient outcomes (e.g., percentage of patients with diabetes under control, incidence of surgical site infections), risk-adjusted size of the patient panel managed by the physician and his or her team, resource utilization and cost-effectiveness of the care delivered, and patient experience (e.g., average waiting time for an appointment, efficiency of scheduling). These factors depend upon both cooperation among physicians and their team members within different provider groups and a focus on the outcomes, efficiency, and patient experience of care.

One of the best examples of an aligned incentives structure is a commercial ACO program initially piloted in 2010 by Blue Shield of California, Hill Physicians Medical Group, and Dignity Health to manage the California Public Employees' Retirement System's (CalPERS's) member population in the Sacramento area (the program has since been extended to employees of the City and County of San Francisco, adding the University of California, San Francisco, as a partner, and to Blue Shield HMO enrollees in San Joaquin County, the majority of whom are CalPERS enrollees). All three partners are jointly at risk for managing to the budgeted cost of care for the population, with a percentage of the capitated payment for the managed population withheld from each partner. Monthly reports compare actual costs against per member per month (PMPM) targets. At the end of the year, if the partners come in at or below budget, they receive payment for the withheld funds and any surplus. In a deficit situation, the withheld payments would be applied to the deficit.

In its first year, the pilot achieved a zero cost increase against historical growth of 8 to 12 percent per year by saving more than $15.5 million (which included a 20 percent reduction in PMPM costs for inpatient admissions). At the same time, patient outcomes improved across a range of metrics, including:

- A 15 percent reduction in 30-day inpatient readmissions
- A 15 percent reduction in inpatient days per 1,000 hospitalized pilot beneficiaries
- A 50 percent reduction in inpatient stays of 20 days or more per 1,000 hospitalized pilot beneficiaries
- A half-day reduction in average patient length of stay[44]

David Joyner, COO of PriMed, which manages Hill Physicians, notes that good population management practices are not radically different from what should always be intended for patient care—for example, smoothly transitioning patients between sites of care or identifying chronically ill patients and keeping them out of the hospital. "But they happen more effectively where there are aligned incentives and parties working closely together, rigorously and consistently," Joyner says.

IT AND DATA ANALYTICS

Effective population management is driven in large part by timely information. Ideally, organizations that are partners in a population management initiative share a common EHR. In many instances, however, such synchronization is not feasible; in those cases, rigorously observed protocols for the timely exchange of relevant information are critical.

When DuPage Medical Group formed Illinois Health Partners (IHP), a joint venture with Edward Hospital & Health Services in west-suburban Chicago, it sought "integration without ownership" and saw clinical integration through IT with its IHP partners as one way to achieve this goal. In addition to Edward Hospital and its medical group, IHP also includes Elmhurst Memorial Hospital (which merged with Edward Hospital), the Elmhurst Clinic, and ELMCARE (the Elmhurst physician-hospital organization), as well as Northwest Community Healthcare's Physician Hospital Organization. Most IHP partners are on the same instance of the same EHR, giving physicians in the hospitals and in the practices a complete view of the patient that has contributed to a significant reduction in redundant tests and procedures.

In connection with its participation in the Pioneer ACO program and other at-risk managed care contracts, OSF HealthCare has built decision support tools into its EHR to help with chronic disease management and at-risk patient populations. The system's hospitals and employed physicians are all on the same instance of the EHR, but the system has faced greater connectivity challenges with independent physicians, who may be able to view the EHR only when they are in a system facility. OSF HealthCare is

[44] Outcomes reported in *An Accountable Care Organization Pilot: Lessons Learned*, Blue Shield of California, 2012.

pursuing system hosting of the EHR for independent groups as one solution.

Hill Physicians Medical Group has invested in technologies that identify gaps in care or data, and offers a subsidized EHR to physician practices, with approximately a third of the practices now on a common platform. But even if all were on the same platform, connectivity issues could still prevent access to hospital-based systems that use a different vendor. The partners in the commercial ACO have worked to identify key data exchanges, including pharmacy data and twice-daily census data from the hospital partners that augment claims data from Blue Shield of California, which is useful but not real-time.

With data systems in place, the focus turns to data analytics and predictive modeling. Stephen Hippler, MD, vice president for quality and clinical programs at OSF HealthCare, defines the challenge as being able to prospectively identify the small percentage of the population that consumes the greatest share of healthcare resources, rather than identifying those patients retrospectively. An initial focus has been on identifying patients at risk of readmission. OSF HealthCare found that 53 percent of its patients have less than a 3 percent risk of readmission, while 2 percent have a 38 percent risk. They are intensively targeting that 2 percent of the patient population at greatest risk, while also providing extra care and attention for patients within the upper two quartiles of risk. Forbes, the system's chief clinical officer, estimates that if classic predictive modeling tools had about a 50 percent success rate in predicting readmissions, OSF HealthCare is now closer to 60 percent and is looking to move to 65 to 70 percent.

Hippler cautions that interventions resulting from predictive modeling cannot be too prescribed. "Sometimes, the medium- or low-risk patient needs more attention than the higher-risk patient," Hippler says. "Our approach is to remain patient-focused—looking at the patient holistically from the patient's perspective, not a disease management perspective. Predictive modeling needs to be paired with an understanding of patient needs to craft solutions that are best for the patient."

NEW CARE MANAGEMENT MODELS

Effective population management also focuses on reducing fragmentation of services and improving coordination of care and access to care for the managed population. Organizations are developing and implementing a wide range of techniques to meet these goals.

PriMed, the group that manages Hill Physicians, recognized that case management activities could be fragmented or duplicative and has created more centralized points of service to work with the physician practices. In particular, it has created a "virtual care" team of case managers, pharmacists, social workers, and advanced practice nurses to support and coordinate case management efforts in the physician practices. The team uses predictive modeling to proactively identify patients for whom an investment in case management makes sense. "We have added resources to do this, but the payoff under our at-risk contracts has been multiples of any incremental resources that have been deployed," says Rick Messman, PriMed's CFO.

At OSF HealthCare, which has many facilities in relatively rural areas, ensuring access to needed services across the system's four regions is one of the biggest challenges. The system has implemented a telehealth program that offers, for example, neurology support from the Central Region to its Northern Region sites, and is developing an e-Pharmacy platform that will spread pharmacy services more evenly across the system, including the ability to perform pre-discharge medication reconciliations for every patient. An e-ICU program also has been implemented across the entire system, reducing lengths of stay in the intensive care unit.

OSF HealthCare also is analyzing the possibility of virtual e-visits for primary care patients, especially its young and relatively healthy patients, so time in the clinics can be devoted to sicker patients. Additionally, the health system has piloted PromptCare clinics to supplement and support primary care offices. The PromptCare clinics are walk-in, open on evenings and weekends, and are staffed with both physicians and advanced practitioners.

DuPage Medical Group is also experimenting with the idea of virtual visits for younger, healthier patients, which Kasper, the group's CEO, sees as the next step in convenient access for patients. Already implemented are two examples of "niche care" programs—BreakThrough Care Centers and herDMG—designed to effectively address the needs of specific patient groups.

BreakThrough Care Centers focus on seniors with chronic diseases, with referrals coming from IHP

THINKING THROUGH VIRTUAL VISITS

Virtual visits offer a promising approach to meeting the needs of patients who want a quick medical consult without scheduling a live clinical visit. Such visits cannot meet all patient needs, however. Health systems, medical groups, and physician practices should think through some basic questions when establishing the parameters for when virtual visits are appropriate and when they are not. James Stamos, a Chicago-based attorney specializing in medical malpractice, describes some key points to consider.

Is the program patient-focused or system-focused? Virtual-visit programs that are designed to meet a clear patient demand for access and convenience are on a stronger footing than those that are driven by a desire to reduce health system costs.

Will physicians involved in the program be able to say that the program meets an appropriate standard of care? Physicians are responsible for making an independent medical judgment for the individual patient. They should have the ability to independently determine the practicalities of a virtual visit that will allow them to address the patient's needs within the standard of care.

Would patients be comfortable that they are receiving the appropriate level of care through a virtual visit? A patient's perspective on what happened during a virtual visit might differ from the physician's perspective. There should be clear communication to the patient throughout the virtual visit of what the visit is intended to accomplish (as well as what issues the visit may not be able to address).

Would the care rendered in a program visit be defensible in front of a jury? The parameters for a virtual visit should clearly delineate conditions that can be discussed and diagnosed remotely versus those for which a physical visit would be more appropriate. The more the program moves away from what people might have expected to happen in a personal visit, the more difficult the care might be to defend.

physicians. The centers are a joint venture between the medical group and Humana and are designed to care for the 5 to 10 percent of the patient population that drives the majority of healthcare costs. The centers offer care teams that include a physician, nurse practitioners, health coach, pharmacist, physical therapist, dietitian, licensed social worker, and licensed behavioral health specialist. The centers have on-site labs and diagnostic imaging, as well as a fitness center. DuPage Medical Group is managing approximately 1,000 patients through three centers in west-suburban Chicago and is seeing encouraging early results.

The medical group's second niche care program, herDMG, addresses the often-fragmented delivery of women's health services as well as women's need for convenience as they balance families and careers. The program segments women by age bracket, with all needed services available through one appointment. Women in the over-40 age bracket, for example, are able to get a screening mammogram during a visit, and other services include breast and pelvic exams, pap smears, blood work, and referral to specialists as needed. The program was introduced in April 2014, with plans to make it available at more than 20 sites within the medical group.

Several common themes run through these new care management models:

- The need to ensure that a managed population has access to a full range of services
- The need to better understand specific population segments and their care requirements, and then bundle services or implement new services to make meeting those requirements more convenient
- The need to alleviate pressures on primary care physicians by deploying care teams and technologies that can free up time to care for patients most in need of the physician's attention

CONCLUSION

The reconfigurations of care delivery by organizations in markets where the transition to value-based payment is well underway are indicative of changes that most healthcare organizations across the country are anticipating, even in markets that have not moved as quickly toward value-based models. Demands for improved outcomes, more convenient access to care, and greater cost efficiency will be impossible to meet without the active participation of physicians and the appropriate alignment of incentives across the system.

Although the realignment of incentives is only beginning in many markets, most organizations understand the need for a renewed focus on their physician strategies and are actively moving forward. Many strategies will be market-specific, but certain fundamental elements of a physician strategy pertain to all organizations.

Determining the best alignment opportunities for physician practices in the market. For hospitals and health systems, the trend is clearly toward employment of physicians, but this is not always appropriate for, or desired by, every specialty. Physician practices are experiencing pressures to achieve scale, but large, independent medical groups offer an alternative to alignment with a hospital or health system. CINs and ACOs offer opportunities for alignment and collaboration among hospitals and health systems, independent medical groups and physician practices, and other provider organizations.

Building a sufficient primary care base to support specialty services. The proper balance between primary care and specialty services is, and for some time will remain, a moving target, especially as new population management techniques intended to reduce utilization of specialty and acute care services take hold. A solid primary care base nevertheless will help to ensure adequate referrals to specialists today while laying the foundation for population management.

ABOUT THIS CHAPTER

The findings in this chapter are based on:

- Responses (118 total) to an HFMA survey sent to a random selection of senior financial executive HFMA members in March 2014. Of the respondents, 55 percent represented stand-alone hospitals and 45 percent represented systems (19 percent at the system headquarters level and 26 percent at the system facility level).
- Site visits and interviews with the following hospitals, health systems, and medical groups:
  - DuPage Medical Group (Chicago metropolitan area)
  - Floyd Memorial Hospital and Health Services (Louisville, Ky., metropolitan area)
  - HealthONE/HCA Continental Division (Denver metropolitan area)
  - Hill Physicians Medical Group (Northern California)
  - OSF HealthCare (multiple locations throughout Illinois and in upper Michigan)
- Interviews with strategic consultants, finance executives, and legal subject matter experts.

Communicating the need for flexibility and change in physician compensation agreements. As public and private payers introduce new payment models designed to reward improved quality and cost efficiency, physician compensation agreements will need to change accordingly. Many organizations have begun to experiment with new compensation models, but everyone should understand that these new models are a work in progress and will continue to evolve. Communication is essential here, as is collaboration with physicians on the development of new models and metrics.

Developing physician leadership and governance structures. Change in physician culture and practice patterns requires trusted and strong physician leadership. Ensure that physicians have meaningful forums in which to share their ideas and concerns with both clinical and administrative leadership and that mechanisms are in place to identify, cultivate, and promote physician leaders within the organization.

Ensuring that the contributions of physicians are accurately valued and described. Looking at the system as a whole, what is an acceptable level of expense to generate sufficient revenues (or, increasingly, avoid negative financial risk) to maintain the system's financial health? What other services do physicians provide to the organization, and what is the appropriate value of these services?

Recognizing that physicians will be critical to an organization's success in making the transition to value. The success of any physician strategy will depend on its effectiveness in engaging the physicians themselves.

CHAPTER 23

Strategies for Reconfiguring Cost Structure

EXECUTIVE SUMMARY

Value creation for care purchasers depends on both optimizing the efficiency with which care is delivered today and investing in new technologies, infrastructure, and innovations that can improve the quality and cost-efficiency of care delivery in the future. Key lessons from HFMA's research on strategies for reconfiguring cost structure include:

Understand that reconfiguring cost structure is different from reducing cost structure. Hospitals and health systems today must emphasize cost reductions in established operations and services but also increased investments in new care management models and infrastructure.

- Understand the lessons health care can learn from the airline industry's reconfiguration in the special feature on page 231.

Give your organization the benefit of time. Organizations that start their efforts early will have an easier time maintaining staff morale.

- See the three promises Benefis Health System made to staff when it launched its "break even at Medicare" initiative on page 236.

Look within the organization for the knowledge required to accomplish the organization's goals. Individuals within an organization know where opportunities to improve efficiency lie, and also understand the obstacles to realizing those opportunities.

- Learn how Banner Health and Vanderbilt University Medical Center (VUMC) leveraged organizational knowledge through the use of internal project management teams on pages 237.

Work to sustain the gains your organization achieves. Gains in labor productivity can be eroded if a system does not have a strategy for maintaining or building on them.

- Read about Benefis Health System's use of a position control committee to review new staffing requests on page 238.

Realize that standardization can be overdone. Standardization is important to ensure consistent quality and patient experiences across a system, and can save money on supplies. But a "one size fits all" approach can be inappropriate or limiting in some settings. Also remember that words matter. For example, "reducing unnecessary variations in care" will resonate with clinicians more than "standardization," which may suggest an effort to overly restrict a clinician's ability to make decisions based on individual patient needs.

- See how examples from Banner Health demonstrate the need to standardize at the appropriate level on page 239.

Develop strong physician leadership models to achieve savings from clinical transformation. HFMA members identify clinical transformation as the area with the greatest potential to achieve savings, but clinicians must trust that transformation efforts will be best for their patients. As earlier Value Project reports have noted, it is important to emphasize quality in clinical transformation; typically, cost savings will follow. Physician leadership is critical to building trust that the focus of clinical transformation will be improved quality of patient care.

- Learn how Providence Health & Services and Banner Health use physician consensus models for clinical transformation on page 242.
- Read about VUMC's diagnostic management teams on page 243.

Account for local market and political considerations when seeking to rationalize assets or service lines. A decision to consolidate service lines in a single facility or reduce the capacity of a facility can have both competitive and economic effects.

- See the factors that can influence service line and asset rationalization decisions on page 243.

Invest in population health management infrastructure for the long term, but be alert to opportunities for returns in the short term. Investments in networks and infrastructure capable of managing—and assuming risk for—the health of a population can be equated with "laying the cable" for the next generation of healthcare delivery. Even so, systems can realize savings from these investments in the short term that can help mitigate the expense.

- See how Banner Health Network identifies cost-saving opportunities within its accountable care organization on page 248.
- Learn how clinicians at Swedish Health Services developed a business plan to realize a positive return on a requested investment in population health infrastructure on page 248.

Embrace the likelihood of disruption in health care by investing in innovation. An organization is better off disrupting its own business model than having it disrupted by others.

- Learn how Providence Health & Services is funding and operationalizing an innovation agenda for the system on page 249.

Consider affiliation as a cost-effective alternative to ownership when developing a population health management network. Affiliating can help healthcare organizations avoid the substantial costs of acquiring new facilities, minimize antitrust concerns, and help network participants achieve economies of scale while maintaining their independence and local governance structures.

- See how the Vanderbilt Health Affiliated Network benefits its members on page 250.

INTRODUCTION

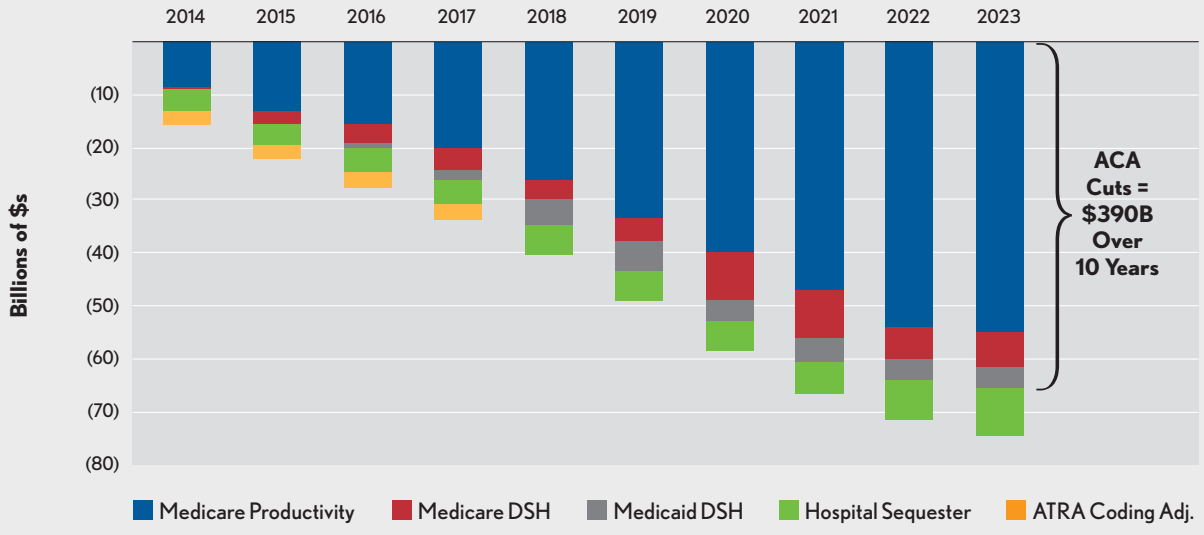
The need for health systems to reconfigure their cost structure is being driven by two imperatives in today's market. The first is the reality of declining payments. A combination of legislative actions in recent years—including the Affordable Care Act (ACA), the American Taxpayer Relief Act, and the Budget Control Act of 2011 (which introduced automatic budget sequestration)—amounts to cumulative reductions in Medicare and Medicaid payments to hospitals of an estimated $460 billion from 2014 through 2023 (see the exhibit below); reductions in the ACA alone account for 85 percent—or $390 billion—of this total. Not surprisingly, almost two-thirds of respondents to an HFMA survey cite decreased Medicare and Medicaid payments as the main external driver of the need to control costs (see the exhibit on page 226).

Whereas cuts in public programs traditionally have been balanced by a "cost shift" to other payers, this option is growing increasingly limited. More than 70 percent of respondents to a recent HFMA survey indicated that they are unable to offset declining revenue from government payers with increased commercial rates. Indeed, commercial payers are feeling pressure from both employers and insurance exchanges (both public exchanges created pursuant to the ACA and private exchanges emerging in response to market demand) to keep rates low.

The pressure of declining or flattening revenue streams is compounded in many markets by declines in utilization, identified by HFMA survey respondents as the second most significant driver of the need to control costs. Industry analysts are still debating the reasons for these

ESTIMATED REDUCTIONS IN MEDICARE AND MEDICAID PAYMENTS

85% of Projected $460 Billion in Hospital Federal Cuts Are ACA-Related



Sources:
1. HFMA analysis
2. Elmendorf, D.W., Congressional Budget Office, letter to Speaker John Boehner, July 24, 2012.
3. Bank of America, "2-Year Budget and 3-Month Doc Fix Legislation," Dec. 12, 2013.
4. Mitchell, A., *Medicaid Disproportionate Share Hospital Payments*, Congressional Research Service, Dec. 2, 2013.
5. Hatch-Vallier, L., "Medicaid and Medicare Disproportionate Share Hospital Programs," CHRT, Jan. 22, 2014.
6. American Hospital Association, "Hospitals Have Absorbed Nearly $122 Billion of New Cuts Since 2010."

declines—arguably a combination of continuing economic headwinds from the Great Recession, the impact of increasing consumer exposure to healthcare costs through the growing use of high-deductible health plans, and changes in healthcare delivery that already are starting to affect utilization of higher-acuity services. Regardless of the cause, declining utilization is a reality for many health systems, especially those in more mature markets that are not experiencing population increases.

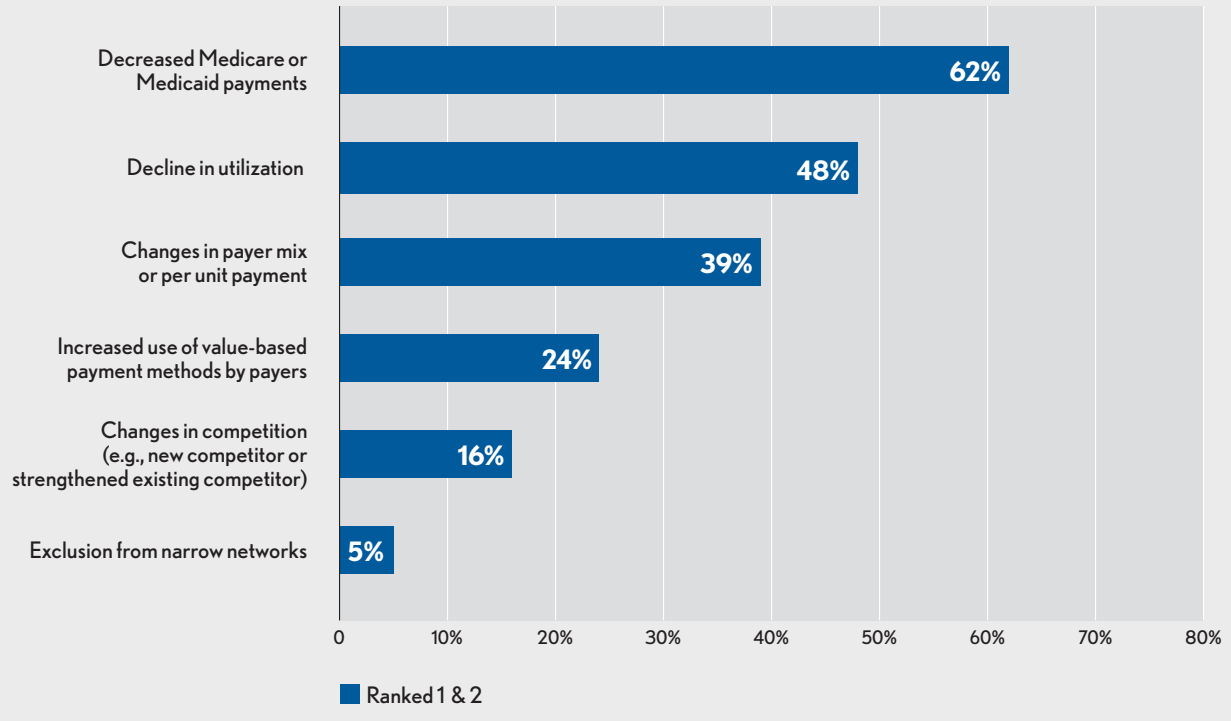
While ranked fairly low by respondents to the HFMA survey (see the exhibit below), changes in competition—especially in the form of new entrants into the healthcare marketplace—have the potential to significantly affect the price of healthcare services, particularly in primary and secondary care. Many of these services—including lab and imaging, chronic disease management, and common procedures such as colonoscopies—are "bread and butter" for many hospitals and health systems. Competition-driven reductions in prices for these services would reduce the ability of systems to cross-subsidize less profitable services and would put further pressure on cost structures.

Even as payments come under pressure, health systems are facing a second imperative: to develop the infrastructure and capabilities needed to thrive in the emerging value-based payment and care delivery environment. These investments include IT and analytics, expansion of primary care services, care coordination, and related technological capabilities to increase patient engagement. While systems are looking to contain costs or reduce spending in key areas of their operations, they simultaneously must plan for increased investment in new areas. Seven in 10 HFMA survey respondents identify investments in IT, clinical data warehousing, and reporting to better manage utilization (see the exhibit on page 227), and more than half predict increased spending in the areas of IT and physician organization and clinical services (see the exhibit on page 228). In short, the need health systems face today is not simply to contain costs, but rather to *reconfigure* cost structure so that spending reductions in one area can free up resources needed for new investments in another.

Accordingly, this report will consider both efforts to reduce costs and strategies to fund the investments in

DECLINING PAYMENT AND UTILIZATION ARE LEADING DRIVERS OF COST CONTROL

What are the main external drivers to control costs in your market?



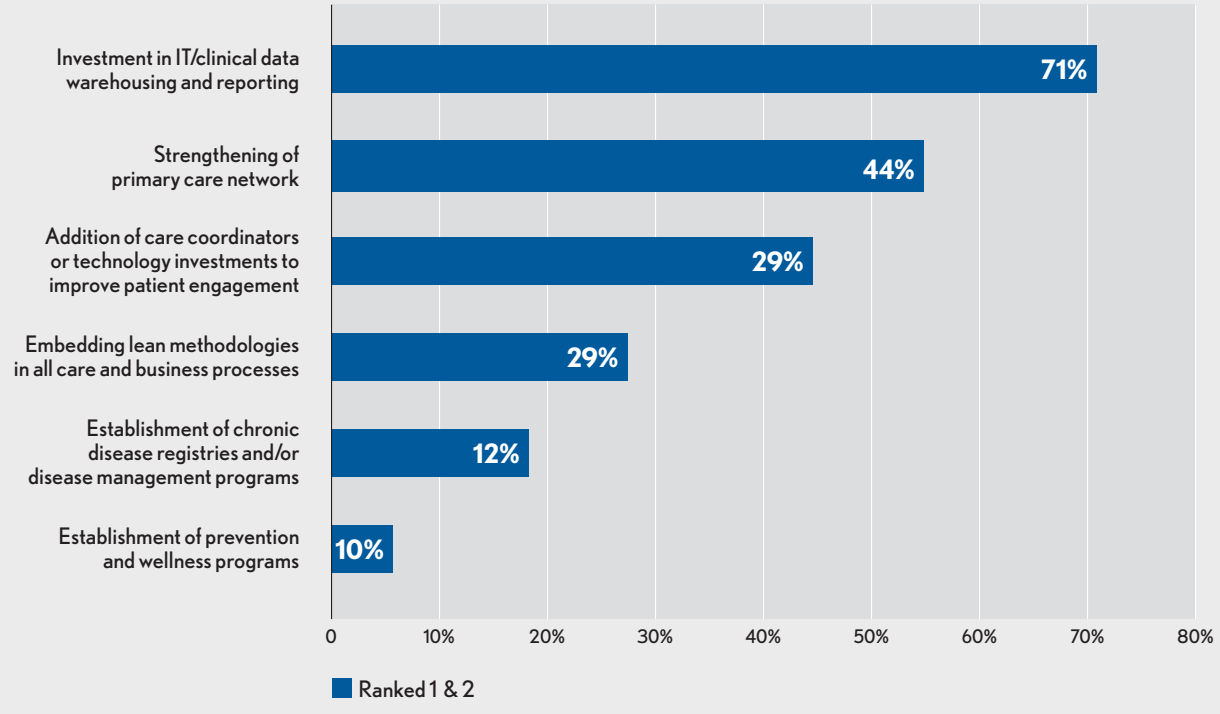
technology, clinical services, and innovation that health systems are making to engage in risk-based contracting and population health management and to prepare for potential disruptions in the competitive landscape. There can be overlap between these areas: For example, clinical transformation initiatives that seek to reduce variation in clinical pathways and supply choices can both generate cost savings and build capabilities to assume risk.

For many years, the industry could afford to pay less attention to costs because the effects of rising healthcare prices to a large extent were not visible to healthcare consumers. With employers eventually reacting to rising prices by raising the deductibles on employer-sponsored insurance, and with health plans increasing deductibles and out-of-pocket maximums to make premiums affordable on the healthcare exchanges, consumers are growing ever more sensitive to the high price of care and are demanding greater value for the significant healthcare dollars they now have at stake.

There clearly are many opportunities to reduce and reconfigure the cost of providing healthcare services. A report from the Institute of Medicine estimates that excess costs in the U.S. healthcare system in 2009 totaled $750 billion, with unnecessary services, needless administrative complexity, and inefficiently delivered services representing the three largest categories of waste.[45] Results of HFMA's survey of senior financial executives for this report depict an industry that has not fully addressed the challenges of cost structure reconfiguration: Less than a third of respondents described their cost-reduction capabilities as "strong" in any of the four categories listed on the survey (see the exhibit on page 228). "These are honest survey results," says Dan Piro, president of MedAssets Advisory Solutions. "Most systems don't have this figured out; even the systems that are looked to as leaders in the field would probably rate themselves as a 6 or 7 on a scale of 10 in terms of where they think they need to be to thrive in a value-based environment. The key is to have a vision of where your organization needs to go, a plan to get there, and the patience to realize it will take some time to put everything into place."

INVESTMENTS TO BETTER MANAGE UTILIZATION

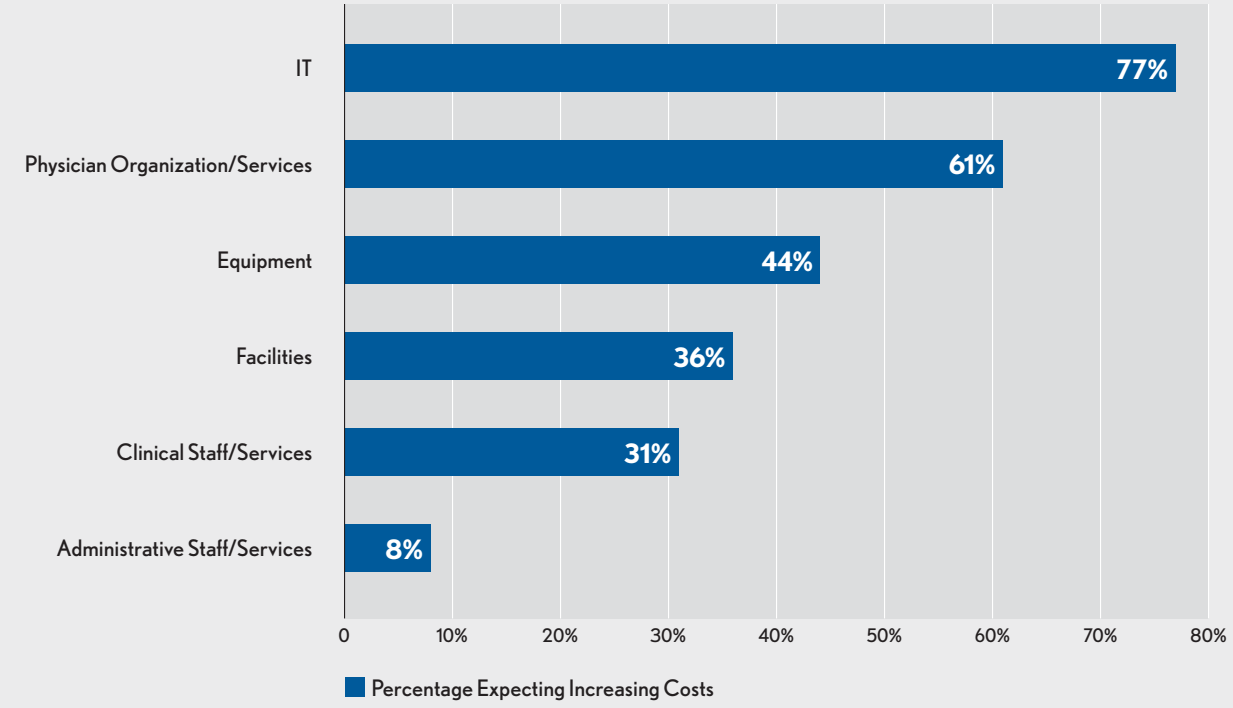
Assuming future value-based payment methodologies will reward appropriate utilization of services, please identify the types of investments your organization is making to better manage utilization.



[45] Smith, M., et al., *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, Institute of Medicine, 2012.

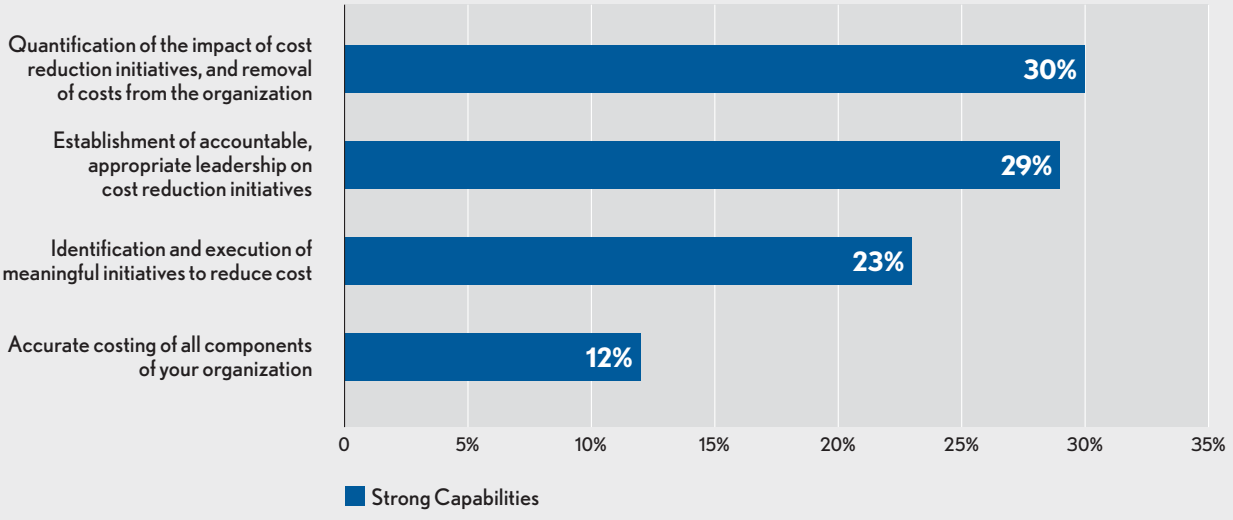
ANTICIPATED CHANGES IN COST STRUCTURE

Five years from now, how do you expect your organization's costs to differ from today?



ASSESSMENT OF COST-REDUCTION CAPABILITIES

Please evaluate your organization's capabilities in the following cost-related areas by utilizing the following scale: (Weak, Moderate, Strong).



LESSONS FOR HEALTH CARE IN THE AIRLINE INDUSTRY'S RESTRUCTURING

The airline industry has been described as "capital intensive, labor intensive, and [with] high fixed costs with revenues and profits closely tied to the nation's business cycle."[46] It has experienced significant disruptions, beginning with deregulation of fares and routes in 1978 and followed by the emergence of price transparency through the rise of Internet booking. Although airfares, routes, and market entry have been deregulated, the industry remains subject to federal regulatory oversight on issues of passenger safety. Concerns over passenger safety also make the industry vulnerable to crises both natural (e.g., the SARS outbreak of 2002) and human-made (e.g., the terrorist attacks on Sept. 11, 2001). These pressures have created the need for significant cost restructuring.

As the healthcare industry experiences what is likely to be a significantly disruptive period of change, the experiences of the airlines can offer hospitals and health systems lessons to help guide their own transition.

AIRLINE INDUSTRY DISRUPTIONS

In 1978, the federal government's Airline Deregulation Act opened the industry to free-market forces, ending the Civil Aeronautics Board's tight regulation of airline fares, routes, and entry to the market.[47] Deregulation was followed by the emergence of low-cost carriers, a significant disruption to the business of the "legacy" airlines that had existed previously. Whereas the mission of legacy airlines is to provide service from anywhere to everywhere, operating complex hub-and-spoke systems that require relatively high investments in labor and aircraft, low-cost carriers primarily operate point-to-point services from and between select cities. They typically have high aircraft utilization rates, with quick turnaround times between operations, and fleets consisting of just one or two types of aircraft. Their focus has been primarily on price-sensitive traffic, especially leisure travelers. Their market share grew quickly, from 11 percent in 1998 to 30 percent in 2006.

A second significant disruption to the airline industry was the emergence of the Internet as the predominant means of booking tickets. Although this method is less expensive for airlines than are traditional travel agencies, it also has given consumers the ability to compare ticket pricing and schedules. Increased transparency has been a significant factor in downward pressure on airfares.

The combination of low-cost carriers and price transparency on the Internet commoditized the airline industry. In other words, it created a market in which products are largely undifferentiated—particularly on routes on which both low-cost carriers and legacy carriers compete—with price a significant factor in consumers' choices. Commoditization of the product has affected carriers' ability to improve financial performance through revenue enhancement and cost containment. Moreover, the emergence of these disruptive forces has significantly reduced opportunities for legacy carriers to cross-subsidize services and flights by charging higher prices on some routes to make up for losses incurred elsewhere (e.g., at less frequented airports or less traveled routes).

THE AIRLINES' RESPONSE TO CHANGE

To meet the new challenges to their businesses, legacy airlines focused on three main strategies: cost containment, revenue enhancement, and consolidation.

Cost containment strategies. The tactics used by low-cost carriers opened significant cost gaps between them and the legacy airlines. In 2004, for example, there was a 36 percent gap in operating costs per available seat kilometer between Southwest Airlines and the three largest U.S. legacy airlines.[48] The two primary reasons for the cost gap were labor costs and asset utilization.

Labor costs. As in health care, employee-related expenses are the highest cost factor for any airline. As legacy carriers have addressed the issue of high fixed labor costs, the most effective strategy has been to file for Chapter 11 bankruptcy protection to allow for restructuring of pension arrangements. Legacy carriers also have found opportunities to address ground personnel staffing by engaging in "load smoothing." This strategy seeks to diminish spikes in departure and arrival loads during peak times, which require excess labor capacity on the ground. Fewer opportunities exist with respect to in-flight personnel because the Federal Aviation Administration largely dictates in-flight staffing requirements.

Asset utilization. Legacy airlines have older fleets and require more types of aircraft than do low-cost carriers. An older, more diverse fleet increases costs of maintenance, fuel, and pilot

[46] General Accounting Office, *Commercial Aviation: Legacy Airlines Must Further Reduce Costs to Restore Profitability,* August 2004.

[47] Passenger safety remained subject to regulatory oversight by the Federal Aviation Administration.

[48] International Air Transport Association, *Airline Cost Performance: IATA Economics Briefing #5,* July 2006.

training. Moreover, the legacy airlines' hub-and-spoke model makes them unable to operate their aircraft for as many hours per day as low-cost carriers can with their point-to-point operations. Legacy airlines have taken on debt for new aircraft and other capital expenditures, but also have chosen to reduce capacity in some areas, especially on routes where they compete head-to-head with low-cost carriers and face low or negative profitability.

Revenue enhancement strategies. Legacy airlines have become experts at finding new opportunities for incremental revenue based on passengers' willingness to pay for such "extras" as early boarding, exit-row seats, or aisle seats near the front of the cabin. They also have become more sophisticated in pricing differently on different days of the week, based on analysis of past demand. They also tend to increase rates for open seats on dates close to the date of travel, knowing that travelers who book late are likely to have a high need for travel. In many cases, extra services are offered to the customer after booking, keeping base rates more competitive on price comparison websites.

Consolidation strategies. Since Delta merged with Northwest in 2008, Continental has merged with United and American Airlines has merged with US Airways, reducing the number of major legacy carriers in the United States to just three. Low-cost carriers are also beginning to consolidate, as with Southwest's acquisition of AirTran in 2011.

Consolidation has provided advantages in terms of both cost and revenues, especially for the legacy carriers. By consolidating routes and operations, and rationalizing capacity on routes, airlines using a hub-and-spoke model can optimize key industry metrics, including:

- Revenue per passenger mile (the average price an airline is able to charge per mile flown by a passenger)
- Load factor (the ratio of the number of occupied seats to the total number of seats flown)
- Flight stage (the average distance of flight per leg of travel; longer flight stages—more typical of the legacy airlines, with their international networks—lessen the overhead impact of takeoffs and landings and reduce exposure to cascading network disruptions caused by flight delays)

Consolidation also is generating some pricing power among carriers.

VALUE CREATION

Have the various disruptions to the airline industry led to increased value for the airlines' passengers? The evidence is mixed. Passenger safety clearly has improved, evidence of price savings to the passenger is uneven, and quality (including the passenger experience) arguably has suffered. One industry observer sees in the legacy airlines "a group of battered, eternally struggling companies trying to come up with a sustainable industry model."[49] In short, significant disruptions of an industry create a lot of dust—and it can take a very long time for the dust to settle.

LESSONS FOR HEALTH CARE

"Legacy" providers in health care are likely to experience effects similar to some of those experienced by the legacy airlines.

Federal action to spur competition. The airline industry experienced deregulation, while health care is experiencing a host of new regulations passed pursuant to the Affordable Care Act (ACA) and other recent laws. In both cases, however, the government's intent is to spur competition among providers on the basis of price, service, and quality. The value-based payment provisions of the ACA are an example of federal efforts to improve value in health care.

Emergence of low-cost alternatives. Just as low-cost carriers emerged as a major disruptor of the airline industry, so too are low-cost providers expected to disrupt healthcare delivery. Stand-alone radiology centers, urgent care options and retail clinics in strip malls and pharmacies, and independent labs already have appeared on the scene. Also on the horizon are cost-effective technological solutions for care that today is delivered in person.

Commoditization of services. It is widely expected that the ACA insurance marketplaces will to some degree commoditize the health insurance market, particularly among cost-sensitive individual purchasers. The exchanges seem quite similar to the use of the Internet to purchase airline tickets; over time, evidence has shown that online ticketing contributed to undifferentiated products and downward pressure on prices. Between that trend and the emergence of new low-cost providers, it is likely that hospitals and health systems, as with the legacy airlines, will need to minimize or forgo cross-subsidization of services over time to remain competitive.

[49] Fox, J., "Which Is Worse: Airline Monopolies or Airline Competition?" *Harvard Business Review*, Aug. 15, 2013.

Elasticity of demand. Due to continuing financial pressures, improved care coordination, commoditization of the market, and further cost shifting to patients, the healthcare industry may experience increased elasticity of demand for services that perhaps are overutilized or unnecessary.

Such effects may also trigger strategic responses in health care that mirror some of those deployed by the legacy airlines, including:

Transitioning from fixed to variable costs. The legacy airlines took extreme action to reduce some of their most significant fixed costs, most notably labor. In health care, the biggest challenge may lie in moving from a traditional bricks-and-mortar care delivery system to one that is more decentralized or, in some instances, virtual. As they do this, hospitals and health systems may have an opportunity to reduce the variety of physical assets they manage, just as low-cost carriers have gained a cost advantage by managing relatively uniform aircraft.

Customer segmentation and revenue enhancement. Just as airlines have sought incremental revenue enhancement through improved access, convenience, or comfort for segments of their passenger base that are willing to pay more for these services, healthcare providers are likely to become more focused on segmenting customers and developing innovative new service enhancements for some segments of their market. To do so, they will need a clear understanding of their value proposition for different segments and an objective view of whether they can meet targeted customers' needs better than their competitors can.

Rationalization of services. As airlines have shed or reduced traffic on routes where over-capacity exists, so too are hospitals and health systems likely to eliminate or reduce service lines if sufficient capacity exists elsewhere in the market.

Consolidation. As documented in HFMA's Value Project report on acquisition and affiliation strategies (hfma.org/valueaffiliations), healthcare organizations of all types and sizes are considering opportunities to improve scale through affiliation, acquisition, or merger. The value to passengers of consolidation within the airline industry still is being debated, and has attracted the scrutiny of federal antitrust agencies. As consolidation among healthcare organizations increases, they also will be challenged to tangibly demonstrate the value of consolidation to patients and other care purchasers.

While there are obvious differences between the airline industry and health care, there are many similarities as well. As the U.S. healthcare system embarks on what likely will be decades of significant transformation, the experiences of the airline industry may provide some guidance on strategies to remain financially viable during this period of change.

Note: This feature is based on an analysis prepared for HFMA by McManis Consulting.

RECONFIGURING COST STRUCTURE: OPPORTUNITIES, CHALLENGES, AND STRATEGIES

Most members of the healthcare industry would admit that there are opportunities for cost savings throughout the system, and this report will not attempt an exhaustive inventory of these opportunities. Instead, it will focus on major cost categories that represent the greatest opportunities for savings: labor and productivity improvement, supply chain, clinical transformation, and service line and asset rationalization.

This report will not draw major distinctions between "fixed" and "variable" costs, with the understanding that many costs considered fixed today will become variable over time. As Piro of MedAssets notes, "All costs are variable in the long run. The magnitude of cost reductions necessitated by the dynamics of today's healthcare marketplace has not been encountered before. Cost restructuring must be foundational, with all cost categories on the table."

LABOR COSTS AND PRODUCTIVITY IMPROVEMENT

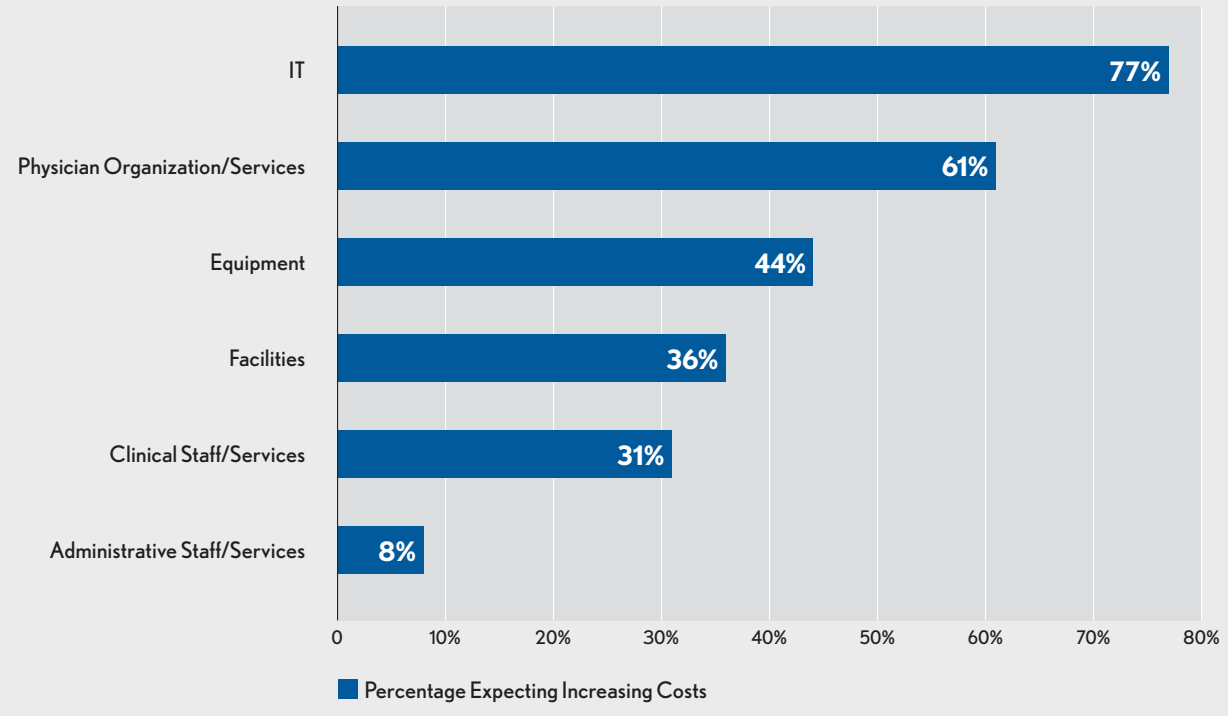
With labor comprising 50 to 60 percent of total costs for the average health system, any effort to reconfigure cost structure should address the efficiency of the labor force and seek opportunities to optimize staff productivity.

Administrative and clinical staff and services. When seeking labor productivity improvements or opportunities to reduce the size of the labor force, most systems are segmenting between administrative and clinical staff. More than two-thirds of respondents to the HFMA survey expect to decrease administrative staff and services over the next five years, while fewer than half expect to decrease the costs of clinical staff and services (see the exhibit below).

The health systems that participated in site visits for this project similarly have emphasized administrative over

ANTICIPATED CHANGES IN COST STRUCTURE

Five years from now, how do you expect your organization's costs to differ from today?



clinical staff and services in their cost reconfiguration efforts. When Banner Health initiated a transformational change initiative to reduce costs approximately three years ago, it began with the system's general and administrative expenses—an effort it described as corporate services optimization (CSO). Internal cross-functional teams identified and brought to senior leadership 123 recommendations for CSO, 116 of which were approved for implementation. The CSO initiative generated $31 million in savings in 2012 (including estimated efficiency gains), an additional $27 million in 2013, and an estimated additional $13 million for 2014.

When Vanderbilt University Medical Center (VUMC) launched its Evolve to Excel initiative, it deployed a team of 30 individuals taken from their regular positions and placed in a program management office. Their task was to look at staffing levels across academic, clinical, and support functions and establish targets for reductions. The team emphasized reductions in administrative and management positions, not those involving direct clinical care. Reductions were accomplished through substantial restructuring. For example, VUMC streamlined administrative support for its research enterprise—moving from support services dispersed across more than 30 units to centralization within four new "regional pods" that handle finance and human resources functions for the various departments within the pod.

At the time of HFMA's site visit, Providence Health & Services was approximately two-thirds of the way toward meeting the system's goal of consolidating many of its administrative services—including revenue cycle, finance, human resources, real estate, and IT—at the system level. As this process nears completion, the organization is beginning to reduce administrative and operational expenses at the regional and facility levels. The challenge now is determining the right level of support to maintain at these levels.

Banner Health also has begun centralizing support services. Prior to its CSO initiative, each facility had a public relations representative on-site. The PR group was realigned around separate service categories (e.g., owned media, earned media) and centralized to provide the same level of service at a lower cost.

While initial focus typically is on administrative staff and services, many systems have also identified opportunities to optimize the efficiency and productivity of clinical staff. As part of its "break even at Medicare" initiative, for which the goal was to achieve a neutral to positive margin on Medicare services, Benefis Health System sought to substantially reduce its use of premium labor. Nursing staff agreed to "flex up" two shifts per quarter (i.e., they agreed to be scheduled for up to two shifts above the regular FTE load). At the same time, nurse managers agreed to be on each of the three nursing shifts at least once per month, which Terry Olinger, president of Benefis Acute Care Group, describes as "a huge morale booster" for the nursing staff. As a result, at the time of HFMA's site visit in late October 2014, the system had used no "traveler" nurses since 2003.

Providence Health & Services relies heavily on benchmarking of productivity across both administrative and clinical services. Benchmarks are derived from a variety of industry services (e.g., state hospital associations, professional associations, consulting groups), and the system then budgets to benchmarks, with annual improvement goals built in. Local facilities are asked to develop their own strategies to achieve the benchmarks, with a good deal of flexibility in implementation so the appropriate mix of "under" and "over" benchmark decisions can be determined based on facility-specific factors, even as the facility manages to the overall benchmarked number. Dan Harris, CFO of Swedish Health Services, an affiliate of Providence Health & Services, notes, "The system does not necessarily strive to be in the top decile of benchmarks. In clinical areas, for example, Providence has adopted the 35th percentile as its productivity benchmark, in the belief that a harder push may lead to sacrifices in quality of care and morale."

Outsourcing and insourcing. Significant cost savings can be achieved through outsourcing appropriate services or, in some cases, bringing outsourced services back in-house.

Having accomplished its staff reduction goals, VUMC is considering which services can be outsourced. It already has outsourced servicing of desktop computers within the system to a national vendor, with estimated savings of 15 to 20 percent on a $5.6 million budget. Providence Health & Services likewise is looking for savings within its IT budget. Given the size of the organization, it has a sufficient volume

of business to support an IT equipment distribution center located at the system's new consolidated service center in Lacey, Wash. The center offers centralized formatting of all IT equipment before it ships and a vendor-certified repair service for damaged equipment.

Conversely, Banner Health has realized an estimated $6 million in annual savings by insourcing a formerly outsourced service. Banner had contracted with a vendor to perform secondary physician reviews for observation-status patients and denials management. The vendor was paid "by the click," with a minimum number of clicks required by contract. Banner realized that the vendor's physician advisors were talking with Banner physicians over the phone, but not fully engaging with them on potential underlying issues. Banner created a new position, medical director of care coordination (MDCC), and put MDCCs into its larger facilities as well as in a central hub. The MDCCs have helped assign the correct status to patients up front, and they can go immediately to the physician for a secondary review if any issues arise. They also have helped with concurrent care denials and in engaging the system's physicians in clinical documentation. Most importantly, they spend a considerable portion of their time on-site and have been able to develop strong working relationships with Banner's physicians.

QUESTIONS TO IDENTIFY LABOR EXPENSE REDUCTION OPPORTUNITIES

Banner Health has developed a series of questions to help managers identify labor expense reduction opportunities in their departments:

- If our goal is reduce labor expenses as a percentage of revenue over the next six to eight years, how do you think we can reduce labor expense each year? For example, can we reduce overtime, callback, and premium/casual labor?
- In thinking about reducing labor costs, is there an opportunity to improve or change your department's skill mix to ensure associates are working at the top of their credentials? Alternatively, is there an opportunity for self-service or automation?
- Have you considered FTE mixes: 1 (80 hours), 0.8 (60 hours), 0.6 (48 hours), etc.? The best balance of full-time and part-time staff? Interns? Temporary contract employees?
- Do you employ any temporary or contracted staff to handle volume or the cycle of your work?
- Have you adjusted your staffing for any recent acquisitions or new lines of business?

Strategies for implementation. Because efforts to reduce the size of staff or increase productivity can have a significant impact on an organization's culture and morale, a strategic approach to labor- and productivity-focused initiatives is critical. The following considerations are especially important.

Timing. Benefis Health System purposely launched its "break even at Medicare" initiative in 2009, before the system was feeling the full impact of reductions in Medicare and Medicaid payment rates (it achieved its goal in 2012). With approximately 70 percent of its patient revenues coming from government payers, the system knew it had to reduce its cost structure to remain viable over the long term. By getting an early start, the system was able to make three promises to its staff when it launched the initiative:

- There would be no staff layoffs
- There would be no cuts to staff benefits
- There would be salary increases each year

"The commitment to no layoffs and regular salary increases was very important for employee trust, and was enabled by the fact that Benefis was looking ahead instead of being reactive with the initiative," Olinger says.

The three promises to Benefis staff were supported by two additional emphases: to "retain and retrain" employees, moving people into new roles or asking them to take on new responsibilities; and to communicate regularly and openly with staff. "Communication is key to employee satisfaction," says system CEO John Goodnow. "We sponsor employee open forums three times per year, make use of an internal newsletter, and send an annual thank you letter to staff after the holidays congratulating them on the year's accomplishments."

A system may not always enjoy the benefit of time, of course. Rapid changes in the payer environment left VUMC facing a $250 million gap, and the system needed to respond quickly. It decided to eliminate both vacant and filled positions over a short time period (approximately four months), thus minimizing the duration of the inevitable pain caused by staff reductions. C. Wright Pinson, CEO of Vanderbilt Health System, describes the biggest

lesson from the experience as the need to identify and act upon problems as quickly as possible, ideally creating a greater time frame for action. "A system our size naturally turns over approximately 2,500 people each year, and our targeted staff reductions of 1,100 positions were less than half this number," Pinson notes. "With more time, we could have handled the problem primarily through attrition."

Regardless of the time available, systems that are reconfiguring the size of their labor force should also remember that, as positions are eliminated or combined, work flows must be redesigned to align with new staffing models—ideally before the new model is implemented.

Use of internal project management teams. Both Banner Health and VUMC created special internal teams to identify opportunities for staff reductions and workforce reconfiguration. At VUMC, as noted previously, a team of 30 individuals were taken out of their regular jobs and assigned to a program management office full-time. Team members were chosen based on their knowledge of the health system and were guaranteed a return to their regular positions. The team included analysts, registered nurses, finance department members, and IT staff who could help with data pulls. The team went unit by unit through the system, looking at existing staff levels and establishing targets for reductions. The review was based on a "rank and select" process that considered factors such as needed skill sets and degree credentials for the positions. Out of 15,000 positions reviewed, 1,100 were identified for elimination.

For its CSO initiative, Banner Health put together eight cross-functional teams, comprising middle managers, a consultant from a firm Banner had engaged for the initiative, and a sponsor or steward from the system's leadership team. Each team was given an eight-week schedule to identify changes that would drive cost reductions within each division of corporate services. The work of the teams was done confidentially, an approach that has both pros and cons. "On the one hand, it ensures that there are no 'sacred cows' and that team members can talk about anything," says Kirsten Drozdowski, Banner's optimization senior program director. "On the other hand, it can undermine employee morale and means that individuals who are not members of the team can dispute data or other premises of the team's work." On balance, the short time period that team members were given to identify recommendations probably helped

WORKING WITH CONSULTANTS

Most of the health systems interviewed for this report have engaged consultants to assist in their efforts to identify opportunities for cost savings and to implement strategies to achieve those savings. Consultants often bring a valuable outsider's perspective on a system's operations that can identify opportunities not readily apparent to individuals who are working within the system on a daily basis. They also have experience in implementing cost-reduction strategies across a variety of organizations. At the same time, systems should take care to distinguish between what a consultant recommends and what the system is willing to "own."

Some tips gleaned from our conversations with health systems include:

Use consultants to validate the need for cost reductions, but own the issue. When Vanderbilt University Medical Center (VUMC) faced what it projected as a $250 million gap, the opinion of an outside consultant verifying the need to address that shortfall gave management the support it needed to pursue cost reductions. At the same time, VUMC's leadership made clear that it was taking full responsibility for an initiative, known as Evolve to Excel, that took those costs out of the system. For example, VUMC leadership, not the consultants, made any public presentations to staff.

Understand that recommendations must be paired with realities. Very few systems will be able to achieve all the cost-saving opportunities that a consultant might identify. Leadership typically will have a much stronger sense of an organization's unique culture and capabilities than will an outside consulting firm. Consider all recommendations, but give priority to those that seem the most achievable.

Use consultants to "train the trainers" within your organization. Consultants can bring valuable skills in project implementation and management to an organization. Leaders should identify staff who are strong project managers and make sure they have the opportunity to observe and learn from the consultants' work. Banner Health assigned staff to learn the process for facility-based optimization efforts from its consultants so the work could be continued internally at additional facilities within the system.

Bring talented consultants in-house. Consulting firms are incubators for industry talent. System leaders should consider making an offer to employ individuals who have displayed standout skills.

to mitigate any negative consequences that a more drawn-out period of confidential work could have amplified.

Maintaining and building on gains. Gains from a significant reconfiguration of staff can be eroded if a system does not have a strategy for maintaining or building upon those gains. At Benefis, a position control committee has been put in place to review all requests for staffing. Comprised of six to seven members, the committee is peer-staffed and includes managers, directors, and the chief administrative officer. When a request for staffing is made, the committee looks first at working with the manager making the request to see whether changes in work flow or processes would make a new position redundant. The committee also looks at how well the requesting manager is performing against his or her productivity and budget goals, and scrutinizes a request more closely if these goals are not being met. Peter Gray, executive director of Benefis senior care, currently leads the committee and notes that its ability to make timely adjustments to system finances is a big part of its success. "If Benefis is having a more difficult month, the committee can 'turn off the spigot' for new hires," Gray says. "When the system rights itself, the spigot reopens."

At Banner Health, the CSO initiative was successfully transferred to several of the system's facilities and then system-wide. Staff from several Banner facilities had served as "external" members of the CSO cross-functional teams to give feedback and challenge the team's assumptions. Members of the Banner-University Medical Center (formerly Banner Good Samaritan) staff who had participated on the CSO teams suggested making a similar effort at the hospital, and identified almost 100 ideas for implementation at the facility. Subsequently, the idea was taken up at Banner North Colorado Regional Medical Center, Greeley, Colo. Results of the facility-based optimization projects, reported in the *Harvard Business Review*, included a reduction of 15 percent in Banner-University Medical Center's cost structure, with $15 million in direct savings realized over 12 months; and savings valued at 17 percent of Banner North Colorado's labor and non-labor cost base, with more than $13 million in annualized savings captured in the first year.[50] Banner since has launched

OPTIMIZING "SYSTEMNESS"

Multi-facility health systems have the opportunity to magnify the gains that one facility is able to achieve. They also can tap into a depth of expertise not available to smaller organizations. These advantages may not be realized, however, unless a system makes a conscious effort to optimize "systemness." Examples of these efforts include:

Clinical performance groups. Both Providence Health & Services and Banner Health are assembling clinical groups that draw members from across their organizations, organized around a particular clinical area or specialty. While these groups are useful in defining clinical pathways and protocols on behalf of their peers, they also serve as networking opportunities within a specialty, bringing to the surface different areas of expertise that may not have been recognized before.

A "broadcast" approach to cost savings. Doug Bowen, vice president of supply chain management for Banner Health, distinguishes between a "broadcast" approach and a "serial" approach to cost savings. In a broadcast approach, many different things are happening in different places at the same time. In a serial approach, the organization as a whole is pursuing the same objective via the same series of steps. Bowen notes that a big, system-wide serial approach "can take up a greater amount of time and energy than 100 smaller projects that achieve the same result." When a broadcast approach is able to produce a lot of good ideas, the impact of those ideas can be multiplied by sharing them across the many facilities within a system.

System-level services. Providence Health & Services has made a significant effort in recent years to consolidate administrative services at the system level. As the process nears completion, the system can reduce administrative and operational expenses at the regional and facility levels.

Again, optimizing systemness requires a conscious effort—and a smaller size can have its own advantages. An interviewee at Benefis Health System who formerly worked for a large system notes, "What you can lose with economies of scale is accountability. Benefis is more lean and nimble, and it is impossible to hide here."

[50] Dahlen, D., and Bailey, C., "Cutting Costs Without Cutting Corners: Lessons from Banner Health," *Harvard Business Review*, Oct. 18, 2013.

a system-wide optimization effort across its acute care hospitals and healthcare facilities.

SUPPLY CHAIN

Supply costs are second only to labor, with supply chain and purchased services budgeted at approximately 18 to 20 percent of net healthcare revenue at the health systems HFMA visited for this report. While supply chain optimization has been a focus of many systems in recent years, supply chain managers are under constant pressure to compensate for inflation, new technology, and other new areas of spend.

Several interviewees commented on the impact of specialty pharmaceuticals. For example, Doug Bowen, vice president of supply chain management for Banner Health, notes that in 1985, 4 percent of the supply spend was on pharmaceuticals. By 2014, that share had grown to 28 percent, with the increase attributable to the rise of biological drugs, new cancer drugs, and other specialty pharmaceuticals. Dave Hunter, vice president of supply chain management for Providence Health & Services, cites similar statistics, noting that the organization's spend on specialty pharmaceuticals rose from 25 percent to 33 percent of total supply spend over the past five years. Although little can be done to check the rise in the cost of specialty pharmaceuticals, these increases add to the imperative to find savings elsewhere in the supply chain.

Physician preference items. Supply chain managers actively are seeking opportunities to collaborate with physicians, and are putting in place formalized structures for clinical participation in supply chain management and review of supply chain spend. At VUMC, supply chain leader Teresa Dail works closely with the Medical Economics and Outcomes Committee, members of which are on stipend and focus on new product and technology acquisitions and requests to deviate from established vendors. The committee is increasing its engagement with the system's patient care centers (including surgery, oncology, and cardiology) to demonstrate how opportunities with different suppliers could help reduce variations in care and produce more consistent patient outcomes.

At Banner Health, Bowen is working closely with Terry Loftus, MD, Banner's medical director of surgical service and clinical resources, to assist physician value-added analysis teams representing each specialty in the development of supply formularies. Banner is committed to the belief that reduced variation in clinical care produces high-quality, reliable outcomes. Accordingly, when a formulary has been developed for a specialty or service line, physicians must request an exception and present evidence on why an exception is justified.

At Providence Health & Services, one of the largest not-for-profit healthcare organizations in the nation, consolidation of supply chain operations at the system level is enabling a cross-system view of spending, which is helping to reduce "special spends" by clinicians and promoting greater standardization of clinical supplies. Clinicians requesting "special spend" items now are required to complete a product request form. Before making the purchase, supply chain management can check a database to see whether the system already has contracted for that supply at another facility and, if it has, see the contracted price. It can then either insist on the contracted price for the "special spend" request or negotiate a better price based on increased volumes for the supply.

Standardization of supplies. Standardization—or "reduced variation," as it is known on the clinical side—is a focus of most supply chain managers. Less variation means greater volume of the "standardized" supply, which can be a bargaining point for a lower price from a vendor. Standardization also is a strong factor in ensuring the quality and reliability of a service or product. But, as Banner Health's Bowen cautions, "Standardization can be overdone, and when you do standardize, you want to do so at the appropriate level."

Bowen offers two examples to support his point. In its operating rooms, Banner was using an evacuator and waste management system that had four manifolds available to evacuate smoke and fluids. A nurse identified a two-manifold device that worked for 80 percent of the cases in the OR. Banner now uses the more expensive, four-manifold device only where needed. "You want to meet specifications, but you don't need to exceed them," says Bowen.

In the second example, one of Banner's facilities wanted to standardize its IV tubing. But there are many different types of IV tubing, ranging from single-port to multiple-port tubes. The only way to standardize would be to go with one "all capable" tube, which would drive up costs because

the more expensive tube would be used in all circumstances, and often when it was not needed. As Bowen observes, "You don't always need to drive a Mercedes if a Chevy can get you to the same place."

Strategies for implementation. All of the systems interviewed for this report participate in a national group purchasing organization (GPO). Both Providence Health & Services and VUMC have worked with their national GPO vendor to develop customized contracting models that enable them to operate what is in effect a regional GPO within the framework of the national GPO.

Originally named ProvSource, the contracting model at Providence uses a three-pronged approach to achieve supply chain savings. First, it can use the national GPO's portfolio. Second, the national GPO's portfolio options can be enhanced to provide additional benefits to Providence. Third, Providence can develop customized pricing with vendors out of the national GPO's portfolio to meet unique system needs. Under this structure, Providence is able to negotiate for the custom-pricing arrangements based on price benchmarks negotiated by its national GPO; as ProvSource, it also offered its services to other systems in the Pacific Northwest. ProvSource's goal was to negotiate pricing 5 percent below contracted price benchmarks negotiated by its national GPO, and it achieved between 11 and 12 percent. The original ProvSource affiliations have changed as participants have merged with other systems and moved out of the arrangement with Providence. Following its affiliation with Swedish Health Services, however, Providence is big enough to maintain the customized pricing model.

VUMC's Dail also describes the purchasing affiliate her system has created as a regional purchasing collaborative operating inside the framework of its national GPO, with VUMC serving as the contracting agent for affiliate members (note that the purchasing affiliate and its members are distinct from the Vanderbilt Health Affiliated Network, described later in this report). Participation in a particular supply purchase is voluntary for affiliate members—VUMC shows the value it can obtain for the member, which chooses whether it wants to participate. After choosing to participate, an affiliate member signs a letter of commitment and monitors its spend on a monthly basis to ensure that it is meeting its commitment. Dail notes that the arrangement also appeals to vendors because, unlike the national GPO, VUMC can leverage its relationships with affiliate members to drive compliance with contract terms. This approach lets vendors confidently put the revenue for the supply purchase on their books.

Other strategies for reconfiguring costs in the supply chain include:

Consolidating supply chain functions. As part of its effort to consolidate administrative services at the system level, Providence Health & Services has built a consolidated service center for the organization's Washington, Oregon, and Montana facilities. The center is moving to "just in time" distribution, which lowers inventory costs, and has invested in carousels that use "pick to light" technology for handling inventory, which can double conveyor rates. The system also has hired industrial engineers to analyze nursing carts, operating rooms, and catheter labs to estimate "just in time" inventory needs and reduce losses from obsolescence and waste, especially on higher-cost items. The fill rate on supply orders in the consolidated service center has gone from between 93 and 94 percent to between 98 and 99 percent.

Establishing vendor expectations. Benefis has established what supply chain leader Bryan Buckridge describes as a strict "we do not price-shop" policy. When working with a new vendor, Benefis does not disclose its current price or engage in lengthy negotiations. Vendors are told to come in with their best offer and that if they fail to do so, they will not be allowed to rebid for a six- to 12-month period. At the same time, an existing vendor is given a "one shot" opportunity to rebid. With this policy in place, Benefis secured $3 million in savings over the prior year's budget in 2007-08, an additional $1.9 million in 2011, and $956,000 in 2013.

CLINICAL TRANSFORMATION

When asked where they saw opportunities to achieve cost savings, respondents to the HFMA survey identified clinical transformation (clinical-process and work-flow redesign and greater use of clinical pathways based on evidence-based medicine) as the greatest opportunity by a substantial margin (see the exhibit on page 239). Yet this is an opportunity that many systems are just beginning to explore. Clinical transformation can be

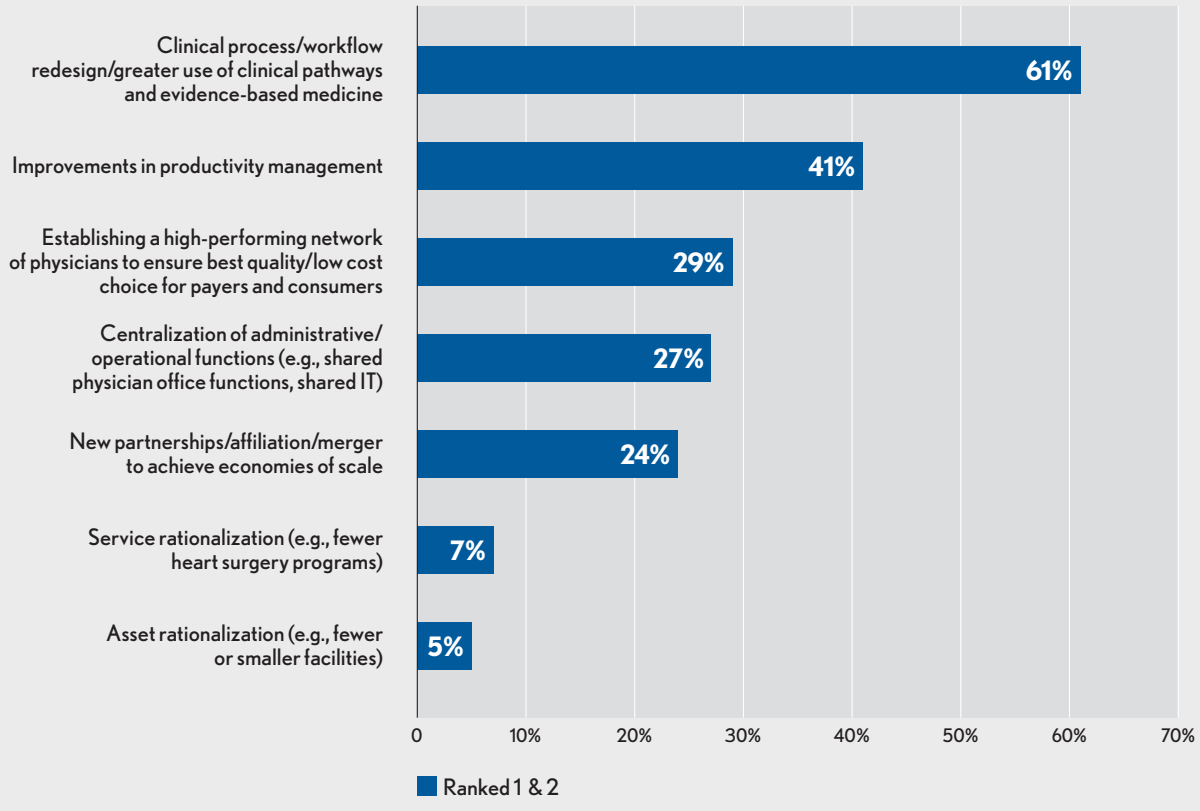
a difficult process for a number of reasons: It can require significant changes to a physician culture that has long prized autonomy in clinical decision-making, it can disrupt long-standing relationships between physicians and medical supply representatives, and it requires a delicate balance between reducing variations that do not improve clinical outcomes and giving clinicians adequate flexibility to address individual patient needs.

Twila Burdick, vice president of organizational performance at Banner Health, described the system's emphasis on clinical transformation work as "increasing clinical reliability." There are clear virtues to reducing variation—particularly when there is good evidence—including delivering superior outcomes, ensuring that patients have a common experience across the system, and creating a platform for ongoing learning and improvement. Banner is a diverse system in terms of geography and facility size. When the system's clinical consensus groups get to work on designing a new clinical practice, they address the granular effects at the patient level and the specific needs of patient sub-cohorts. Charles Agee, MD, chief medical officer for Banner's Arizona West Region, notes, "Our intent is not to implement 'cookbook' medicine. Instead, it is to provide basic pathways for patient care that allow clinicians to use their acumen to focus on outliers."

VUMC in 2011 launched its Vanderbilt Health Affiliated Network (VHAN), a network of health systems and other providers across Tennessee and adjoining states that will be VUMC's primary vehicle for entering risk-based contracting. William Stead, MD, chief strategy officer for VUMC, and David Posch, CEO of Vanderbilt University Hospital & Clinics and executive director of Vanderbilt

OPPORTUNITIES TO ACHIEVE SAVINGS

What have you identified as the greatest opportunities to achieve savings, either directly or through utilization impacts, over the next three years?



Medical Group, describe a "spine" of care transformation capabilities that VUMC is developing to support the provision of reliable, value-based care across the network. Stead describes the approach to extending these models across the network as "mass customization of a standard chassis" to adapt models to the needs and capabilities of particular network members.

Consensus models for clinical transformation. One of the biggest challenges in clinical transformation initiatives is engaging clinicians in the value of the work and securing their commitment to new clinical pathways and protocols. Physician leadership is critical to meeting this challenge, building on peer-to-peer relationships to establish a foundation of trust. Banner Health and Providence Health & Services have developed clinical transformation models that bring together teams of clinicians from across the organization to address variations in clinical practice, develop evidence-based clinical pathways and protocols, and build consensus on new care delivery models with their peers.

To date, Banner Health has formed approximately 20 clinical consensus groups throughout the system to develop formularies and clinical pathways designed to reduce variations in clinical processes. Each clinical consensus group is co-led by a clinician and a physician (who often is not employed by Banner). Agee notes, "The fact that ideas for new clinical pathways come out of these groups means that change isn't being driven top-down. Members of the group go back to their colleagues and hospitals and help move them in a new direction."

Successes so far include discontinued use of adhesion barriers in Cesarean sections and a simplified total knee arthroplasty (TKA) clinical pathway. In the first example, adhesion barriers that were effective in abdominal surgery also were being used for obstetrics, but the clinical consensus group agreed that there was not a sound basis of evidence for their use in C-section procedures. Once the use of the barriers was discontinued in obstetrics, Banner saw $1 million in annual supply cost savings without an increase in complications for repeat C-sections.

In the second example, a simplified TKA pathway focused on two elements: avoiding placement of a continuous urinary catheter following the procedure and encouraging early ambulation (avoiding the use of continuous passive motion machines). Banner found that patients who did not have the catheter placed were 5.9 times more likely to ambulate postoperatively on the day of surgery, and that patients who ambulated on the day of surgery then were 2.9 times more likely to ambulate two or more times on the first postoperative day. After adoption of the new pathway crossed the 40 percent threshold, reductions in complications, length of stay, and readmissions amounted to $3 million in savings and drove overall improvements to patient care.[51]

As of the date of this report, Providence Health & Services has brought together 16 system-wide clinical performance groups (CPGs) comprising 2,000 physicians, both independent and employed. The CPGs are related to service lines, but because they take a "condition" rather than a "procedure" view of clinical care, they also may include emergency physicians, primary care physicians, and other clinicians in addition to the relevant specialists.

Efforts of Providence's CPGs are focused on six "pillars":

- Resource standardization
- Evidence-based medicine and resource utilization
- Clinical technology assessment and adoption
- Research
- Accountable care and reform readiness
- Optimization of the system's electronic health record (EHR) and data warehousing

CPG members are recruited from across the system to ensure all of Providence's nine regions across five states are represented in the groups. Once formed, a CPG holds an initial summit, beginning with general sessions that include information on the effects of clinical practice reform and both national and system perspectives on the CPG's specialty. The CPG then breaks into rigorously facilitated affinity groups to address key questions and brainstorm ideas related to each of the six pillars.

As an example of the CPGs' work, the cardiac rhythm management and prevention affinity group within the cardiovascular CPG discovered that Providence had 13 contracts for cardiac rhythm management. Physicians from that affinity group then signed confidentiality and conflict-of-interest documents and engaged in a thorough review of opportunities with vendors. Any vendor product that the group perceived as substandard in terms of quality

[51] For more information on the results of the total knee arthroplasty simplified pathway, see Loftus, T., et al., "A Simplified Pathway for Total Knee Arthroplasty Improves Outcomes," *The Journal of Knee Surgery*, June 2014.

immediately was ruled out. After the group identified a list of agreed-upon superior devices, the system posted a request for proposal (RFP) for those vendors and, as a result, saved $15 million in the first year.

Providence also is forming advisory councils to serve as governance bodies for each CPG. The advisory councils include clinicians and executives from each of the system's nine regions. Clinician chairs are elected internally from each council and are paired with a co-chair from the system's clinical program services team (one of the team's vice presidents, who have a mix of clinical and executive backgrounds) to form a leadership dyad for each council. The advisory councils will lead discussions with the system's leadership about capital needs or business opportunities on behalf of their CPG.

Clinicians engaged in the CPGs are discovering the breadth of expertise that is available across the organization. A longer-term goal for the CPGs as their work progresses is the development of research institutes for CPG specialties that will help drive further clinical transformation within the system and also build Providence's reputation for specialty care to enable greater retention of high-acuity patients within the system.

Diagnostic management teams, predictive modeling, and clinical transformation. At VUMC, the role of the academic medical center as a "convener of significance" for the hospitals and health systems in the Vanderbilt Health Affiliated Network also positions VUMC as an innovation hub for evidence-based clinical transformation initiatives that flow from VUMC's clinical research capabilities. Once VUMC proves the validity of a new clinical model, that model can be disseminated through VHAN, giving clinicians within the network access to cutting-edge, evidence-based clinical practices and strengthening the value of affiliating with VUMC for the VHAN hospitals and health systems.

A primary focus of VUMC's clinical transformation work is developing diagnostic protocols that can be disseminated across VHAN, and potentially adopted on a national scale. Stead, the chief strategy officer, notes, "No one talks about diagnostic error, and it is large. Our goal is to focus on the predictive, not the reactive, in our clinical transformation work."

The potential of evidence-based standard-ordering protocols (SOPs) for diagnostic testing was demonstrated in VUMC's development of SOPs for cytogenetic and molecular testing that pathologists applied to bone marrow biopsies on adult patients. To develop the SOPs, VUMC implemented a diagnostic management team that brought together clinicians from pathology, hematology, and biomedical informatics. The team compared testing for biopsies performed during the six months before implementation of the SOPs with testing for biopsies performed during the 12 months following implementation. The results included a significant reduction in the total number of ordered cytogenetic and molecular tests, a decrease in the omission of recommended tests, and a reduction in the cost of laboratory testing to payers from an average of $2,390 per bone marrow in the six months preceding SOP implementation to $1,948 per bone marrow 12 months after implementation (for a savings of $442 per bone marrow). Extrapolation of these numbers to an estimated national bone marrow volume of 666,000 annually would result in a savings opportunity to payers of between $191 million and $392 million per year.[52]

Both the clinical consensus and diagnostic management team models represent physician-led approaches to clinical transformation that leverage cross-functional expertise within a system to develop new approaches that can be disseminated across broader networks. Originating from clinical teams, and carrying the endorsement of those teams, these approaches to clinical transformation are designed to gain acceptance from other clinicians within the system or network.

SERVICE LINE AND ASSET RATIONALIZATION

Service line and asset rationalization holds significant promise for cost reconfiguration efforts. Changing utilization patterns increasingly favor outpatient over inpatient care, and that trend is beginning to create excess hospital bed capacity in some markets. In the longer term, a focus on population health management is likely to reduce demand for certain specialty and high-acuity services. "In many respects, by restructuring a major category of fixed costs for most healthcare systems, service line and asset rationalization goes to the heart of the topic of reconfiguring cost structure," says Piro of MedAssets. "But restructuring fixed costs is not an easy job. It's also

[52] For a full description of Vanderbilt University Medical Center's bone marrow testing protocols, see Seegmiller, A., et al., "Optimizing Personalized Bone Marrow Testing Using an Evidence-Based, Interdisciplinary Team Approach," *American Journal of Clinical Pathology*, November 2013.

important to note that, as care delivery changes, organizations may seek to eliminate redundant services offered within a market while pursuing new services that support new care delivery models."

Both the challenges and the potential of service line and asset rationalization are reflected in HFMA's member survey. When asked where they saw the greatest opportunities to achieve savings over the next three years (see the exhibit on page 239), only 7 percent of respondents identified service line rationalization (e.g., fewer heart surgery programs) as a highly ranked opportunity, and still fewer chose asset rationalization (e.g., fewer or smaller facilities). At the same time, more than 4 in 10 respondents indicated that their organizations are looking at service reductions or service line rationalization as a strategy to reduce costs (see the exhibit below).

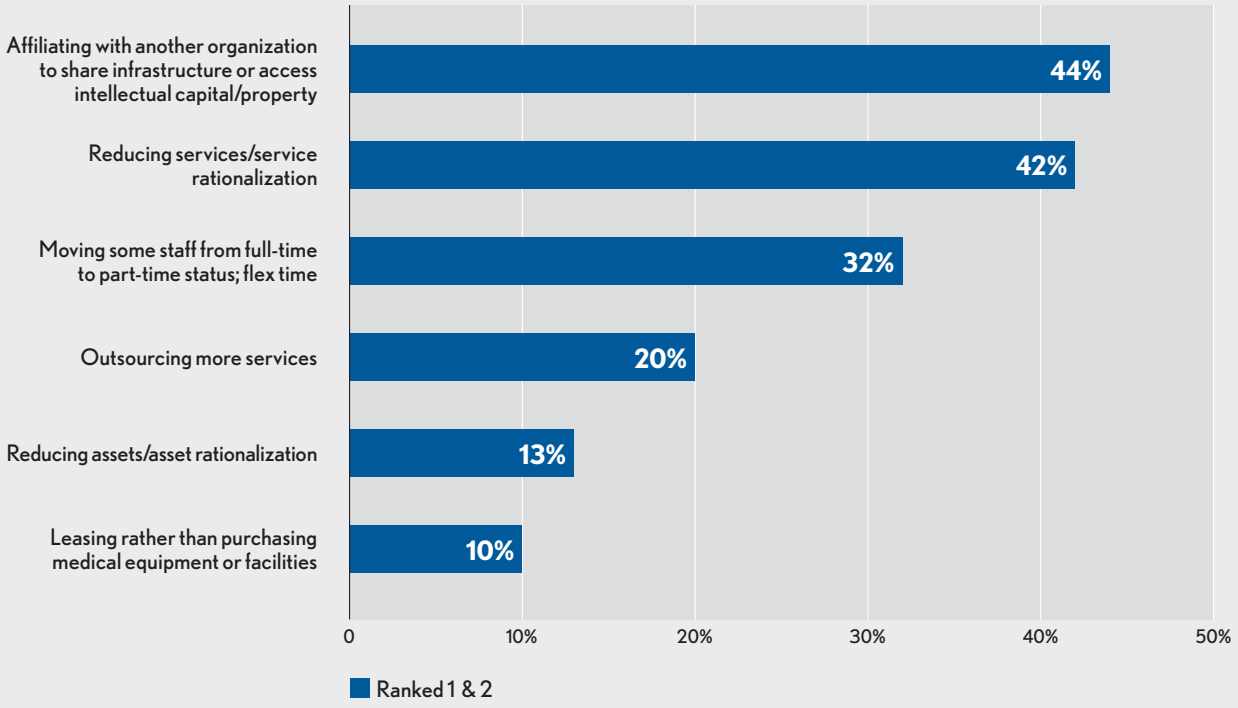
Opportunities for service line and asset rationalization can be limited by both market and political considerations. A system may be reluctant to consolidate a service line if, by taking that service out of a facility, it creates an opportunity for a competitor to move in and take market share. Downsizing or eliminating an existing facility can be politically unpopular if it takes jobs and visitors out of the local economy.

A number of the systems HFMA interviewed have begun to look at opportunities for service line and asset rationalization. In considering these opportunities, key factors include:

- Community needs (e.g., urgent care services may be able to replace more expensive emergency department [ED] services)
- Willingness of patients to travel to a new facility if a service line is discontinued in their primary facility

STRATEGIES TO REDUCE COSTS

What strategies, if any, is your organization employing to reduce its costs?



- Willingness of physicians to refer patients to a new facility
- Degree of competition within the market for the service line in question
- Organizational impediments to service line or asset rationalization (e.g., if individual facilities within a system are held to facility-specific budgets, they may be more territorial when rationalization opportunities across the system are considered)

While many of the systems represented by the respondents to HFMA's survey have not prioritized service line or asset rationalization as one of their top cost management strategies, a majority of the systems that have done so identify reductions in both the number of inpatient beds or inpatient facilities within a system and in imaging equipment as key areas of focus.[53] More than a third also are targeting other radiology equipment, and approximately one-fourth are targeting surgery equipment.

ADDITIONAL OPPORTUNITIES

Opportunities for cost reduction or reconfiguration are not limited to the categories described above. A stand-alone hospital or small system that merges with a larger organization may have opportunities to restructure and reduce its debt burden. Systems may be able to reduce administrative costs by simplifying and streamlining governance structures—both Banner Health and Providence Health & Services, for example, rely on essentially a single board for system governance (although they also use advisory boards at the facility or community level). A single technological solution for the organization as a whole can contribute to economies of consistency and avoidance of error.

The key is to build a culture in which individuals are encouraged to pursue opportunities to improve cost efficiencies (and are recognized or rewarded for doing so). In the words of Goodnow, the Benefis CEO, "Health care has become outlandishly expensive; there is so much that can be done on the cost reduction side."

[53] Nineteen of the 146 respondents to the HFMA survey (13 percent) identified asset rationalization as one of their top two cost reduction strategies.

PREPARING FOR THE TRANSITION TO VALUE

For many organizations, the focus on cost containment in system administration and hospital-based services and facilities is balanced by new investments in networks that systems are assembling to engage in risk-based contracting and population health management. Among the major areas of investment are healthcare IT—including data-warehousing technologies that are able to draw information from disparate EHRs and other data sources—and clinical networks that meet the demand for better management of patient care at the primary and secondary levels to avoid more expensive care at tertiary and quaternary levels.

This reconfiguring of cost structure—reduced spending on administration, facilities, and equipment, and increased spending on physician networks and healthcare IT—is reflected in the results of HFMA's member survey. Clear majorities expect increased expenses in the areas of healthcare IT and physician organization and services (77 and 61 percent, respectively), while fewer than half anticipate increased costs in other areas. At the lowest end of the scale, just 8 percent of respondents expect increased costs for administrative staff and services (see the exhibit on page 228).

BUILDING NETWORK INFRASTRUCTURE

Approximately three years ago, an RFP put out by a major Washington employer for a narrow network health plan product for Seattle-area employees was a catalyst for Providence Health & Services' creation of the Providence-Swedish Health Alliance (the Alliance). The Alliance's product ultimately was one of two selected by the employer. The contract employs a "shadow capitation" methodology: The Alliance commits to a downward cost trend on a per member per month basis over the course of the contract's five-year term, with any costs above this trend line refunded to the employer on an annual basis. Providence Health & Services has recently built out the infrastructure required to support this new contract—and shared with HFMA the key components of the infrastructure, which also will be used to pursue additional risk-based contracting opportunities.

Joseph M. Gifford, MD, chief executive of the Alliance, estimates that Providence Health & Services has invested approximately $150 million to build the infrastructure needed to support the Alliance. Investments have been made in the following areas.

Network development. To ensure a network adequate to meet the needs of employees across the Seattle area, Providence Health & Services and Swedish Health Services (an affiliate of Providence Health & Services since 2012) have combined their employed physicians with a number of medical groups that historically have had links with the systems (including Edmonds Family Medicine, the Everett Clinic, Minor & James Medical, Pacific Medical Centers, the Polyclinic, Proliance Surgeons, and Western Washington Medical Group). This arrangement required the development of risk-sharing contracts with each of the network members.

To ensure compliance with federal antitrust guidance on clinically integrated networks, which require a focus on both clinical and financial integration, monthly joint-operating committee meetings are held with physicians and other clinicians from the network member organizations (thus satisfying the requirements regarding clinical integration). In addition, the Alliance's risk-sharing contracts make at least 30 percent of any member organization's risk dependent on the performance of the network as a whole (thus satisfying the requirements regarding financial integration).

Healthcare IT and data analytics. The Alliance has made significant investments in ensuring network members' ability to communicate within a highly complex IT ecosystem. Four instances and multiple versions of the same vendor's EHR system are in place across network members, as are other vendors' systems. The network has been able to take advantage of Washington state's Emergency Department Information Exchange (EDIE), which initially was developed to help emergency physicians track patients who were seeking pain medication from multiple providers. With most systems in the state reporting into EDIE, it has become a good tool for tracking

admissions information across provider organizations. To meet its goal of providing real-time, actionable utilization and quality information to network members, the Alliance is sending out daily reports that combine three different data feeds. The Alliance also has embedded flags in network members' EHRs that enable them to recognize patients who are members of the Alliance's narrow network product.

Patient experience. As part of its initial contract with the employer, the Alliance committed to providing an enhanced patient experience. Accordingly, it has developed a high-touch call and concierge center for the network, a web portal for patients to access their electronic medical record, a directory of network providers, and a mobile phone app that gives network members direct access to nurse practitioners.

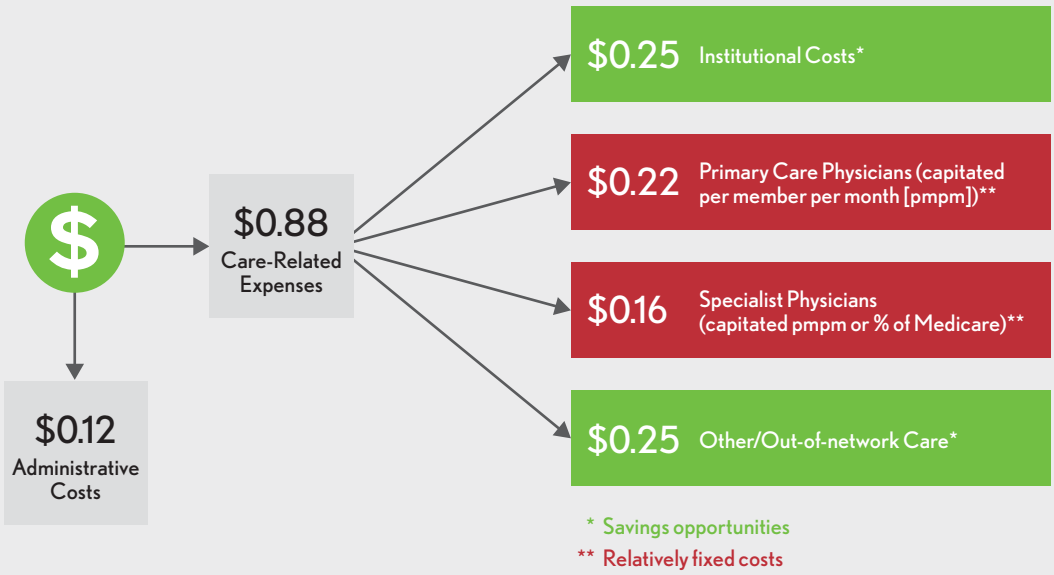
Care management. The employer is amenable to the Alliance's efforts to keep patients out of expensive sites of care, with a particular focus on reducing unnecessary hospital admissions and ED visits. The Alliance thus has invested in a variety of care management strategies—including 21 registered-nurse care coordinators, patient-centered medical homes certified by the National Committee for Quality Assurance, and innovative holistic care delivery models developed by organizations such as Geisinger and Stanford—to ensure that network members receive timely care in appropriate settings.

Contract management and benefit design. Another key element of network infrastructure is getting the right benefit design into place to ensure that narrow network members seek their care from in-network providers. Gifford cites an ideal coinsurance differential of 40 percent—in other words, a narrow network member might have 90/10 coinsurance for in-network providers but 50/50 coinsurance for out-of-network providers.

Network support staff. A staff of more than 25 FTEs supports the Alliance, with functions in finance and contracting, analytics, communications and PR, and sales and marketing (a key component in expanding enrollment in the Alliance's network products).

PREMIUM-DOLLAR BREAKDOWN FOR SHARED SAVINGS AGREEMENT

Goal: To bring care-related expenses below the $0.88 benchmark. The network's share of savings is then split evenly between the network as a whole and member organizations.



Gifford notes that systems should not expect an immediate positive return on these infrastructure investments. Instead, he equates the investment with "laying the cable" and building relationships with employers in the market.

FINANCING THE TRANSITION TO VALUE

Although the investment in new care delivery networks and methodologies may not produce immediate returns, health systems obviously have an interest in minimizing their losses in the early years and moving to a positive margin or profit as quickly as possible. The health systems interviewed for this report are deploying a number of strategies to help offset the initial costs of new investments.

Identify opportunities for cost savings. The Banner Health Network is a clinically integrated network comprising the Banner Medical Group (approximately 1,200 employed physicians), the Banner physician-hospital organization (approximately 1,000 independent physicians), and Arizona Integrated Physicians (a group that consists of approximately 1,000 physicians and is owned by DaVita Healthcare Partners). Major contracts for the network include a Pioneer accountable care organization (ACO); Medicare Advantage plans; shared savings agreements with commercial health plans and Banner employees and dependents; and most recently a major local employer. In total, more than 350,000 patients receive care under these contracts.

Greg Wojtal, vice president and CFO of Banner Health Network, offers a basic breakdown of the premium dollar in the risk-based agreements Banner Health Network has entered into (see the exhibit on page 245). The breakdown assumes a historical average spend of 88 cents of care-related expenses for each premium dollar (the remaining 12 cents go to administrative costs). Opportunities for shared savings lie within the network's ability to bring the total care-related spend below the 88-cent historical benchmark.

Services for in-network physicians, both primary and specialty, take up just under 45 percent of care-related expenses, and Wojtal sees these expenses (generally paid on a per member per month basis or, in the case of some specialties, a percentage of Medicare) as relatively fixed. Greater opportunities for savings come from controlling the spend on institutional costs and out-of-network care.

Regarding institutional costs, Banner Health Network has identified two of its greatest savings opportunities in end-of-life spending and elimination of redundant testing. Regarding out-of-network care, side, Banner Health Network is developing apps for network physicians that will enable them to see whether a referral will be to an in-network or out-of-network physician, and also has implemented a dashboard that identifies providers who are meeting quality and efficiency goals.

Wojtal also stresses the need to understand how volume can affect the return on an investment in care delivery and help to prioritize investments. How many patients are high-intensity utilizers of care, for example, and what are their primary disease categories? "This information is important," Wojtal notes, "because you start running into the law of diminishing returns if an investment is not affecting the outcomes of a sufficient number of patients."

Banner Health Network's attention to improved outcomes and cost efficiency has produced positive results in both commercial and Medicare shared savings programs. A shared savings product that it offers to Aetna members achieved $5 million in shared savings and a 5 percent decline in average medical costs per member in 2013 (including 9 percent reductions in both avoidable admissions and radiology services). In the first two performance years of Medicare's Pioneer ACO program, Banner Health Network produced gross savings of 4 percent and 2.8 percent—among the best results of Pioneer ACO participants.

Identify opportunities for early ROI. As systems move toward greater use of narrow networks, accountable care, and population-based payment, "their continued financial viability is a wild card," says Harris, the CFO of Swedish Health Services (affiliated with Providence Health & Services). "Moreover, the question of how to invest now in a world that will change in five years and continue to be financially stable is pressing." Harris's solution is to promote a model that insists on some return today on investments that are being made for a value-based future.

As an example, a group of clinicians at Swedish Health Services had requested an investment of $5 million to build a population health infrastructure, including care managers, that could help care for Medicare Advantage populations under a contract featuring a 50-50 split

between the health plan and providers on savings achieved for the health plan's member population. Harris challenged the clinicians to identify returns on the investment that could cover the cost. Working with the third-party administrator of Swedish's self-funded employee plan, the clinicians were able to calculate $10 million in savings that could be realized if enhanced care management capabilities were extended to employees and their dependents. Opportunities for shared savings with the Medicare Advantage population resulted in another potential $4 million return to Swedish. With up to $14 million in returns now tied to a $5 million investment, the clinicians were given the green light. In the first year of the program, only $3 million of the requested $5 million was spent (in part because of difficulty in finding enough qualified individuals to serve as care managers), but $4 million of the potential $14 million improvement in revenue was realized, producing first-year returns in excess of the first-year investment.

Burdick, the Banner Health vice president of organizational performance, clinical, agrees on the need to identify opportunities that generate returns while preparing the system for risk-based contracting. A good example is improving the efficiency of inpatient care. If efficiency can be improved, it contributes to operating margin on the fee-for-service side

INVESTING IN INNOVATION

In addition to its investments in narrow network products and population health management capabilities, Providence Health & Services is funding an innovation agenda to keep the system ahead of potential disruptions in the healthcare marketplace. The innovation agenda has three components:

- A venture fund to invest in developing healthcare IT companies
- A software and digital innovation team dedicated to building new technologies that enhance patient engagement and experience
- A consumer team focused on developing consumer-oriented businesses in areas where Providence believes it has a competitive advantage.

To lead its innovation agenda, Providence recently engaged Aaron Martin as its senior vice president for strategy and innovation. Martin comes to the system from Amazon, where he led the company's self-publishing and North American publishing businesses.

As Martin considers opportunities for innovation in health care, he draws an analogy to the development of self-publishing at Amazon. The core relationship in publishing is between author and reader. The innovation of self-publishing removed "intermediaries" in the form of agencies and publishing houses that acted as potential barriers between author and reader. In health care, there is an analogous relationship between clinician and patient. Identifying the intermediaries that might frustrate this relationship (e.g., time-consuming coding and documentation tasks) and removing or limiting their impact should be the focus of innovation.

The ultimate goal is for the innovation agenda to become self-sustaining—and ideally produce a return for the system.

The potential value of innovation can be optimized in a number of ways.

Emphasize a "small batch" approach to innovation and product development. This approach uses small experiments in fast iterations to determine whether consumers want a particular product or service. The value of some innovations in health care is obvious—the ability to schedule appointments online, for example. But as ideas become more hypothetical and risky, a small-batch approach can gather solid intelligence at relatively low cost.

Pursue online opportunities. "Online services are by their very definition more efficient than 'offline' services, increasing the number of individuals who can be served and reducing the need for physical facilities to serve them," says Martin. When pursuing these opportunities, understanding the share of consumers who have online access is a key metric to determine, for example, what additional percentage of the business could be seen via telehealth technologies. "If you're going to disrupt your own business, you need to measure your progress in doing so," Martin adds.

Recognize the value gained in terms of improved intelligence. "Offline companies survey consumers; online companies observe their behavior," Martin notes. An understanding of consumer behavior patterns provides better intelligence with which to make decisions.

Identify services that consumers want and are willing to pay for. Some services will generate incremental revenue from consumers if they can see the value in terms of enhanced convenience, access, or service.

of the system's business. At the same time, it helps reduce per member per month costs on the risk-based contracting side.

Affiliate instead of own. All four of the health systems interviewed for this report feature organized networks that blend owned resources with affiliations. Benefis participates in the Northcentral Montana Healthcare Alliance, a consortium of 14 healthcare facilities including many of the smaller hospitals that refer patients to Benefis. As noted earlier, Banner Health Network's ACO includes the system's employed medical group, its physician-hospital organization (with independent physicians), and a third medical group owned by DaVita Healthcare Partners. The Providence-Swedish Health Alliance includes several medical groups that have historical relationships with, but are not owned by, Providence Health & Services and its affiliate, Swedish Health Services. And VHAN comprises nine systems and over 40 hospitals serving Tennessee and portions of seven bordering states.

Affiliation offers several advantages over ownership, although systems that organize networks will not completely avoid costs by pursuing an affiliation model. Indeed, they are likely to incur significant costs—for example, in building the IT capabilities that will enable network members to easily exchange data. Still, organizing systems will avoid the substantial costs of acquiring another facility or system. An affiliated network also is more likely than an acquisition to avoid raising antitrust concerns, especially if the network participants remain free to contract with payers independent of the network. Affiliation also can help network participants achieve economies of scale without giving up their independence and local community governance.

Affiliation with a broader network has become a particular imperative for academic medical centers. Pinson, the CEO of Vanderbilt Health System, notes, "The bulk of health care going forward is likely to occur at the primary care level or below, in the world of mobile apps and lifestyle changes. An academic medical center, with lots of expensive physicians, cross-transfers of funds for education and research, and high-cost overhead, cannot compete effectively in this space. Accordingly, it needs partners that will be much more effective in building out everything below the tertiary and quaternary services that the academic medical center is most effective at." Positioning itself within VHAN enables VUMC to move lower-acuity care back into the community so it can focus on its role as quaternary care provider. "We want our affiliates to have the 'bread and butter' business and bring down the cost of care for VHAN overall," Pinson adds.

VUMC's strategy for VHAN explicitly focuses on affiliation over ownership. It would be cost-prohibitive to acquire a network giving VUMC access to the millions of patient lives that an academic medical center requires to support a full range of quaternary services. "Everybody in health care wants to own and control, but that is not an effective strategy for us," Pinson says. As Pinson notes, a major academic medical center such as VUMC has advantages as a "convener of significance" to attract affiliations, but the long-term success of the network depends on the strength of the partnerships between VUMC and its affiliates, with affiliates gaining access to VUMC's medical expertise and healthcare IT platform and VUMC benefiting from referrals of high-acuity patients.

CONCLUSION

The dynamics of today's healthcare marketplace are creating a fundamental reconfiguration of care delivery, affecting how, where, and from whom consumers access healthcare services. These dynamics flow from a general demand for greater value in health care—a demand that is increasingly urgent for consumers who face increased financial responsibility for their care—and from an understanding of the many opportunities to reduce cost and build better, more affordable models for care delivery.

As care delivery changes, so too must the cost structure that supports it. Accordingly, the challenge that hospitals and health systems face today is twofold:

- To maintain a continued focus on reducing costs in response to increasing pressures on payments and declining utilization driven by the demand for greater value, especially with respect to inpatient facilities and services
- To invest in the infrastructure that will be needed to successfully participate in risk-based contracting and population health as both public and commercial payers transition to value-based payment models

These efforts are linked: cost savings in one area of the organization enables increased investment in others. Efficiencies gained in reducing operating costs can increase margins under existing fee-for-service arrangements, enable greater flexibility in pricing to meet the demands of consumers who seek greater value, and prepare an organization for accepting risk-based contracts.

Payment structure, in other words, has little to do with the basic advantages that any organization can gain from careful cost management. To be sure, every hospital or health system in the country could benefit from the cost management strategies highlighted in the first part of this report.

However, the basic advantages that a system can gain from cost containment today will not be sufficient to thrive in the value-based environment being ushered in by changes to payment structures. Already, for example, shifting consumer needs are creating opportunities for new entrants to the healthcare market. Greater price sensitivity and a demand for more convenient and accessible services are prompting consumers to seek alternatives that can provide the desired level of quality and convenience at a reasonable price. Success in this environment will depend on a reconfiguration of resources to manage risk and population health. Health systems also will need to respond to—or create—the inevitable disruptions to healthcare delivery that will continue to emerge in coming years; as noted elsewhere in this report, disrupting your own business model is better than being disrupted by others. As the systems in this report demonstrate, cost containment, cost structure reconfiguration, and innovation can be managed simultaneously. Focusing on all is imperative.

ABOUT THIS CHAPTER

The findings in this chapter are based on:

- A March 2014 survey of 146 of HFMA's senior financial executive members, including CFOs and vice presidents of finance
- Interviews with industry analysts
- Input of the 14 health systems that serve as members of HFMA's Value Advisory Group
- Site visits to four systems that actively are pursuing significant reconfiguration of their cost structure to address current market conditions and prepare for the future: Banner Health, based in Phoenix; Benefis Health System, based in Great Falls, Mont.; Providence Health & Services, based in Renton, Wash.; and Vanderbilt University Medical Center, based in Nashville, Tenn.

Site visits took place during the fall of 2014 and winter of 2015. HFMA appreciates the willingness of these systems to share their experiences and expertise.

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