HFMA'S VALUE PROJECT

The Value Journey

Organizational Road Maps for Value-Driven Health Care

COMMON ISSUES

hfma
healthcare financial management association

ORGANIZATIONS THAT INFORMED THE FINDINGS IN THIS REPORT

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

PARTICIPANTS IN DEVELOPING ROAD MAPS FOR HEALTH SYSTEM CHANGES

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

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

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

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

Difficulty aligning physicians to organizational goals and initiatives. A common challenge across the organizations interviewed is aligning physicians to help lead and accomplish organizational goals and initiatives. Organizations are experimenting with ways to improve employed physicians' involvement in key care delivery and cost-cutting initiatives, including incentive structures. Organizations are also aiming to improve network physicians' alignment with financial and clinical performance efforts. Providers in states with corporate practice of medicine restrictions face particular challenges in improving physician engagement and alignment in strategic and initiative-level leadership.

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

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

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

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

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

A COMMON ROAD MAP TO VALUE

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

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

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

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

COMMON ROAD MAP TO VALUE

LOWER ←

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

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

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

Degree of Care Transformation & Financial Sustainability → HIGHER

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

COMMON STRATEGIES AND INITIATIVES FOR ACHIEVING VALUE

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

PEOPLE AND CULTURE

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

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

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

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

Strategy and structure. The single most common strategy providers have utilized in the transition toward value has been to focus on their organization's cost structure. An emphasis on provider cost reduction is not a new strategy, but it is being pursued as an urgent strategy in conjunction with value-based payment. For value to be realized, efforts to reduce providers' costs must ultimately improve the relationship between the quality of care and the total cost of care to the purchaser.

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

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

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

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

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

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

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

Physician dashboards are being deployed to help educate physicians and assess their performance, and incentive structures for employed physicians are being modified to reward high-quality care and effective care delivery. Earlier Value Project reports have described the importance of moving away from purely productivity-based compensation models, which contribute to overutilization in a fee-for-service environment, toward compensation structures that are based on dimensions of performance rather than productivity. For example, Nebraska Methodist Health System uses dashboards to assess individual physician adherence to clinical protocols, while Billings Clinic anticipates that its upcoming investment in an improved decision support system will enable better analysis of utilization by physician. Tying performance measures directly to compensation bolsters the impact of individual performance reports.

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

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

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

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

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

BUSINESS INTELLIGENCE

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

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

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

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

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

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

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

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

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

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

PERFORMANCE IMPROVEMENT

The crux of the changes that providers will need to make to transition to the emerging payment environment lies in care delivery. The following areas of focus center on improving the coordination, efficiency, and patient 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 report often appear imbalanced, with a much heavier emphasis on inpatient than outpatient care and service. The predominant reason seems to be the willingness of administrative hospital leaders to drive process improvement efforts and the relative reluctance of physician outpatient leaders to do so in an ambulatory setting. Other factors include the lack of an EHR or costing capabilities in an outpatient setting and lack of payer interest in designing bundled payments focused on outpatient care. Of the participating organizations, Winona Health and Geisinger, both of which employ physicians, are leaders in tackling process improvement within an outpatient setting. At both organizations, this has required persistent physician leadership, data and analytics, and a significant investment of time.

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

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

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

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

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

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

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

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

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

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

CONTRACT AND RISK MANAGEMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

RESEARCH SPONSORS

Research for this report was sponsored by the 16 hospitals and health systems represented on HFMA's Value Steering Group:

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