Hospitals and Care Systems of the Future

September 2011

A report from the AHA Committee on Performance Improvement:

Jeanette Clough (Chair)
Mark Adams, MD
Richard Afable, MD
Susan DeVore
Scott Duke
John Duval
Laura Easton
Nancy Formella, MSN, RN
William Fulkerson, MD
Raymond Grady
Raymond Hino
Russell Johnson
Douglas Leonard
Jonathan Perlin, MD, PhD, MSHA, FACP
Marlon Priest, MD
Pamela Rudisill, MSN, RN, Med, NEA-BC
Jeff Selberg
Donna Sollenberger
Arthur Sponseller, JD
Mary Beth Walsh, MD
Rich Umbdenstock

AHA Board Committee on Performance Improvement

- **Jeanette Clough (Chair)**, President and Chief Executive Officer, Mount Auburn Hospital
- Mark Adams, MD, Vice President and Chief Medical Officer, Franciscan Health System
- Richard Afable, MD, President and Chief Executive Officer, Hoag Memorial Hospital Presbyterian
- Susan DeVore, President and Chief Executive Officer, Premier, Inc.
- Scott Duke, Chief Executive Officer, Glendive Medical Center
- John Duval, Chief Executive Officer, Medical College of Virginia Hospitals
- Laura Easton, President and Chief Executive Officer, Caldwell Memorial Hospital
- Nancy Formella, MSN, RN, President, Mary Hitchcock Memorial Hospital
- William Fulkerson, MD, Senior Vice President, Duke University Hospital
- Raymond Grady, Chief Administrative Officer, Aurora Health System
- Raymond Hino, Chief Executive Officer, Mendocino Coast District Hospital
- Russell Johnson, Chief Executive Officer, San Luis Valley Regional Medical Center
- Douglas Leonard, President and Chief Executive Officer, Indiana Hospital Association
- Jonathan Perlin, MD, PhD, MSHA, FACP, President, Clinical Services and Chief Medical Officer, Hospital Corporation of America
- Marlon Priest, MD, Executive Vice President and Chief Medical Officer, Bon Secours Health System, Inc.
- Pamela Rudisill, MSN, RN, Med, NEA-BC, Vice President, Nursing and Patient Safety, Health Management Associates, Inc.
- Jeff Selberg, Executive Vice President and Chief Operating Officer, Institute for Healthcare Improvement
- Donna Sollenberger, Executive Vice President and Chief Executive Officer, University of Texas Medical Branch Health System
- Arthur Sponseller, JD, President and Chief Executive Officer, Hospital Council of Northern and Central California
- Mary Beth Walsh, MD, Executive Medical Director, Chief Executive Officer, Burke Rehabilitation Hospital
- Rich Umbdenstock (ex officio), President, American Hospital Association

The AHA Committee on Performance Improvement would like to thank Barry Bader, Kevin Van Dyke, and Jill Seidman for their contributions to the development of this report.

Suggested Citation

American Hospital Association. 2011 Committee on Performance Improvement, Jeanette Clough, Chairperson. *Hospitals and Care Systems of the Future*. Chicago: American Hospital Association, September 2011.

For Additional Information
Maulik S. Joshi, DrPH
Senior Vice President of Research, American Hospital Association
(312) 422-2622
mjoshi@aha.org

To access the appendices and presentation slides for this report visit:
http://www.aha.org/about/org/hospitals-care-systems-future.shtml

Table of Contents

Executive Summary

Purpose

The AHA Board Committee on Performance Improvement (CPI) was created in 2010 to provide guidance to the American Hospital Association (AHA) in supporting performance improvement across the membership, including further development of the AHA's strategic platform, Hospitals in Pursuit of Excellence (HPOE).

In the current environment, hospitals need to focus their efforts on performance initiatives that will remain crucial in the long term. As such, the Committee's initial project centers on the role of the "hospital of the future." With economic, demographic, and regulatory changes occurring throughout the health care industry, the Committee's report serves to synthesize best practice strategies for the next decade and potential transition paths to reach the desired future models of care delivery.

This report will mobilize hospital senior leadership teams to consider the strategies they must deploy throughout their individual organizations to adapt and succeed in the future. Change will occur; what will vary is each organization's path to embrace the future. To accomplish its goal, the CPI project team conducted interviews with an initial sample of leaders from hospitals and health care systems throughout the country, and then with multiple AHA member constituency groups and policy boards. The Committee aggregated the results to outline actionable strategies and core competencies for hospitals to pursue.

Background

Hospitals and health systems in the United States face unparalleled pressures to change in the future. Industry experts have projected that multiple, intersecting environmental forces will drive the transformation of health care delivery and financing from volume-based to value-based payments over the next decade. These influences include everything from the aging population to the unsustainable rise in health care spending as a percentage of national gross domestic product.

Economic futurist Ian Morrison believes that as the payment incentives shift, health care providers will go through a classic modification in their core models for business and service delivery. He refers to the volume-based environment hospitals currently face as the *first curve* and the future value-based market dynamic as the *second curve*. Progressing from the *first curve* to the *second curve* is a vital transition for hospitals. This is analogous to having one foot on the dock and one foot on the boat—at the right point, the management of that shift is essential to future success. Within this environmental context, the report is structured as a first step in an ongoing dialogue with the hospital community for identifying and implementing key strategies, tactics, and measures that hospitals may employ for success.

Recommendations

This report groups the findings into four major sections:

1. **Must-do strategies accompanied by case studies profiling hospitals who have taken on those challenges;**
2. **Second-curve metrics to aid in measuring success of the implemented strategies;**
3. **Organizational core competencies that should be mastered; and**
4. **Self-assessment questions to assist in understanding how well the competencies have been achieved.**

Must-Do Strategies

Ten must-do strategies were identified for the hospital field to implement; however, the first four were identified as major priorities.

1. Aligning hospitals, physicians, and other providers across the continuum of care
2. Utilizing evidenced-based practices to improve quality and patient safety
3. Improving efficiency through productivity and financial management
4. Developing integrated information systems
5. Joining and growing integrated provider networks and care systems
6. Educating and engaging employees and physicians to create leaders
7. Strengthening finances to facilitate reinvestment and innovation
8. Partnering with payers
9. Advancing an organization through scenario-based strategic, financial, and operational planning
10. Seeking population health improvement through pursuit of the "triple aim"

Additionally, it was noted that organizational culture is an essential foundation to the success of the strategy execution. A culture of performance improvement, accountability, and high-performance focus is critical to enhancing the organization's ability to implement strategies successfully. The right culture will enable the transformation to the hospital and care system of the future.

In this report, each of the major strategies is accompanied by at least one example from a hospital-based best practice. In addition to being described on the page itself, all of the case studies are available at http://www.hpoe.org.

Second-Curve Metrics

Second-curve metrics are identified to assist in measuring the success of the top four priority strategies.

Aligning hospitals, physicians, and other providers across the continuum of care

- Number of "aligned and engaged" physicians
- Percentage of physician and provider contracts with quality and efficiency incentives aligned with ACO-type incentives
- Availability of nonacute services
- Distribution of shared savings/performance bonuses/gains to aligned physicians and clinicians
- Number of covered lives accountable for population health—e.g., ACO/medical home-covered lives
- Number of providers in leadership

Utilizing evidenced-based practices to improve quality and patient safety

- Effective measurement and management of care transitions
- Management of utilization variation
- Preventable admissions, readmissions, ED visits, and mortality
- Reliable patient care processes
- Active patient engagement in design and improvement

Improving efficiency through productivity and financial management

- Expense per episode of care
- Shared savings or financial gains from performance-based contracts
- Targeted cost reduction goals
- Management to Medicare margin

Developing integrated information systems

- Integrated data warehouse
- Lag time between analysis and availability of results
- Understanding of population disease patterns
- Use of health information across the continuum of care and community
- Real-time information exchange
- Active use of patient health records

Core Organizational Competencies

Organizations that are beginning to implement the must-do strategies will seek to achieve competency in several areas of care delivery and organizational management. Similar to the strategies, these competencies are intrinsically connected and aligned.

1. Design and implementation of patient-centered, integrated care
2. Creation of accountable governance and leadership
3. Strategic planning in an unstable environment
4. Internal and external collaboration
5. Financial stewardship and enterprise risk management
6. Engagement of employees' full potential
7. Collection and utilization of electronic data for performance improvement

Self-Assessment Competency Questions

For an organization to track how successful it has been in establishing the core organizational competencies, the following set of questions can serve as a guide for self-assessment.

Design and implementation of patient-centered, integrated care

- Have we developed a clear and compelling approach to clinician alignment and integration?
- Are we developing sufficient capabilities to measure, manage, and improve the quality and efficiency of patient care across the continuum of care?
- How are we rapidly assimilating best practices into clinical medicine?
- What is our role in improving overall population health?

Creation of accountable governance and leadership

- Does the board drive the organizational strategy for moving toward the second curve while assessing the balance of risks and rewards?
- Does the board have an explicit succession planning process in place to ensure the selection and development of leaders with the right attributes?
- Does physician/clinician engagement in governance and management activities reflect their emerging roles as economic and clinical partners?
- Does the board have the appropriate competencies for executing the must-do strategies?
- Is there transparency in the communication of patient outcomes, financial results, and community benefit to the community?

Strategic planning in an unstable environment

- Do we have a clear/compelling vision for the second curve?
- Do we have a plan and timeline for moving toward the second curve of value-based care delivery, as compared to current financial incentives?
- What is the necessary mix of inpatient beds, ambulatory facilities, physicians, midlevel providers, and emerging technologies to meet future demand?
- What size and scale of our organization will be sustainable in the future?
- Should our organization explore new strategic partnerships? What type of organization best meets our needs while still fitting with our mission?
- Are we utilizing scenario-based planning techniques to monitor key changes in our assumptions and making necessary adjustments?
- Do we assess the health needs of the community we serve? Do we also identify potential partners to improve access to necessary care?

Internal and external collaboration

- Have we examined our mission to determine if we can financially sustain high quality in all of the services we currently provide?
- How well are we developing trust within our organization?
- What is our desired culture? Does it value collaboration, accountability, transparency, excellence, patient focus, and similar core values?
- Are our leaders "role models" for a collaborative culture?
- Are we considered a valuable partner to physicians and other organizations within the community?
- Do we know our partners well enough?

Financial stewardship and enterprise risk management

- Do we have a capital investment plan for testing strategic activities in payment pilot projects and health management strategies (e.g., service line management, population health, use of health information technologies)?
- Can we measure revenues and expenses by each clinical service?
- Are we utilizing an annual enterprise risk management assessment?
- Have we identified long-term financial goals and a plan to get there?

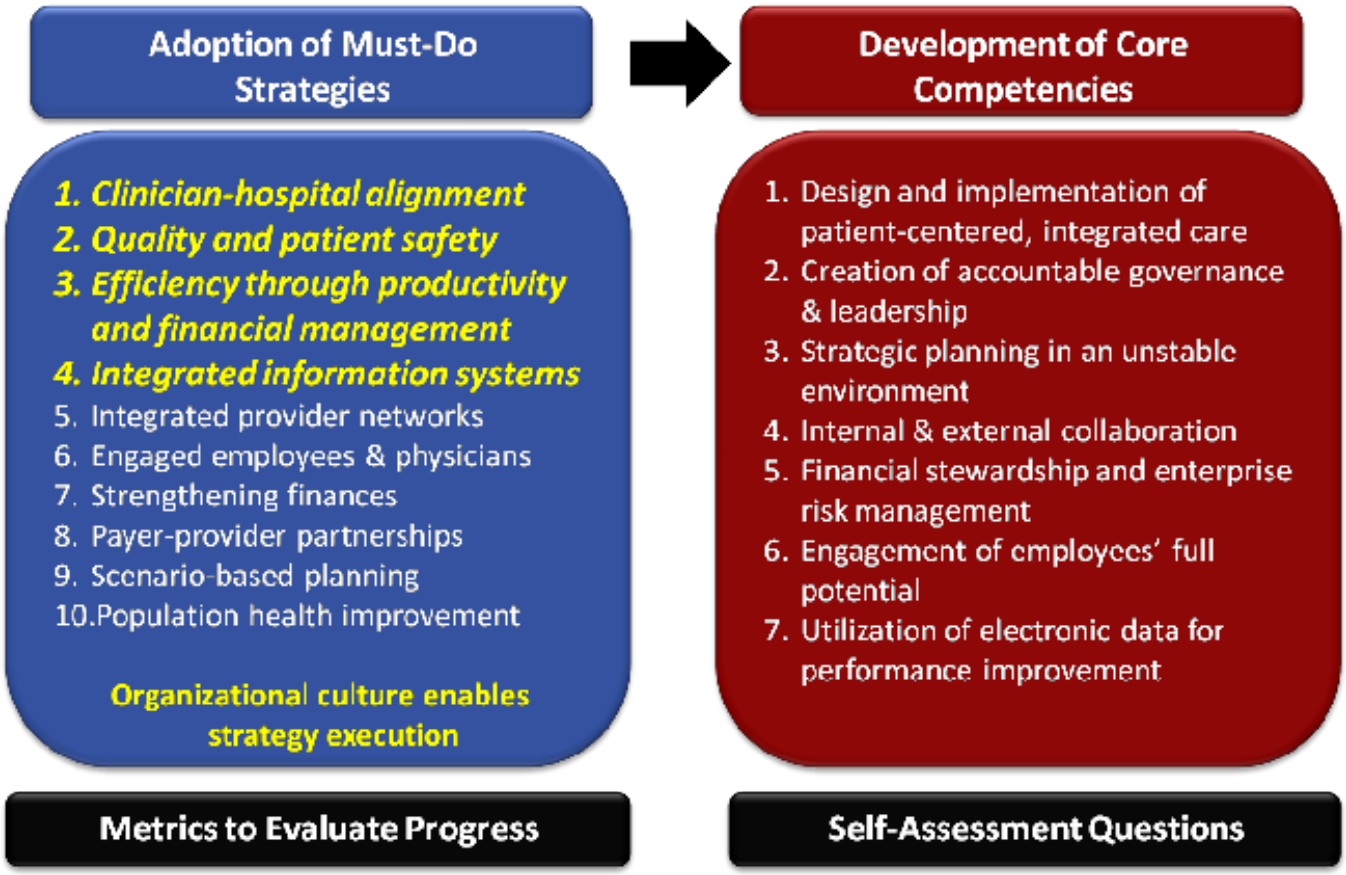
Engagement of employees' full potential

- What is our strategy for employee and physician partner engagement?
- Are our employee and physician recruitment and retention systems aligned with our strategic direction and desired culture? For example, how are we assessing performance and values of collaboration?
- Are we a learning organization? How are we developing the knowledge and skills of physicians, middle managers, employees, and senior executives?

Collection and utilization of electronic data for performance improvement

- When will our information systems bring all pertinent information to the point of care?
- How far along are we in achieving digital connectivity among providers and with patients?
- How often is the data collected from information systems reviewed at clinical and administrative team meetings? What data is brought to senior leadership's attention?

The following diagram outlines the linkage of the four major elements: (1) must-do strategies to be adopted; (2) second-curve metrics to aid in measuring success; (3) organizational core competencies that should be mastered by the end of the decade; and (4) self-assessment questions to assist in understanding how well the competencies have been achieved.



Introduction and Approach

Driving the Change

Hospitals and health systems face unprecedented pressure to change both in the near- and longer-term future. Industry experts have projected that multiple, intersecting environmental forces will drive the transformation of health care delivery and financing over the next decade. These influences include:

- Demand-altering demographic changes
- Employer, government, and consumer pressure to curb the unsustainable increase in health care spending
- Shift in financial incentives away from fee-for-service reimbursement in favor of value-based payments that reward positive outcomes and efficiency
- Rise in provider accountability for the cost and quality of health care
- Consistent demand to reduce care fragmentation by redesigning care delivery
- Increased transparency of financial, quality, and community benefit data
- Projected shortages of nurses, primary care physicians, and other health care providers to match population demand
- Persistent introduction of high-cost medical technology and pharmaceutical advances
- Difficulty in raising capital to meet the strategic needs for new facilities, medical technology, and information systems
- Uncertainty about federal and state health care reform legislation and regulation
- Overall decline in reimbursement
- Recognition and challenge to variations in care provisions and, as a result, cost

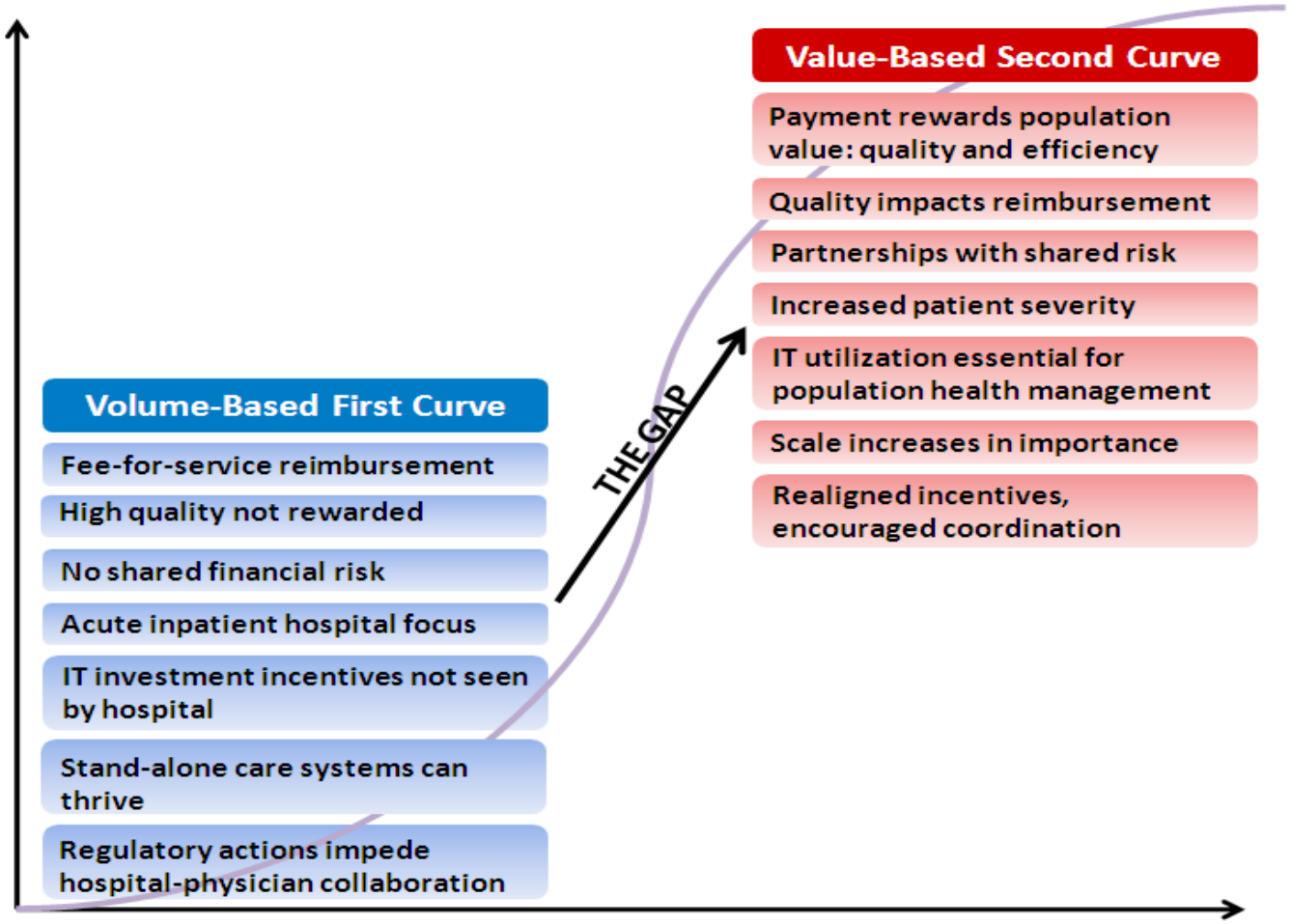
First Curve to Second Curve

These changes are transformational and are the most considerable concerns confronting health care leaders. They are agitating the economic incentives that drive patient, provider, and payer behavior. Economic futurist Ian Morrison believes that as payment incentives shift, health care providers will modify their core models for business and service delivery. He calls this a first-curve to second-curve shift.

As displayed in Figure I, Morrison details the *first curve* as an economic paradigm driven by the volume of services provided and fee-for-service reimbursement. The *second curve* is concerned with value: the cost and quantity of care necessary to produce desired health outcomes within a particular population.

For example, in the first curve, hospitals and physicians are reimbursed different amounts for a patient's joint replacement surgery depending on the number and coding of surgeries, office visits, implants, and related services. If complications occur, divergent incentives generate more payments to the provider. As reimbursement moves toward second-curve economics, integrated hospital-physician teams will share payment for joint replacements and may be penalized for avoidable readmissions and complications. In return, these integrated care networks may be rewarded for shared savings, quality improvements, and use of best practices. Potential partnerships with health plans may form to share savings from keeping patient populations healthier, such as reducing obesity that increases the joint wear and tear.

Figure 1: First Curve to Second Curve



Life in the Gap

The most significant strategic issue for hospitals and health systems is establishing the transition rate from first-curve to second-curve economics in their respective markets. Morrison refers to this period as *life in the gap*.

Managing this period is an evolving equilibrium. Providers that entirely implement second-curve economics before the market is ready may see significant revenue reduction. For example, one health system executive said that his organization has taken $400 million out of expenses while improving overall quality overall, but the majority of the savings has been realized by the insurance companies.

Conversely, providers that remain in the first curve for too long and do not sufficiently organize themselves will be deficient in the capabilities to succeed when the market transition is complete. *Life in the gap* is challenging on its own; as the number of pilot programs continues to grow and programs are eventually implemented, each individual institution will have to determine the appropriate time for them to make the leap to the second-curve market for the individual aspects of care. In health care, this will require a willingness of all parties—insurers, providers, consumers, and the government—to enter into shared-savings arrangements.

Approach

In 2011, the AHA conducted telephone and in-person interviews with senior leaders from health systems, hospitals, and stakeholder organizations. These interviewees, listed in **Appendix A**, represent a cross-section of providers, including safety-net and specialty hospitals; in urban, suburban, and rural communities; with tertiary, community, and critical-access facilities; and hospitals with independent medical staffs as well as those with closely integrated medical groups.

Interviews overwhelming refrained from describing the organizational models of the "hospital of the future" with much specificity due to the large degree of uncertainty surrounding national health care policy platforms and upcoming payment models. However, the majority of leaders believe hospitals will evolve to become part of "care systems" or "integrated networks," encompassing everything from home-based chronic care management to inpatient acute treatment.

The AHA Committee on Performance Improvement synthesized the results of the interviews, identifying the strategies for organizations to consider and the core organizational competencies developed from adoption of each of the specific actions; all are critical to survival in the second-curve economic dynamic. To prioritize the results, the strategies and aligned core organizational competencies were put in front of each of the nine AHA regional policy boards during June of 2011. The members voted on the most urgent of the strategies, developing the priority list. Accompanying each of the strategies is at least one example of how a hospital is following the strategy to reach the second curve. Although written summaries are provided within the report, the case studies are all available on http://www.hpoe.org.

Overall, the results provide a well-organized summary of the most important priorities of health care leaders from organizations of all sizes and geographic locations. The report serves to articulate a broad vision of the future and identify the right questions leaders should ask to chart their organization's path. The description of strategies, core competencies, and suggested metrics can shape leaders' strategic thinking about the future.

Assumptions Drive Strategic Planning Initiatives

The interviews for this report indicated that leaders are making a number of assumptions about the future that serve as the foundation for their strategic planning processes. Although large portions of this report express the uncertainty hospital leaders feel about the future and the shift from the first to second curves, strategic planning necessitates the creation of certain hypotheses which serve as the foundation of strategic plan development and capital investment. Such a foundation represents the "expected scenario" and therefore forms the basis not only for articulating a vision and strategic plan, but also for periodically reassessing the organization's strategic direction in the context of a fast-changing environment and making necessary adjustments. The synthesis of the assumptions revealed from the interviews is detailed in **Appendix B**.

Must-Do Strategies Lead to Second-Curve Core Competencies

The results of the interviews indicated that there are two categories of elements critical to success in the second-curve market: actionable strategies and core competencies. The must-do strategic approaches are actions that organizations must take now to succeed in the first curve, in addition to managing life in the gap until value-based payment pushes institutions into the second-curve dynamic. Before adopting any of the strategies listed on the following pages, organizations must develop a culture that enables performance improvement, high reliability, and accountability.

Implementing the strategies will aid organizations in developing the second-curve core organizational competencies, which are longer-term organizational capabilities that will be crucial for survival in a new market focused on economic value, quality outcomes, service coordination, performance accountability, information transparency, and patient access.

As described previously, the strategies necessary to establish the core competencies are not going to be the same for every hospital and will depend on the organization's own capabilities, external collaboration potential, and the market. Additionally, the strategies are nonexclusive, meaning organizations cannot expect to pursue only one of the must-do strategies and succeed on the second curve. For example, it is difficult to focus on improving patient safety, quality, and efficiency without developing integrated information systems.

On each of the top-priority strategies, metrics[1] are listed which can help organizations measure the success of their institution in these actions.

Must-Do Strategies

Ten must-do strategies were identified for the hospital field to implement; however, the first four were identified as the major priorities.

1. Aligning hospitals, physicians, and other providers across the continuum of care
2. Utilizing evidenced-based practices to improve quality and patient safety
3. Improving efficiency through productivity and financial management
4. Developing integrated information systems
5. Joining and growing integrated provider networks and care systems
6. Educating and engaging employees and physicians to create leaders
7. Strengthening finances to facilitate reinvestment and innovation
8. Partnering with payers
9. Advancing an organization through scenario-based strategic, financial, and operational planning
10. Seeking population health improvement through pursuit of the "triple aim"

Additionally, it was noted that organizational culture is an essential foundation to the success of the strategy execution. A culture of performance improvement, accountability, and high-performance focus is critical to enhancing the organization's ability to implement strategies successfully. The right culture will enable the transformation to the hospital and care system of the future. With each of these strategies is a case study, profiling organizations that have effectively implemented these strategies in a way that is amenable to their culture.

1 Moody's Investors Service, Special Comment: Achieving Greater Cost and Quality Accountability will be Credit Positive for not-for-Profit Hospitals in Era of Reform, May 2011.

Second-curve metrics

Second-curve metrics are identified to assist in measuring the success of the top four priority strategies.

Aligning hospitals, physicians, and other providers across the continuum of care

- Number of "aligned and engaged" physicians
- Percentage of physician and provider contracts with quality and efficiency incentives aligned with ACO-type incentives
- Availability of nonacute services
- Distribution of shared savings/performance bonuses/gains to aligned physicians and clinicians
- Number of covered lives accountable for population health–e.g., ACO/medical home covered lives
- Number of providers in leadership

Utilizing evidenced-based practices to improve quality and patient safety

- Effective measurement and management of care transitions
- Management of utilization variation
- Preventable admissions, readmissions, ED visits, and mortality
- Reliable patient care processes
- Active patient engagement in design and improvement

Improving efficiency through productivity and financial management

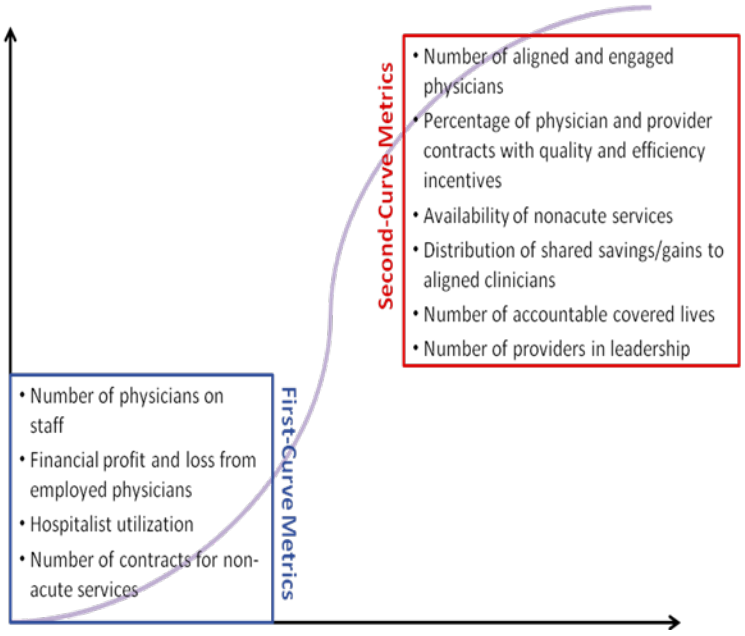
- Expense per episode of care
- Shared savings or financial gains from performance-based contracts
- Targeted cost reduction goals
- Management to Medicare margin

Developing integrated information systems

- Integrated data warehouse
- Lag time between analysis and availability of results
- Understanding of population disease patterns
- Use of health information across the continuum of care and community
- Real-time information exchange
- Active use of patient health records

Strategy #1: Aligning hospitals, physicians, and other providers across the continuum of care

Over the past three decades, the relationship between physicians and hospitals has evolved from necessary association to competition to interdependency. The market and regulatory forces leading to tight budgets and second-curve economics are putting pressure on both sides to pursue physician employment and other alignment strategies. Hospitals are partnering with physicians to improve care coordination, reducing unnecessary admissions. Physicians seek partnerships with acute-care providers in the face of higher administrative costs and the threat of lowered payments through Congressional action on the sustainable growth rate. Seventy-four percent (74%) of hospital leaders participating in a 2010 survey revealed that they planned to increase the number of their employed physicians over the next year.[2] However, the interviewees overwhelmingly said that simply employing physicians does not effectively secure alignment beyond financial incentives. To succeed and move to the second curve, hospitals must collaborate with physicians and all other clinical providers not only on financial goals but also on quality and strategic objectives. This can only be accomplished through open and regular communication of progress. Successful alignment arrangements across the care continuum will create a system where all parties are accountable and rewarded for achieving high performance, reaching patient-centered goals, and allowing for an advantageous transition into the value-based payment systems.



Wenatchee Valley Medical Center
Wenatchee, Washington

Background: WVMC has a multisite clinic associated with 190 physicians and 86 nurse practitioners treating 160,000 patients and providing 750,000 ambulatory visits annually. Analysis found that 48% of Medicare costs were due to ER visits and inpatient hospital charges, making their priority to reduce unnecessary ER visits and readmissions. WVMC engaged in a three-year CMS demonstration project to work with high-risk, high-cost-Medicare beneficiaries to reduce their costs of care.

What they did: WVMC created an effective approach to secure provider involvement throughout the process by: (1) holding preliminary meetings with all providers to gain momentum, ask for input, and create a "shared vision" on the project, (2) acting on provider suggestions for improvement throughout the engagement, (3) economically incenting group physicians with shared-savings agreements and outside physicians with upfront payments, and (4) creating a collaborative culture by releasing data as soon as it was available, including patient testimonials, and congratulating providers on strong performances.

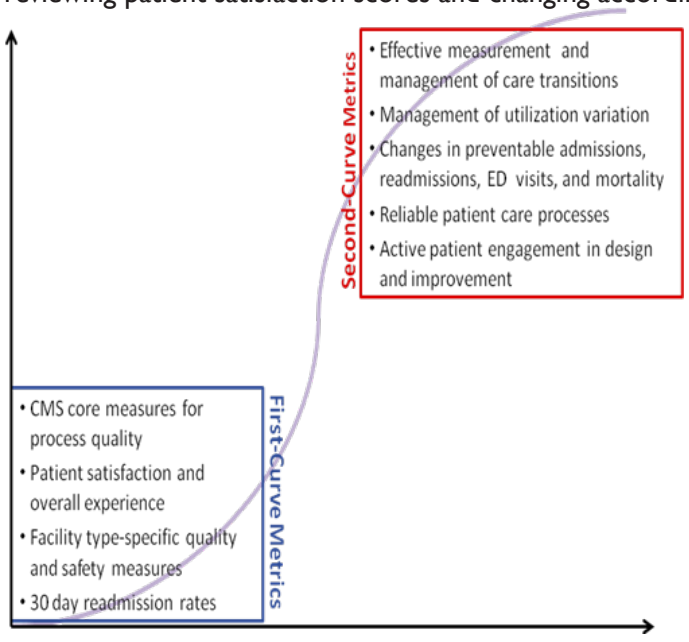
Results: WVMC saw a decrease in inpatient admissions, length of stay, ER visits (17.7%), and SNF days as well as an 18% increase in outpatient visits, with the majority of benefit realized within the chronic heart failure population. Quality metrics increased, and the cost of providing care to the experimental group as compared to the control group decreased.[3]

2 Cantlupe, J. Physician Alignment in an Era of Change. *HealthLeaders Media Intelligence*. www.healthleadersmedia.com/intelligence, Sep. 2010. Accessed July 2011.

3 Freed, SD. Delivering Patient-Centered, Accountable Care. *AHA Health Care System Reform Fellowship Retreat 3: Physician Alignment and Clinical Integration.* July 14, 2011. San Diego, CA.

Strategy #2: Utilizing evidence-based practices to improve quality and patient safety

Increasing quality and patient safety in health care has been a significant hospital-based objective for more than a decade. Although considerable gains have been made within defined areas, moving to the second curve requires widespread expansion of these programs. Medicare spent $17 billion, or 20%, of all Medicare payments on unplanned readmissions in one year.[4] Therefore, reimbursement is scheduled to eliminate payment for unnecessary readmissions in 2013, increasing the demand for quality in health care. Potential new value-based models tie quality metrics to financial reimbursement, and facility accountability will only increase. Several methodologies have been employed in this mission, ranging from evidence-based medicine and patient-focused care delivery to practice bundles and multidisciplinary team training. Additionally, organizations noted that reviewing patient satisfaction scores and changing accordingly is essential to obtain higher-quality scores in the future. High-quality care in the first curve is based on core measure improvement and sustainability of those values over time in addition to patient satisfaction scores. Moving to the second curve requires measurement, analysis, and reduction of clinical variation to improve quality.



Flowers Hospital *Dothan, Alabama*

Background: Flowers Hospital has 235 licensed beds, with a daily census averaging 160 patients. Flowers' CMS core measure scores were in the 85%–90% range. Through analysis, the team realized it was the delay in identifying the higher-risk patients, which led to lower outcomes.

What they did: Working with patients who experienced heart failure or pneumonia, the approach utilized a nurse reviewer to identify patients early and monitor their progress to ensure that appropriate care was provided. Floor staff received a color-coded packet to assist them in delivering the appropriate and expected care. To secure long-term longevity of potential improvements, multidisciplinary teams reviewed cases which failed and modified the recommended processes, if necessary.

Results: Flowers Hospital attained a 99.7% compliance rate with CMS core measures in 2007, the second highest score in the country. In future initiatives, Flowers is going to spread the same efforts to prevent several hospital-acquired conditions, which are tied to financial reimbursement.[5]

Borgess-Lee Memorial Hospital *Dowagiac, MI*

Background: BLMH is a 25-bed critical access hospital that was seeing a spike in the number of hospital-acquired urinary tract infections due to unnecessary provisions of urinary catheters.

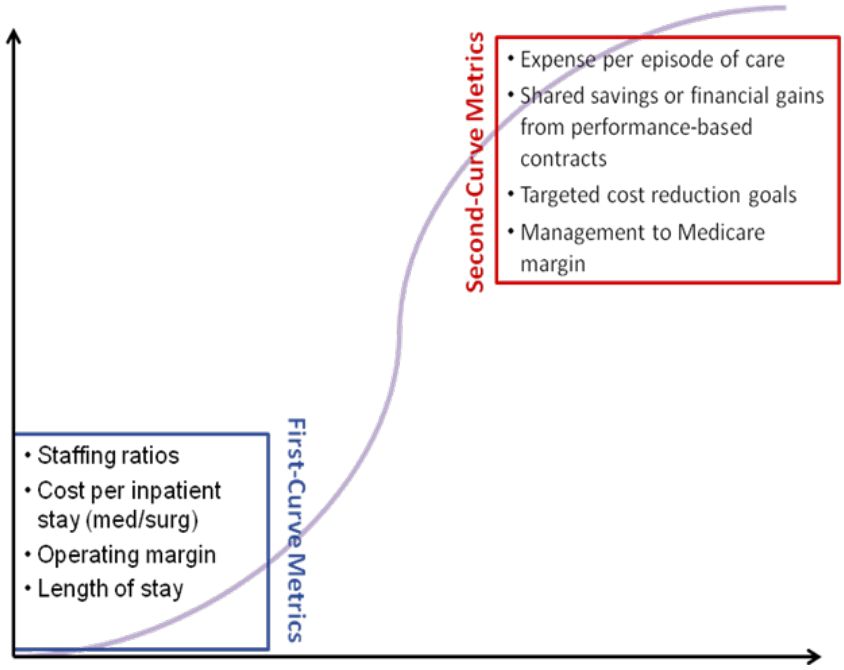
What they did: BLMH created cards which were distributed at medical staff meetings, documenting appropriate times to utilize catheters and when not to, and they assigned a point person to monitor each patient for appropriate catheter usage. The results were shared with the staff. Hourly rounding was implemented to monitor urinary catheters.

Results: BLMH reduced indwelling catheter usage by 25%, and appropriate use of catheters has reached 90%.[6] For more information on reducing readmissions, please see HPOE's ***Health Care Leader Action Guide to Reduce Avoidable Admissions*** (http://www.hret.org/care/projects/guide-to-reduce-readmissions.shtml)

4 Jencks, SF et al. Rehospitalizations among patients in the Medicare Fee-for-Service Program," *N Eng J Med* 2009. 360(14): 1418-1428.
5 Edwards, J. Flowers Hospital: Nearing Perfection on Core Measures. *The Commonwealth Fund.* December, 2008.
6 Borgess-Lee Memorial Hospital. Michigan Critical Access Hospital Best Practices 2010. MPRO. Accessed at www.mpro.org

Strategy #3: Improving efficiency through productivity and financial management

The demand for increased efficiency through productivity and financial management improvement is felt on all sides of the acute-care organization. For providers, the combination of a 29% increase in the primary care workload by 2025 with only a 2%–7% growth in the number of providers demands increased efficiency.[7] The renewed focus by government and payers on quality-based reimbursement combined with tightening margins commands hospital leadership to eliminate duplicative efforts and standardize processes through a combination of operational improvements (such as Lean process design/Six Sigma) and redesigned care-delivery models. While some interviewees said that their organizations have achieved greater efficiency and cost management through a renewed focus on quality and access, others have said that financial margins are always considered throughout process improvement projects.



North Mississippi Medical Center

Tupelo, Mississippi

Background: NMMC is a 650-bed teaching hospital serving the northern half of Mississippi and part of Alabama. A member of the five-hospital Northern Mississippi Health Services, the system also includes 34 primary and specialty care clinics. The efficiency-based projects have two different goals: to improve patient satisfaction in the ED and to increase standardization in purchasing.[8]

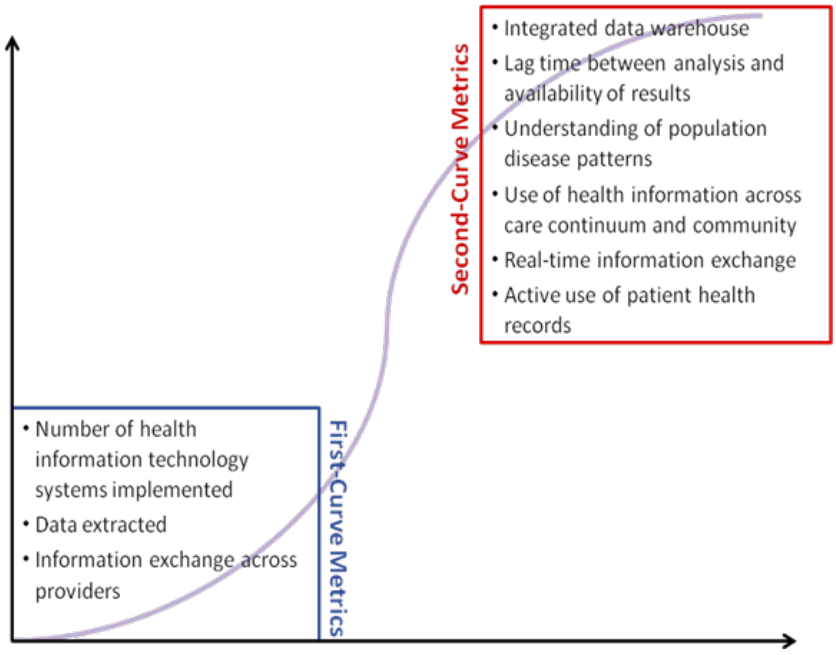
ED project: A community-based survey told hospital administration that patients were extremely dissatisfied with the ED's atmosphere and wait times. After analyzing their challenges and capabilities, NMMC undertook several projects that would streamline the diagnostic and treatment processes, therefore increasing efficiency. The NMMC projects included instituting bedside triage, placing a computer in every room to provide physicians with histories and test results in the most convenient place, creating the ability to view and take X-rays in each patient room, and installing a computerized tracking system to increase knowledge of patient flow. These improvements, combined with other strategies, aided in reducing the average total time that patients spend in the ED by two to three hours.

Purchasing project: NMMC standardized orders for types of products in the purchasing department. To ensure that they purchased the best products, each potential supply enters a trial period, in which opinions of physicians and other providers are solicited in addition to thorough investigation of outcomes. Not until clinicians confirm buy-in are the supplies made standard. Standardization allows the hospital to keep more inventory on hand, buy in larger bulk to decrease price per item, reduce complications that arise during trainings, and decrease practice variation across physicians. In total, annual supply costs were reduced by almost $3 million.[9]

7 Bodenheimer, T et al. Primary Care: Current problems and proposed solutions. *Health Affairs* 2010. 29:799-805.
8 Edwards, JN et al. Achieving Efficiency: Lessons from four top-performing hospitals. *The Commonwealth Fund.* July 2011.
9 Silow-Carroll, S. North Mississippi Medical Center: Improving efficiency through hospital, system, and community-wide practices. *The Commonwealth Fund.* July 2011.

Strategy #4: Developing integrated information systems

The policy arena has positioned health information technology (HIT) as a key initiative to decrease costs within the health system through reductions in administrative overhead, duplicative tests, paperwork, and medication errors. While the Health Information Technology for Economic and Clinical Health (HITECH) Act within the American Recovery and Reinvestment Act (ARRA) in 2009 provided a financial incentive for physicians and hospitals to adopt electronic health records, the interviews revealed that the organizations who installed IT systems have found that the literacy, cultural, and work flow barriers were much more critical than the cost barrier to successful implementation. Well-established and utilized systems are critical to future success in the second curve, connecting providers and providing critical real-time information to actively plan, measure, and improve efficiency and quality everywhere, from the bedside to the C-suite. It is not enough just to possess information systems or extract the important data. The ability of an organization to leverage the technology to perform sophisticated data mining and analysis in real time for continuous care improvement is critical for long-term organizational sustainability.



Piedmont Clinic

Atlanta, Georgia

Background: Piedmont Clinic is a physician hospital organization consisting of four hospitals and almost 700 physicians, of which 250 are employed by the hospitals. Although organized as an integrated system, Piedmont faced a data challenge similar to other organizations: several sources of electronic data were incompatible for analysis.

What they did: Piedmont created Clinical Integration Trust (CIT), a single data warehouse designed to be used for clinical integration, population health analysis, and quality improvement and reporting. This one source combined recorded information on patient satisfaction, core measures, Physician Quality Reporting Initiative (PQRI), overall population health statistics, and billing. This information is available in real time without analytical delays. Providers and administrators can access the results daily and examine them for trends over time. To ensure understanding and procedure compliance, the CIT team initially met with each physician practice individually.

Results: Information that had never been readily available was retrievable with ease. Provided with daily updates of the data critical to their specific functions, both senior management and providers were able to adjust their functions to improve outcomes. Prior *inpatient* hospital-based quality initiatives had delivered 10% improvement over time, while within nine months CIT had improved *overall* performance by 11%.[10]

For more information, please see HPOE's ***Health Care Leader Action Guide on Implementation of Electronic Health Records*** (http://www.hret.org/quality/projects/health-care-leader-action-guide-on-implementation-of-ehr.shtml)

10 Hamby, LS et al. Integrated quality measures improve patient safety and care. *Patient Safety and Quality Healthcare*. November/ December 2010.

Strategy #5: Joining and growing integrated provider networks and care systems

The interviews revealed that the large majority of organizations have already, are in the process of, or are planning on extending their care reach. These expansions come in a variety of forms: mergers; co-management agreements; acquisitions; alignment with physicians; and strategic alliances of hospitals, ambulatory facilities, physician groups, and other providers. In a challenging environment, organizations have recognized that arrangements with well-chosen and directed partnerships with joint accountability to outcomes and cost measurement provide the opportunity and scalability to coordinate care, improve quality, increase efficiency, leverage expensive technology, increase profitability, and achieve service excellence. As the second curve commands a dedication to the overall patient population, these expanded affiliations facilitate an organization's ability to manage patient health across the continuum. Beyond traditional acute-care partnerships, health systems will begin to collaborate with community health, public health, government agencies, education departments, and criminal justice systems, developing a new competency for many management teams. While interviews revealed that the same model will not be successful for every organization, the thriving relationships all benefited each party involved in the transaction.

Hoag Hospital Newport Beach
Newport Beach, California

Background: A 489-bed member of the two-facility Hoag Memorial Hospital, HHNB was seeing such a large volume of orthopedic cases that the ORs were constantly occupied with small-margin cases.

What they did: HHNB established a joint-venture/co-management agreement to create the Hoag Orthopedic Institute with 30 surgeons, 70 beds, and 9 ORs, overseen by joint governance and leadership.

Results: The institute performed over 1,600 joint replacements in its first 10 months of operation (above the annual average of 1,200). The increased economies of scale have improved quality. No hospital-acquired infections were recorded in 500 hip replacements. Margins have improved, with a 30% decrease in the overall cost per case.[11]

Johns Hopkins Medicine *Baltimore, Maryland*
All Children's Hospital *St. Petersburg, Florida*

Background: Johns Hopkins Medicine (JH) is financially successful and wanted to expand its reach of care beyond its immediate market area. Simultaneously, All Children's Hospital (AC) was assuming debt and faced decreased Medicaid payments.

What they did: JH essentially acquired AC—its first hospital outside of the Baltimore-D.C. area—without any financial exchange. This agreement provides JH with an opportunity to expand its market into Florida as well as potentially in the Caribbean and South America. AC does not give up ownership of its daily operations and will increase its research capabilities as well as the supply of primary care physicians through additional residency programs to meet the area's demand.[12]

11 Cox, J. Physician Alignment/Clinical Integration: A Place for Co-Management Agreements. Presentation to AHA Health System Reform Fellowship. July 14, 2011.
12 Hundley, K. Ripples from All Children's-Johns Hopkins merger could touch many. *St. Petersburg Times*. July 21, 2010.

Strategy #6: Educating and engaging employees and physicians to create leaders

Several of the interviewees relayed that the power and success of their organization is completely based on the culture, desire, and dedication of their employees. To thrive in a second-curve market, every clinical and administrative employee must be involved in initiatives to control expenses, improve efficiency, increase quality, and understand the new accountability that hospitals have to overall population health. Interviewees emphasized that change is going to happen, and that their respective organizations must train a new breed of administrative and clinical leadership to manage that change effectively. This can be accomplished with a variety of educational and involvement strategies. Organizations noted that even small engagement in employee health and wellness programs positively impacted turnover rates. As physicians continue to become better aligned with the interests of acute-care facilities, it is a necessity to provide leadership training to clinicians who may be able to guide the integration process.[13]

Henry Ford Health System

Detroit, Michigan

Background: One of the country's largest health systems, Henry Ford Health System achieves more than 3.1 million patient contacts annually, providing care for the large majority of Southeastern Michigan. Almost a decade ago, HFHS was struggling financially and facing high turnover with dissatisfied providers and administrative staff. It became obvious that HFHS needed to change its culture, and the health system began by focusing on learning and development.

What they did: Beginning with just one general program, HFHS now offers five separate leadership and development academies for its own employees, specific to each group's needs. The Renewal Program, offered to all employees, is a two-day workshop that focuses on successful management behavior. The Leadership Academy includes 50 to 60 midlevel managers every year, and participants are selected by upper-level management. The New Leader Academy is required for any individual new to a managerial position. The Advanced Leadership Academy serves employees already at a higher level within the organization who display the potential to become senior leaders within the next three to five years. Finally, although physicians participate within the other academies as well, HFHS still recognized their unique needs and created the Physician Leadership Institute.

Results: Although these statistics are not released publically, HFHS analyzes the program's impact on the performance of the individuals participating in the programs as well as the departments where they are applying their new knowledge. Overall, HFHS reports that the continued presence, expansion, and utilization of these programs has led to diminished turnover (as compared to those not involved in the programs), higher promotion rates, greater engagement, and generally better performance.[14]

For more information please see HPOE's guide ***Using Workforce Practices to Drive Quality Improvement: A Guide for Hospitals*** (http://www.hret.org/workforce/index.shtml).

13 Bakhtiari, E. Don't Skimp on Physician Leadership Development. *HealthLeadersMedia.* March 12, 2009. Accessed August 2, 2011.
14 Sinioris, M. Best practices in healthcare leadership academies. The National Center for Healthcare leadersip. 2010.

Strategy #7: Strengthening finances to facilitate reinvestment and innovation

Hospitals must prepare for tightening margins. The future of decreased reimbursement and a more severe case-mix commands today's organizations to find the means to cut costs and improve their operating margin without sacrificing any quality in the care provided. Simultaneously, technologies are being designed that significantly improve outcomes but are also a huge financial investment for the majority of institutions. Interviewees commented that without maintaining or improving current operating margins, they would not have the financial resources to perform any of the other must-do strategies such as focusing on quality and patient safety, creating strategic alliances with physicians and other providers, or engaging employees. To achieve the financial status desired for future innovation, organizations will have to fix their current service offerings, capital, and management structure to meet the needs of their population and reduce fixed costs throughout their budget.

Novant Health
Charlotte, North Carolina

Background: Novant Health is a 13-hospital integrated health care system centered in Charlotte and Winston Salem with an extended service area covering North Carolina, South Carolina, Virginia, and Georgia. As with most organizations, Novant was concerned about future potential payment reductions.

What they did: Novant transferred from cost shifting to a payer-neutral revenue (PNR) system, essentially considering all payers as if they were Medicare to prepare for the days of lower payment. They analyzed the resulting data in various ways as a means to reduce variation between organizations and providers and establish best practices. The new evidence-based practices were presented to hospital leadership and put into place systemwide to increase standardization across the system.

Results: After the first round of analysis, Novant identified 12 opportunities to trim more than $24 million in variation, ranging from differences in labor costs between two different imaging facilities to a 25% cost differential between joint replacement surgeries in their top-performing orthopedic programs. Their operating margin was significantly better in the first few months of 2009, 4.5% compared to 1.5% for the same period the year prior. Costs improved from being at 20% of Medicare reimbursement in 2008 to 16% after the variation analysis was performed.[15, 16]

For additional information please see HPOE's ***Striving for Top Box: Hospitals Increasing Quality and Efficiency*** (http://www.hret.org/topbox/index.shtml) and HPOE's **A Guide to Financing Strategies for Hospitals – With Special Consideration for Smaller Hospitals** (http://www.hret.org/financial-strategies/index.shtml).

15 Striving for Top Box: Hospitals increasing quality and efficiency. Hospitals in Pursuit of Excellence. www.hpoe.org accesses August 11, 2011
16 Weinstock, M. A model for efficiency. *Hospitals and Health Networks*. July 2009. Accessed August 11, 2011.

Strategy #8: Partnering with payers

As hospitals undertake several quality and patient safety initiatives to improve overall care in the current fee-for-service reimbursement system, savings have the potential to be realized mostly by the payer if new agreements are not signed. Additionally, as CMS and private payers increasingly reward clinical integration and high-quality care, health care organizations will need to assume greater accountability. For these reasons, the majority of interviewed organizations has considered or has already entered into contractual arrangements with payers to align the risk and rewards of new projects and payment systems. It is not expected that accountable care organizations will be the appropriate arrangement for all organizations. However, it is essential for organizations to work closely with their clinical staff throughout the negotiation process, to receive buy-in, and to expose the means by which clinical quality improvements might be able to reduce costs overall.

Advocate Health Care

Chicago, Illinois

Background: Advocate Health Care is the largest health care system within Chicago and its surrounding suburban areas. Growing in prominence and market share over the past few years, the health system partnered with over 3,800 of its affiliated physicians to become Advocate Physician Partners and work to integrate and improve patient care. However, Advocate encountered a Chicago market with an unsecure future, and it wanted to prove the value of clinical integration to payers as well.

What they did: Advocate signed an agreement with Blue Cross Blue Shield of Illinois to manage over 300,000 HMO and PPO patient lives in an accountable care agreement worth approximately one billion dollars. Effective since the beginning of 2011, the deal requires Advocate to limit the rate increases it typically negotiates annually with BCBS over the two-year agreement. In return, Advocate receives an undisclosed share of any savings realized by meeting established performance targets tied to the quality, safety, and efficiency of provided care.

Results: While the project is still in its infancy, Advocate adopted a first mover strategy within the Chicago market. Due to its prominence, it can serve as a tipping point for other organizations within the area.[17]

17 Japsen, B. Blue Cross, Advocate Raise Bar on Accountability. *Chicago Breaking Business.* http://archive.chicagobreakingbusiness.com/2010/10/blue-cross-advocate-deal-raises-bar-on-accountability.html. *October 6, 2010.* Accessed July 28, 2011.

Strategy #9: Advancing an organization through scenario-based strategic, financial, and operational planning

In a turbulent and unpredictable market facing economic and regulatory changes, it is essential that organizations move beyond expected future-focused strategic planning. They must use methods that prepare them for a large number of potentially new situations, including the incorporation of financial and operational considerations into these plans. This is an advanced strategy for many organizations and requires a strong basis in financial management and established core-planning capabilities. The common route of scenario-based analysis includes a market environment scan, analysis of internal capabilities, identification of the unknown, development of key scenarios, and plans to implement the necessary strategies.

Additionally, this skill commands attention to risk assumption. Organizations should ensure that the proper infrastructure is in place for flexibility due to any of the expected scenarios. Potential scenarios described by interviewees include planning for health exchanges, Medicaid cuts, natural emergencies, and the dissolution of a large employer. While this is going to vary between organizations, interviewees said that the most important aspect of the process occurs through the collaborative efforts between clinical and administrative professionals to define the potential scenarios and the organizational skill development necessary to get there. Successful strategic planning is market- and organization-specific, and this process allows for the entire team to determine their future direction and success within the second-curve market.

HealthPartners

Minneapolis, Minnesota

Background: HealthPartners is the largest not-for-profit, consumer-governed, health care system in the United States. Minneapolis is an advanced market, already seeing high consolidation. HealthPartners had already realized success with initiatives focused on integration and care improvement, but it remained concerned about how future policy and regulations were going to impact its larger system.

What they did: The strategic planning department inspected future political and regulatory scenarios and performed data analysis which revealed that quality within their outpatient primary care and disease management programs was below their standards. HealthPartners transitioned care delivery into a medical home-based model for a specific group of patients with complex chronic diseases. While planning the design of this initiative, the health system enforced principles that would be beneficial in both the first- and second-curve market dynamics, including transparency, efficiency, and quality.

Results: While creating more cohesive patient-provider relationships is only acknowledged through provider stories, this program realized dramatic improvements across health measures. Forty-one percent (41%) of patients achieved optimized levels of diabetes control, and 98% of current patients involved in the program said they would recommend HealthPartners Clinics. Additionally, analysis from HealthPartners' information system verified that the system had reached benchmark levels for employee and physician satisfaction as well as clinical productivity.[18]

18 Etchen, L et al. Transition Economics- Strategic Challenge and Opportunity. The Chartis Group Management Consultants. July 2011.

Strategy #10: Seeking population health improvement through pursuit of the "triple aim"

In a cooperative environment, hospitals historically were able to leave population health considerations to public health officials and organizations throughout their market area. However, the increased aging population and the onset of value-based payment structures have encouraged hospitals to take a more prominent role in disease prevention, health promotion, and other public health initiatives. The "triple aim" is an initiative launched by the Institute for Healthcare Improvement in 2007 to encourage hospitals to simultaneously focus on population health, increased quality, and reduction in health care cost per capita. The pursuit of these three goals permits organizations to identify and fix a wide range of problems, but most importantly, it allows them to redirect resources to activities that will have the greatest impact on overall health. For the organizations interviewed, these activities included community-wide education and wellness projects, disease screening initiatives, and chronic disease management programs.[19]

Genesys Health System

Flint, Michigan

Background: Genesys is an integrated health care system focused on providing care within its surrounding county. Anchored by a 410-bed acute care facility, the care network also includes a convalescent center, home health agency, durable medical equipment store, and hospice care. Genesys also is affiliated with more than 150 community-based primary care physicians through a PHO. In the Detroit area, the financial status and health of the Genesys market is extremely dependent on the status of the motor industry. As the economy worsened, the health of the health system's patients and their ability to pay both declined significantly.

What they did: Genesys pursued three key programs that highlighted the importance of primary care, community health involvement, and the involvement of patients in their own care. The health system became affiliated with community-based primary care providers through a PHO, highlighting its emphasis on primary care. They employed a large number of health navigators who supported Genesys patients in adopting a healthy lifestyle to improve the management of current chronic diseases and prevent any future ones. Finally, Genesys partnered with community organizations to extend its care model beyond the health system's regular patients and to improve the health and screening capabilities of the entire county population.

Results: The new care delivery model lowered the cost of care per patient over specific periods of time, while also improving overall physician performance on analyzed quality measures. A study released by General Motors revealed that the automaker was spending 26% less on health care for employees enrolled and receiving care at Genesys as compared to other local competitors. The commitment of the health navigators led to improved patient health behavior in areas such as smoking, body mass index, physical activity, alcohol drinks, and medication compliance.[20]

19 McCarthy, D et al. The triple aim journey: improving population health and patients' experience of care, while reducing costs. *The Commonwealth Fund.* Vol. 48. July 2010.

20 Klein, S et al. Genesys HealthWorks: Pursuing the triple aim through a primary care-based delivery system, integrated self-management support, and community partnerships.

Core Organizational Competencies

Interviewees were asked for their insights on the essential capabilities that will be critical for hospitals to master in an environment that demands delivery systems to provide economic value, quality outcomes, service coordination, information transparency, performance accountability, and greater patient accessibility.

Acting on the strategies detailed in prior sections determines not only the successful movement of a hospital from the first curve and volume-based payment to the second curve and value-based payment, but it also facilitates these longer-term core organizational competencies. These competencies reflect essential capabilities that enable an organization to implement its strategies and deliver great value. Utilizing the strategies to develop the core competencies is not a mathematical equation—that is, there is no exact action combination that will lead to a specific competency.

The core competencies are described below. Additionally, discussion questions are listed for each core competency, so organizations can establish where success has already occurred or where future strategies need to be developed to ensure an appropriately timed move to the second curve.

Similar to the strategies, these competencies are intrinsically connected and aligned.

1. Design and implementation of patient-centered, integrated care
2. Creation of accountable governance and leadership
3. Strategic planning in an unstable environment
4. Internal and external collaboration
5. Financial stewardship and enterprise risk management
6. Engagement of employees' full potential
7. Collection and utilization of electronic data for performance improvement

Self-Assessment Competency Questions

For an organization to track how successful it has been in establishing the core organizational competencies, the following set of questions can serve as a guide for self-assessment.

<u>Design and implementation of patient-centered, integrated care</u>

- Have we developed a clear and compelling approach to clinician alignment and integration?
- Are we developing sufficient capabilities to measure, manage, and improve the quality and efficiency of patient care across the continuum of care?
- How are we rapidly assimilating best practices into clinical medicine?
- What is our role in improving overall population health?

<u>Creation of accountable governance and leadership</u>

- Does the board drive the organizational strategy for moving toward the second curve while assessing the balance of risks and rewards?
- Does the board have an explicit succession planning process in place to ensure the selection and development of leaders with the right attributes?
- Does physician/clinician engagement in governance and management activities reflect their emerging roles as economic and clinical partners?
- Does the board have the appropriate competencies for executing the must-do strategies?
- Is there transparency in the communication of patient outcomes, financial results, and community benefit to the community?

Strategic planning in an unstable environment

- Do we have a clear/compelling vision for the second curve?
- Do we have a plan and timeline for moving toward the second curve of value-based care delivery, as compared to current financial incentives?
- What is the necessary mix of inpatient beds, ambulatory facilities, physicians, midlevel providers, and emerging technologies to meet future demand?
- What size and scale of our organization will be sustainable in the future?
- Should our organization explore new strategic partnerships? What type of organization best meets our needs while still fitting with our mission?
- Are we utilizing scenario-based planning techniques to monitor key changes in our assumptions and making necessary adjustments?
- Do we assess the health needs of the community we serve? Do we also identify potential partners to improve access to necessary care?

Internal and external collaboration

- Have we examined our mission to determine if we can financially sustain high quality in all of the services we currently provide?
- How well are we developing trust within our organization?
- What is our desired culture? Does it value collaboration, accountability, transparency, excellence, patient focus, and similar core values?
- Are our leaders "role models" for a collaborative culture?
- Are we considered a valuable partner to physicians and other organizations within the community?
- Do we know our partners well enough?

Financial stewardship and enterprise risk management

- Do we have a capital investment plan for testing strategic activities in payment pilot projects and health management strategies (e.g., service line management, population health, use of health information technologies)?
- Can we measure revenues and expenses by each clinical service?
- Are we utilizing an annual enterprise risk management assessment?
- Have we identified long-term financial goals and a plan to get there?

Engagement of employees' full potential

- What is our strategy for employee and physician partner engagement?
- Are our employee and physician recruitment and retention systems aligned with our strategic direction and desired culture? For example, how are we assessing performance and values of collaboration?
- Are we a learning organization? How are we developing the knowledge and skills of physicians, middle managers, employees, and senior executives?

Collection and utilization of electronic data for performance improvement

- When will our information systems bring all pertinent information to the point of care?
- How far along are we in achieving digital connectivity among providers and with patients?
- How often is the data collected from information systems reviewed at clinical and administrative team meetings? What data is brought to senior leadership's attention?

Core Competency #1: Designing and implementing patient-centered, clinically integrated models of care that optimize quality, safety, the patient experience, and economic value

Hospitals, as parts of care systems, will need the capacity to integrate with physicians as economic and clinical partners, working together to redesign delivery systems. Key strategies will include developing a collaborative culture among previously independent physician practices; investing in physician leadership development training; adopting evidence-based care protocols; developing care delivery models and maps that cover all network providers and the full continuum of care; deploying accountable multidisciplinary teams including primary care partners and nurse practitioners; developing the capability to extend pilot projects in value-based payment to all payers; and putting patients at the center of all care plans, encouraging them to make healthy lifestyle changes and follow recommended treatments. These can be accomplished with several different methods.

Core Competency #2: Creating accountable governance and leadership

Hospitals and care systems will demand boards and leadership teams that have a passion for their mission, understand the changing environment, and are prepared to accept accountability for making and overseeing visionary decisions. Successful boards will consist of trustees with relevant expertise, equipped to meet the rising demands for timely direction-setting, diligent oversight, and public accountability. They will need to approve and monitor metrics of the first-to second-curve strategic goals and culture. On the management side, thriving hospitals and medical groups will increasingly reject traditional hierarchies in favor of structures that reflect the integrated properties of networks and care systems. The combination of governance teams and management will be responsible for optimizing care system performance, rethinking system performance metrics**,** recruiting trustees based on their skill sets for specific facility needs**,** engaging physician participation in major decisions and initiatives**,** constructing effective and efficient decisions, managing change as it occurs, and ongoing board development. (Please see **Appendix C** for more detail).

Core Competency #3: Strategic planning in an unstable environment

Strategic planning is not a new competency. Driven by their mission and assessment of community needs, the majority of hospitals and health systems develop a rolling, multiyear strategic plan with annual updates to address market and regulatory changes. Numerous hospitals and systems have adopted a clear vision for the future, with defined approaches and performance metrics. However, as transformational change looms overhead, hospitals and health systems must add new dimensions to their strategic planning process. The majority of interviewees agreed that this planning must be continuous to reflect ongoing changes in the operating environment. Scenario-based planning will be needed to retest assumptions against developments. Some leaders called for conducting community health needs assessments to study the health needs and characteristics of a community and linking those results with forecasting activities. Financial pressures to operate more efficiently will compel not-for-profit hospitals and health systems, particularly safety-net providers and rural hospitals, to establish a finely honed "mission discipline," which will objectively assess the appropriate combination of facilities and services that the organization can continue to provide based on both financial and quality metrics. Hard choices may be necessary.

Core Competency #4: Facilitating internal and external collaboration

Knowledge-driven organizations in the second-curve arena are complex webs rather than hierarchical structures, with multidisciplinary leadership groups, patient care teams, and working committees. In such organizations, leadership authority is exercised more by relationships, influence, and shared processes than by formal management methods. Therefore, in the care systems of the future, interviewees overwhelmingly listed collaboration at the top of every core competency list. The prerequisites for collaboration are trust, communication, a history of mutually beneficial relationships, common goals, integrating mechanisms such as joint committees and teams, shared economic incentives, and a performance-based system of evaluation. Health care will increasingly be delivered by multidisciplinary teams using real-time information and evidence-based practices. These teams will be accountable for results. True collaboration, however, extends beyond patient care teams. A culture of collaboration inside an organization will be scalable outside an organization, in partnerships with community- and regional-based physicians, other providers, and the extensive public health community. True collaboration will necessitate considerable investment in data analysis capabilities, technology, and infrastructure.

Core Competency #5: Exercising financial stewardship and enterprise risk management

In the second-curve market, hospitals and health systems need accurate financial and operational information, including cost accounting systems for clinical service lines, which enable them to understand their expenses and resource use. Effective organizations will have the capability to analyze this information to reduce drivers of unnecessary costs. They need to embrace improvement methodologies such as Lean/Six Sigma and to apply best practices that will increase efficiency, reduce costs, improve productivity, and increase value. Adopting best practices should involve systemwide coordination and standardization. Successful organizations will require strong capabilities in enterprise risk management and capital financing.

Core Competency #6: Engaging employees' full potential

Hospitals and care systems are fundamentally knowledge-driven organizations that require an extremely educated and engaged workforce. The ability to recruit, retain, engage, and develop highly motivated clinical and administrative teams will be essential for hospitals and care systems to succeed. Aligned physicians and other health care professionals will be trained in leadership skills and team-based care to increase collaborative abilities as well as to generate succession planning for the next generation of health care leaders.

Core Competency #7: Collecting and utilizing electronic data for performance improvement

Hospitals and health systems in the second curve need to achieve digital connectivity by fully integrating information systems into all patient care and giving providers and patients real-time information at the bedside and in ambulatory facilities. Successful implementation will facilitate care coordination through informed, shared, and evidence-based decision making. However, such coordination is not sufficient to thrive in the next generation. Organizations must implement explicit programs of focused knowledge management, in which providers and executives use the organization's information for continuous learning, planning, evaluation, and improvement.

Conclusion

This report has drawn on interviews with hospital and health care leadership as well as published literature to synthesize a list of essential strategies to implement in the first curve today in order to develop the core competencies necessary to thrive in the future second curve. Additionally, metrics are listed by each of the actionable strategies, which allow an organization to assess its own status in the implementation process while living life in the gap between volume-based and value-based payments. Organizations are urged to think about and discuss the questions listed under each of the core competencies as a means to evaluate the institution's current capabilities and to identify areas for potential improvement.

In addition, **Appendix D** contains a summary of ideas and steps taken by interviewed organizations as they undergo their individual transitions into the next market and regulatory environment. **Appendix E** provides a list of the additional resources available on the *Hospitals in Pursuit of Excellence* website at http://www.hpoe.org to aid organizations in adopting the must-do strategies and core competencies. **Appendix F** is a Power Point presentation based on the report, which organizations can customize and use as a discussion tool in their own leadership and board meetings in the future.

This is the initial phase of the *Hospitals and Care Systems of the Future* series. The AHA Committee on Performance Improvement will be continuing a dialogue with the field about this report and subsequent efforts as the committee continues focusing on strategies to improve performance today in order to succeed tomorrow.