HFMA'S VALUE PROJECT

The Value Journey

Organizational Road Maps for Value-Driven Health Care

MULTIHOSPITAL SYSTEMS

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ORGANIZATIONS THAT INFORMED THE FINDINGS IN THIS REPORT

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

PARTICIPANTS IN DEVELOPING ROAD MAPS FOR HEALTH SYSTEM CHANGES

Academic Medical Centers

- New York-Presbyterian Hospital
- Partners HealthCare
- Rush University Medical Center
- University of Alabama at Birmingham (UAB) Hospital
- Vanderbilt University Medical Center

Aligned Integrated Systems

- Billings Clinic
- Cleveland Clinic
- Dean Clinic
- Geisinger Health System
- Group Health Cooperative
- Scott & White
- Spectrum Health

Multihospital Systems

- Advocate Health Care
- Baptist Health South Florida
- BJC HealthCare
- Bon Secours Health System
- Catholic Health East
- CHRISTUS Health
- Dignity Health
- Fairview Health Services
- OSF HealthCare
- Novant Health
- Nebraska Methodist Health System

Rural Hospitals

- Andalusia Regional Hospital
- Copper Queen Community Hospital
- Crete Area Medical Center
- Franklin Memorial Hospital
- New Ulm Medical Center
- Whitman Hospital and Medical Center

Stand-Alone Hospitals

- Elmhurst Memorial
- Enloe Medical Center
- Holy Spirit Health System
- Longmont United Hospital
- Platte Valley Medical Center
- Winona Health

MULTIHOSPITAL SYSTEMS

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

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

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

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

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

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

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

CHALLENGES AND OPPORTUNITIES

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

KEY RECOMMENDATIONS

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

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

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

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

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

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

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

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

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

Differences in governance and management between multihospital systems. Some multihospital systems make most key governance decisions at a centralized level, whereas others emphasize local, market-specific decisions. Similarly, management processes may be more or less centralized.

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

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

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

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

UNIQUE CHALLENGES AND OPPORTUNITIES FOR MULTIHOSPITAL SYSTEMS

Challenges	Opportunities
• 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

THE ROAD AHEAD: STRATEGIES AND INITIATIVES

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

Under value-based payment, multihospital systems expect to:

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

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

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

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

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

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

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

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

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

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

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

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

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

MULTIHOSPITAL SYSTEM ROAD MAP TO VALUE

LOWER ←

ORGANIZATIONAL CAPABILITIES

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

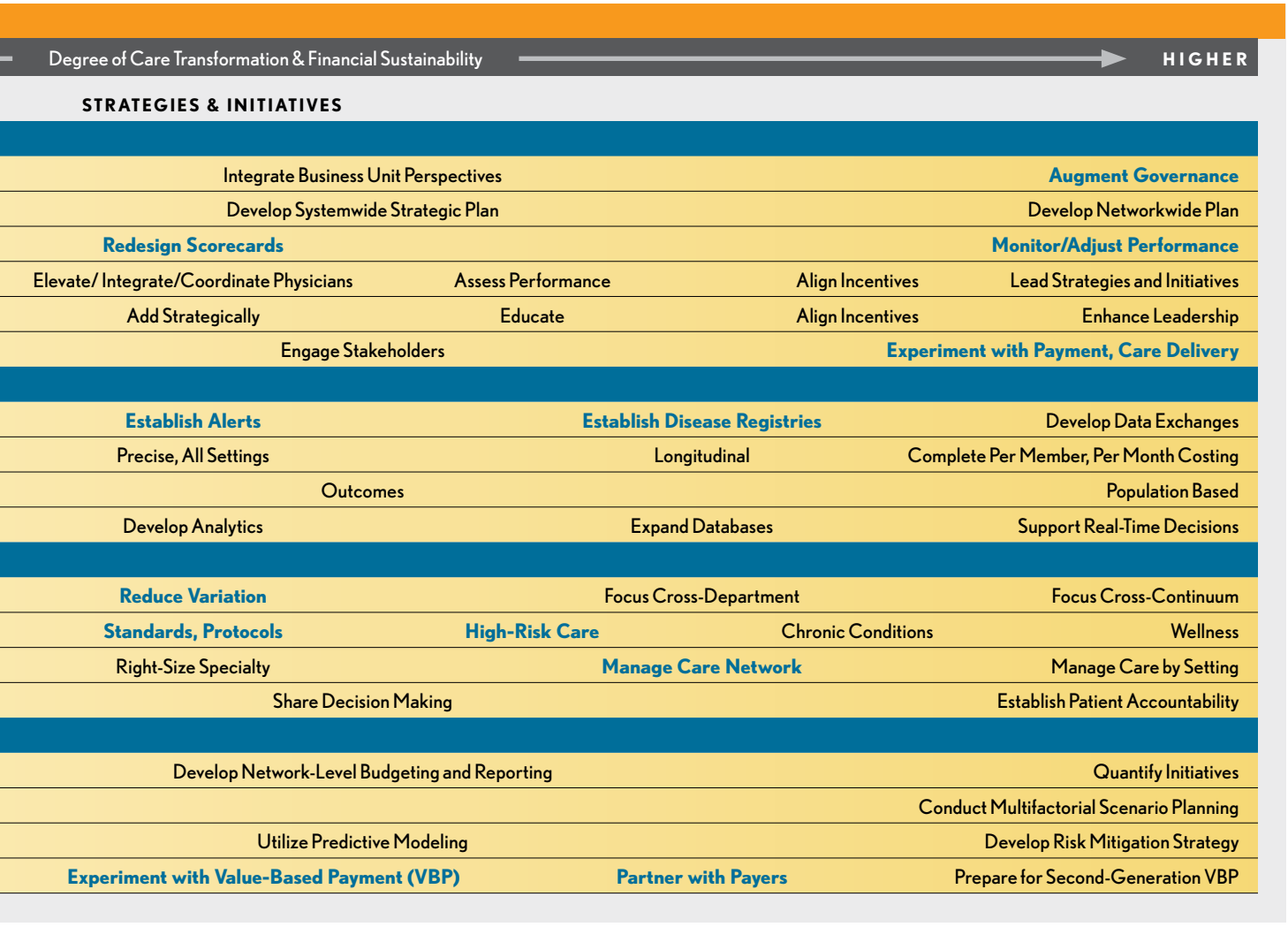
such areas as medical and technological infrastructure, clinical effectiveness, efficiency, patient safety, and patient experience. The measures, based on national best practices, research findings, and other recognized benchmarks, also align with Advocate Health Care's strategic objectives. Physicians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

Nebraska Methodist has developed a similar point system for sharing the benefits of a new bundled payment pilot and other planned value-based payment initiatives. Points are assigned for elements of preprocedure primary care, the operation itself, and post-care activities, structured in a way that shares accountability across physicians (an anesthesiologist, for example, may receive points for reminding a surgeon to complete a certain task). The points are monitored to ensure compliance, added up, divided by the shared savings amount, and allocated. The system is also developing a module within its business intelligence application to enable physicians to keep track of their points.

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OTHER STRATEGIES AND INITIATIVES

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

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

MULTIHOSPITAL SYSTEM RESEARCH PARTICIPANTS

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATIONS

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

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

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

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

Elevate, train, and integrate physician leaders into effective governing structures, with aligned incentives. Multihospital systems should aim to involve physicians in strategic leadership positions not only related to care delivery, but also other critical areas such as organizational affordability, capital investment planning, and more.

Make integrated, updated clinical and financial analytics available to key decision makers throughout the system and to customers. This is a significant undertaking particularly in multi-hospital systems with disparate EHRs, cost accounting systems, and data definitions, as well as those with systems gaps. To prepare for the emerging payment environment, multihospital systems are determining how to standardize and collect longitudinal clinical and financial data. These data are critical not only for identifying opportunities to reduce variation and improve quality and cost structure, but also for demonstrating to customers the system's ability to deliver high quality, efficient care at a defined population level.

Experiment with payment mechanisms to learn how to succeed in managing care for a defined population without damaging cash flows and (often dominant) market positions. Multihospital systems are uniquely positioned to experiment across locations and disseminate best practices. Further, they are typically large and influential organizations. They can leverage their scale to form unique partnerships with payers, employers, and other providers as a way to further experiment with payment methods and position for improved market share.

Continue to add scale, selecting the most advantageous partnerships through a variety of affiliation models. As described throughout this section, opportunities may exist for a multihospital system to add scale through enhanced IT economies, improved purchasing arrangements, and partnerships with other provider organizations.

RESEARCH SPONSORS

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BJC HealthCare

OSF HEALTHCARE

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CATHOLIC HEALTH EAST

RUSH UNIVERSITY MEDICAL CENTER

CHRISTUS Health

SPECTRUM HEALTH

Cleveland Clinic

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

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