Appendices

Contents

Appendix A: Interview Participants

The American Hospital Association Committee on Performance Improvement would like to express its appreciation to the following individuals and their organizations for the invaluable assistance they provided in the committee's work.

- Joel T. Allison, FACHE, President and Chief Executive Officer, Baylor Health Care System
- Ron J. Anderson, MD, President and Chief Executive Officer, Parkland Health & Hospital System
- Scott Becker, FACHE, President and Chief Executive Officer, Conemaugh Health System
- Sheryl Lewis Blake, FACHE, President and Chief Executive Officer, Pennock Health Services
- Gary Brock, Chief Operating Officer, Baylor Health Care System
- Kent Burgess, President and Chief Executive Officer, St. John's Lutheran Ministries
- Susan D. DeVore, President and Chief Executive Officer, Premier
- James A. Diegel, FACHE, President and Chief Executive Officer, St. Charles Health System
- Scott A. Duke, Chief Executive Officer, Glendive Medical Center
- Daniel F. Evans Jr., President and Chief Executive Officer, Indiana University Health
- Georgia Fojtasek, RN, President and Chief Executive Officer, Allegiance Health
- Nancy Formella, MSN, RN, Co-President, Dartmouth-Hitchcock; President, Mary Hitchcock Memorial Hospital
- Brian Grissler, President and Chief Executive Officer, Stamford Hospital
- Trish Hannon, FACHE, President and Chief Executive Officer, New England Baptist Hospital
- Mark Herzog, Chief Executive Officer, Holy Family Memorial
- Raymond Hino, Chief Executive Officer, Mendocino Coast District Hospital
- Russell Johnson, Chief Executive Officer, San Luis Valley Regional Medical Center
- Douglas J. Leonard, FACHE, President, Indiana Hospital Association
- Todd C. Linden, FACHE, Chief Executive Officer, Grinnell Regional Medical Center
- Scott C. Malaney, President and Chief Executive Officer, Blanchard Valley Health System
- Norman F. Mitry, President and Chief Executive Officer, Heritage Valley Health System
- Jonathan Peck , President, Institute for Alternative Futures
- Chandler M. Ralph, President and Chief Executive Officer, Adirondack Medical Center
- Thomas J. Sadvary, President and Chief Executive Officer, Scottsdale Healthcare
- Kenneth A. Samet, FACHE, President and Chief Executive Officer, MedStar Health
- Bruce J. Schwartz, MD, Deputy and Clinical Director, Psychiatry & Behavioral Sciences, Montefiore Medical Center
- James H. Skogsbergh, President and Chief Executive Officer, Advocate Healthcare
- Art Sponseller, President and Chief Executive Officer, Hospital Council of Northern and Central California
- Susan Starling, Chief Executive Officer, Marcum & Wallace Memorial Hospital
- Jeff Terry, Managing Principal Clinical Operations, GE Performance Solutions, GE Healthcare
- Nick Turkal, MD, President and Chief Executive Officer, Aurora Health Care
- Dennis Vonderfecht, FACHE, President and Chief Executive Officer, Mountain States Health Alliance
- Lorrie Warner, Managing Director, Health Care Group, Citigroup Global Markets Inc.
- Charlotte S. Yeh, MD, FACEP, Chief Medical Officer, AARP Services Inc.

Interviews completed by Barry Bader.

Appendix B: Strategic Planning Assumptions

1. Reimbursements are not going to increase, but they will be sufficient enough to support the provision of high-quality care.
2. The number of value-based payment structures will increase and offer significant financial rewards to justify the joint participation of hospitals, physicians, and other providers.
3. Integrated systems and networks in a value-based environment will prove to be more efficient and effective than fragmented arrangements.
4. Economic incentives to facilitate the integration of providers will become more common to meet the goals of improving outcomes, community health, and efficiency.
5. Midlevel providers will continue to increase in importance, as changing regulations may allow them to deliver patient care in new, cost-effective care delivery models.
6. The use of information technology will be capitalized to evaluate and compare performance metrics between physicians and organizations.
7. Acute hospital inpatient units will see a rising case-mix index and therefore will be increasingly populated by patients in fragile health with multiple illnesses.
8. Although hospitals will remain integral to care delivery, care networks will seek to keep patients out of higher-cost hospitals, providing necessary treatment in less-costly settings.
9. The transparency of price and quality metrics will gradually increase in availability to both internal and external parties.
10. Physician payment will encourage physicians to align themselves with hospitals economically and clinically, but reimbursement will remain sufficient enough to encourage health system investment.
11. Patients will have financial incentives to adopt healthier lifestyles and make cost-conscious choices for their own care.
12. Tax-exempt hospitals will have access to sources of capital for replacement of and innovations in facilities and technology. Additionally, their community benefit obligations will remain within their financial capacity.

Appendix C: Future Successful Governance Structure and Responsibilities

In responding to questions about future board structure and responsibility, most interviewees agreed that high-performing governance will continue to be a critical element to support an organization's sustainability. Additionally, they suggested that the future would bring more attention to these governance responsibilities:

- **Optimizing health system performance.** As health care delivery systems become more integrated to optimize efficiency, governing boards will not only oversee the performance of individual units but also evaluate whether operating units are aligned to optimize systemwide performance. Health system boards will reassess the authority and roles of their subsidiary governance structures for hospitals, medical practices, and local care systems. Some systems will eliminate subsidiary entity governance entirely, while others will retain supplementary boards in advisory roles. A third segment will develop "shared governance" structures in which additional boards have certain delegated responsibilities.

- **Rethinking system performance metrics.** Boards characterize each organization's definition of success when they approve the assessment measures of organizational performance. Management priorities are directly impacted by the board's decisions concerning incentive and bonus programs. The majority of current hospital and health system dashboards reflect *first-curve*, volume-driven financial incentives. Boards review measures of profitability, quality, patient experience, and employee engagement for individual operating units such as hospitals, medical practices, and nursing homes.

  In the future, as payers move toward value-based reimbursements, organizational metrics must evolve. Boards will add *second-curve* metrics of financial and quality measures for clinical service lines and patient populations to first-curve dashboards. Rather than seeking to raise revenue by increasing the volume of services provided, boards will examine whether the average costs per case and the annual per-capita spending for patient populations are being controlled. Boards will examine patients' quality of life after frequently performed procedures such as joint replacements and cardiac bypass surgery. The choice of metrics is powerful; what the board measures, the organization does.

- **Recruiting trustees based on their skill sets to match specific facility needs.** Boards have typically selected members based on generalized judgments of who would make a good trustee, utilizing relatively informal approaches. Many boards have not identified the specific skill areas or personal traits that they seek in prospective trustees, nor do they maintain an ongoing list of potential members for a vacancy occurrence. Many boards say they want greater diversity of ethnicity, gender, and race to reflect the community, but they have no specific plan to make those changes. Today's demands for excellence in governance render these informal approaches outdated and inadequate.

  In the future, board succession planning will be ongoing, based on explicit needs-based criteria, and include a plan to increase diversity. In addition to traditional needs for trustees with backgrounds in finance, investment, audit, human resources, and health care, the transformation from hospitals to care systems suggests a need for such competencies as population and public health; insurance risk management; information technology; quality assurance; mergers and acquisitions; strategic alliances and collaboration; and change management in complex organizations. Community-connected trustees will remain important, but there will be increased recruitment of outside directors who bring specific expertise and an independent perspective.

- **Engaging physician participation in major decisions and initiatives.** It will remain important to have physicians on the governing board for most hospitals and health systems, but the selection criteria for ideal physician members will change as hospitals align and integrate with the medical staff as full economic partners. Over time, physicians who are closely aligned with the hospital economically and clinically will be selected for leadership positions on the board and on the medical staff. Boards must encourage physicians to redesign medical staff structures to reflect the future of financially aligned, integrated, and accountable patient-care teams.

- **Constructing effective and efficient decisions.** Boards will need the ability to make decisions quickly—in the words of one CEO, "to execute with speed, through streamlined governance and management." Systems that are slowed by multiple levels of governance with ambiguous responsibilities and a lack of alignment between systemwide and subsidiary goals will engage in careful governance assessment and redesign processes. Such changes cannot be management-driven because they will alter board authority and trigger concerns of reducing local autonomy. Thus, governance redesign efforts are a culture change that will require trustees' full engagement and support.

- **Ongoing board development.** Increased attention will be paid to director onboarding/orientation, continuing board education, and board self-assessment.

Appendix D: Key Transitional Steps to Achieve the Desired Future State

Interviewees were asked to describe key transitional steps for hospitals and health systems to move from *first-curve* to *second-curve* organizations and cultures. No singular path will fit all situations, and the ultimate organizational models will differ as well.

Transitions will involve three broad and interrelated activities:

- Planning, realizing, and evaluating long-term goals
- Increasing the organization's capacity for change, accountability, and advancement
- Implementing improvements

Each hospital and health system must develop its own transition plan. For example, among our interviewees, Holy Family Memorial in Manitowoc, Wis., has developed a reform road map with engagement of key stakeholders in order to meet financial and quality goals for 2017. Several large health systems have explicit, step-by-step plans for becoming accountable care organizations and transforming their cultures accordingly. Overall, the common elements of transition plans are a clear vision, a carefully thought-out progression, and annual, cumulative initiatives to move toward achieving long-term goals.

Examples of transition steps suggested by interviewees include some of the must-do strategies as well as additional concrete steps.

Planning, realizing, and evaluating long-term goals

- Adopting a compelling, long-term vision
- Implementing a strategy to develop an evolving culture
- Assembling and then integrating the key components of a care system through mergers, acquisitions, and strategic alliances
- Creating a care system based on the values, specialty expertise, and scope of services necessary for a specific community
- Establishing a collaborative and patient-centered culture within an integrated medical group among previously independent practices
- Assuming matrix management in clinical enterprises
- Mastering ongoing, scenario-based planning to retest assumptions, assess progress, and make necessary adjustments

Increasing the organization's capacity for change, accountability, and advancement

- Improving institutional processes to identify and eliminate unnecessary costs
- Implementing an information system that informs both bedside care management and business decisions
- Utilizing data to engage in focused knowledge management and continuous improvement throughout the organization
- Creating physician leadership education programs
- Facilitating multidisciplinary care team development to manage care, improve outcomes, and seek population health
- Investing in health and wellness services
- Assessing and redesigning the governance structure to align with the organization's strategic goals

Implementing improvements

- Engaging multidisciplinary teams to adopt evidence-based care protocols and patient safety bundles
- Contracting with payers and piloting payment innovations to accept risk, generate savings, and improve health care delivery services to target populations
- Executing a medical home initiative
- Improving telemedicine capabilities to provide patients with previously unavailable services
- Reducing avoidable readmissions
- Creating care management programs for chronic conditions such as congestive heart failure, diabetes, and pediatric asthma
- Using predictive analysis tools to assign care navigators to individual patients at high risk for preventable poor outcomes
- Coordinating hospital discharge planning with next level subacute or home care services
- Adopting a program to measure and address health care disparities
- Increasing the organization's capability to share data with payers and patients

Appendix E: Additional Resources Available through *Hospitals in Pursuit of Excellence*

Reports and guides are listed on top, while the available case studies are listed by must-do strategy. All these resources are accessible by clicking on the title, which is a hyperlink. Additional titles are available at www.hpoe.org.

Reports and Guides

- *AHA Research Synthesis Report: Accountable Care Organizations*
- *Health Care Leader Action Guide to Reduce Avoidable Readmissions*
- *Allied Hospital Association Leadership for Quality*
- *Health Care Leader Action Guide: Understanding and Managing Variation*
- *Health Care Leader Action Guide: Hospital Strategies for Reducing Preventable Mortality*
- *Hand Hygiene Project: Best Practices from Hospitals Participating in the Joint Commission Center for Transforming Healthcare Project*
- *Striving for Top Box: Hospitals Increasing Quality and Efficiency*
- *Health Care Leader Action Guide on Implementation of Electronic Health Records*
- *AHA Research Synthesis Report: Patient-Centered Medical Home*
- *Competency-Based Governance: A Foundation for Board and Organizational Effectiveness*
- *Using Workforce Practices to Drive Quality Improvement: A Guide for Hospitals*
- *A Call to Action: Creating a Culture of Health*
- *A Guide to Financing Strategies for Hospitals – With Special Consideration for Smaller Hospitals*
- *Early Learnings from the Bundled Payment Acute Care Episode Demonstration Project*
- *AHA Research Synthesis Report: Bundled Payment*
- *Building a Culturally Competent Organization: The Quest for Equity in Health Care*
- *ACHI Community Health Assessment Toolkit*

Aligning Hospitals, Physicians, and Other Providers Across the Care Continuum

• Cooperation and Mutual Investment Model at Catholic Medical Partners	Buffalo, NY
• Physician Transformation at Memorial Hermann	Houston, TX

Utilizing Evidence-Based Practices to Improve Quality and Patient Safety

• Constant Pharmacy Coverage at Othello Community Hospital	Othello, WA
• Care Process Changes to Increase Quality at Seton Northwest Hospital	Austin, TX
• Managing the Use of Diagnostic Imaging at the Everett Clinic	Everett, WA
• Patient Safety throughout an Organization at Sentara Healthcare	Norfolk, VA
• Promoting Patient Safety through Education at OSF Healthcare	Peoria, IL

Improving Efficiency through Productivity and Financial Management

• Increased Nurse Efficiency through Cambridge Health Alliance	Cambridge, MA
• Lean Principle Adoption at Avera McKennan Hospital and University	Sioux Falls, SD
• Self-Scheduling System at Princeton Baptist Medical Center	Birmingham, AL
• Improving Quality and Reducing Waste at Virginia Mason Medical Center	Seattle, WA

Developing Integrated Information Systems	
• Information System Implementation at Northfield Hospital	Northfield, MN
• Utilization of Electronic Health Records at Northshore University Health System	Evanston, IL
Joining and Growing Integrated Provider Networks and Care Systems	
• Clinic Buy-Out at Perry County Memorial Hospital	Perryville, MO
• End-of-life Care Shifting to Home at Wheaton Franciscan Healthcare	Milwaukee, WI
• Including Behavioral Health Specialists in Primary Care at Kaiser	Oakland, CA
Educating and Engaging Employees and Physicians to Create Leaders	
• Employee Focus Groups at Veteran Affairs Palo Alto Health Care System	Palo Alto, CA
• Nurse Recruitment and Retention at Mayo Clinic Hospitals	Rochester, MN
• Patient Satisfaction through Engaged Employees at Mount Desert Island Hospital	Bar Harbor, ME
• Human Resources Group Transformation at Catholic Health Initiatives	Denver, CO
Seeking Population Health Improvement through Pursuit of the "Triple Aim"	
• Diabetes Management Program at Carilion Giles	Pearisburg, VA
• Engaging Patients in Diabetes Education at Henry Ford Health System	Detroit, MI