American Hospital Association
2013 Committee on Research

Acknowledgments

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Executive Summary

Environmental factors—economic climate, evolving payment models, shifting patient and workforce demographics, political and regulatory pressures and the Affordable Care Act—build the impetus for dramatic change in the health care field. They challenge hospitals and care systems to accelerate organizational transformation to provide better, more efficient and integrated care for patients and communities, while assuming more financial risk and increased accountability.

The health care field will ultimately shift from the "first curve," where hospitals operate in a volume-based environment, to the "second curve" where they will be building value-based care systems and business models. Many hospitals are in a period of transition known as "life in the gap." While this transition may generate fear, it provides health care organizations with an incredible leadership opportunity to play a critical role in reducing the total cost of care.

Hospital leaders need to proactively develop strategies to achieve the second curve; waiting is dangerous. If a fundamental shift in health care happens in three to five years, the time is now for hospital and care system leaders to make strategic, yet swift, movement toward achieving health care's Triple Aim—improve care quality and patient experience, improve population health and reduce per capita costs. Leaders must heed the best practices and lessons learned in the first-curve environment and apply them to the second-curve environment.

When and how to move from the first curve to the second curve are difficult decisions. To survive life in the gap, leaders need to develop the capacity to take risks, and getting to the second curve requires greater clinical, financial, operational and cultural integration. Additionally, redesigning care is essential to any future health care state.

This resource, a product of the 2013 American Hospital Association Committee on Research, outlines several potential paths to manage life in the gap and achieve the Triple Aim. It highlights several successful, integrated delivery programs, as well as different forms of integration, all designed to provide opportunities to accelerate organizational transformation.

Key issues that hospital leaders need to consider in their transformational journey are:

- Health care is moving to new performance models in which organizations are integrating financial risk and care delivery.
- There is no "one-size-fits-all" model, as provider capabilities and community needs are different everywhere.
- The status quo is not a viable strategy because the environment is changing rapidly.
- Each hospital and care system can consider multiple paths.
- Each path has its own distinct risks and rewards.

The figure "Your Hospital's Path to the Second-Curve Framework" lists the environmental factors impacting all hospitals and offers strategies to implement and capabilities to master for the future. It also provides an overview of potential paths—partner, redefine, specialize, integrate, experiment—and describes several steps toward transformation, with key strategic questions and assessments.

Hospital and care system leaders are being called upon to set the course for the nation's health care system. While paths to future success may be different, hospitals can use the framework in this report to dramatically improve care delivery and population health and reduce the total cost of care over the next five years by up to 25 percent.

Figure: Your Hospital's Path to the Second-Curve Framework

IDENTIFY

Potential Paths

- **Redefine:** To a different care delivery system
- **Partner:** With a care delivery system or health plan
- **Integrate:** By developing a health insurance function or services across the continuum of care
- **Experiment:** With new payment and care delivery models
- **Specialize:** To become a high-performing and essential provider

Integrate
Multifacility health systems with health insurance function

Partner
All hospitals

Experiment
Small/rural hospitals, independent community hospitals, academic medical centers, multifacility health systems, specialty hospitals

Specialize
Specialty hospitals, centers of excellence, service lines within all hospitals

Redefine
All hospitals

ANSWER

Top 10 Strategic Questions

1. What are the primary community health needs?
2. What are the long-term financial and clinical goals for the organization?
3. Would the organization be included in a narrow/preferred network by a health insurer, based on cost and quality outcomes?
4. Is there a healthy physician-hospital organization?
5. How much financial risk is the organization willing or able to take?
6. What sustainable factors differentiate the organization from current and future competitors?
7. Are the organization's data systems robust enough to provide actionable information for clinical decision making?
8. Does the organization have sufficient capital to test and implement new payment and care delivery models?
9. Does the organization have strong capabilities to deliver team-based, integrated care?
10. Is the organization proficient in program implementation and quality improvement?

MASTER

Organizational Capabilities

Accept financial risk

Conduct information exchange

Expand reach

Deliver core performance (quality and efficiency)

All hospitals | Fewer hospitals

Environmental Factors
Increasing focus on improving quality and efficiency, greater clinical integration, assuming more financial risk and accountability

H

Critical access hospital
Small/rural hospital
Safety-net health care system
Independent community hospital
Academic medical center
Multifacility health system
Specialty hospital

IMPLEMENT

Must-Do Strategies

1. Aligning hospitals, physicians and other providers across the continuum of care
2. Utilizing evidence-based practices to improve quality and patient safety
3. Improving efficiency through productivity and financial management
4. Developing integrated information systems

Source: AHA COR, 2014.

Introduction

Strategic Issues in the Current Health Care Environment

The current health care system in the United States is fragmented and costly. To improve the quality, value and outcomes of care, incentives need to be better aligned and coordination needs to improve.[1]

Environmental pressures are driving hospitals and care systems toward greater clinical integration, financial risk and increased accountability (see Figure 1). The *2013 AHA Environmental Scan* identified some of these environmental pressures:

1. Patient demographics will shift significantly throughout the next decade.
2. Enhancing care coordination during hospital-to-home transitions has consistently shown beneficial effects on cost and care quality, requiring hospital leaders to focus on care after patients leave the hospital.
3. Political and regulatory pressures are compelling hospitals and care systems to provide efficient and optimal patient care and address market volatility.
4. Hospitals need to serve multiple patient populations effectively—e.g., dual eligibles, Medicaid beneficiaries and chronically ill patients.

To help with health care transformation, in 2010 the AHA Committee on Research released *Strategic Issues Forecast 2015,* which identified five strategic issues for hospitals and care systems:

1. There is increasing pressure on all health care organizations to become more efficient.
2. New payment models are critical to health care system improvement.
3. Bending the cost curve is essential for long-term financial sustainability at the national level and maintaining global competitiveness.
4. New models of care emphasizing care coordination across hospitals and care systems, other providers and the community are critical for quality improvement.
5. Quality is improving but must be further accelerated.

The Future of Hospitals and Care Systems

The 2011 AHA Committee on Performance Improvement released *Hospitals and Care Systems of the Future*, a report that outlined 10 must-do strategies for hospitals and care systems to succeed in a rapidly changing environment. Four of these strategies were identified as major priorities (see Figure 1).

1. **Aligning hospitals, physicians and other providers across the continuum of care**
2. **Utilizing evidence-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

Figure 1: The Future of Hospitals and Care Systems

Environmental Factors
Increasing focus on improving quality and efficiency, greater clinical integration, assuming more financial risk and accountability

H

Critical access hospital
Small/rural hospital
Safety-net health care system
Independent community hospital
Academic medical center
Multifacility health system
Specialty hospital

Must-Do Strategies for Hospitals of the Future
1. Aligning hospitals, physicians and other providers across the continuum of care
2. Utilizing evidence-based practices to improve quality and patient safety
3. Improving efficiency through productivity and financial management
4. Developing integrated information systems

Source: AHA COR, 2014.

The Affordable Care Act, signed into law in 2010, is fundamentally changing the way health care is delivered. It has pressured and encouraged health organizations to innovate and redefine payment and care delivery. Because of the Great Recession that began in December 2007 and rising health care expenditures, there is a growing interest in integrated delivery systems to improve quality and outcomes and reduce health care costs. Pioneering health care systems have tested various IDS models and improved care coordination, physician alignment, performance measures and patient outcomes—accomplishing the four top priorities presented in the *Hospitals and Care Systems of the Future* report. Other health care organizations are testing new payment and service delivery models. The Center for Medicare and Medicaid Innovation, a provision of the Affordable Care Act, funds some of these developments. (See Appendix 2: Current Value-Driven Programs)

Aside from political and regulatory pressures, the health care industry will face a shift in patient and workforce demographics. Over the next decade, the demand for health care services will rise when baby boomers retire—most of them are projected to live longer as a result of new treatments and technology. Future health care demands will not be met by the current and projected labor supply. Nursing and physician shortages alone will continue to get worst. Hospitals and care systems will need to evolve into organizations that are more team oriented and patient centered to adapt to the new workforce culture.

As hospitals and care systems move to different potential paths presented in this report, it is paramount that they focus on how care is delivered. Hospitals and care systems have the opportunity to redefine the industry. Starting with redesigning care delivery, hospitals and care systems can eliminate inefficiencies within the system that will lead to better, integrated care and lower total cost of care.

Redesigning how care is delivered—through greater use of teams and leveraging the skills and capabilities of all care providers in different settings—is essential to achieving patient-centered care. This requires new workforce planning models both locally and nationally, educating and engaging the workforce toward second-curve environment attributes and redeploying the current workforce toward new models of care. All will markedly improve the culture of health care organizations. Redesigning care provides a foundation for any organization embarking on potential paths.

Defining Integrated Delivery Systems

Although there is no current consensus, integrated delivery systems typically are described as collaborative networks linked to various health care providers that offer a coordinated and vertical continuum of services.[2] For this report, a modified definition of IDSs from *Remaking Health Care in America: Building Organized Delivery Systems* is used: **"a network of organizations that provides or arranges to provide a coordinated continuum of services to a define[d] population and is...held accountable for the outcomes[,] health status and financial risk of the population served."[3]**

Characteristics of IDSs

The Essential Hospitals Institute identified seven characteristics of a fully integrated health care delivery system:[4]

1. **Value-driven governance and leadership:** The delivery system's governing body and administrative leadership are committed to and focused on achieving the benefits of integration. Organizational structure supports integration. Strategic, financial and operational planning toward integration is clear. Data are transparent throughout the organization and to the community.

2. **Hospital/physician alignment:** IDSs engage health care providers in developing an integrated model. For example, organizations incorporate feedback from medical providers when making administrative decisions. Clinicians and administrators also work together to make many decisions.

3. **Financial integration:** IDSs are well prepared to assume risk-based payments. With payers, supported by staff, resources and IT infrastructure, they are able to manage contractual relationships.

4. **Clinical integration/care coordination:** IDSs provide a full range of services in their own facilities or on an outsourced or contracted basis. Care transitions and handoffs in IDSs are effectively managed between settings, a result of strong collaborative relationships and accountability among teams and other stakeholders.[5]

5. **Information continuity:** IDSs utilize electronic health records to track patient visits and health outcomes, and these records are accessible to providers within and outside the system.

6. **Patient-centered and population health-focused:** IDSs align their resources with needs of the patient population and provide significant support through social services and convenient access to care. Nearly all staff in IDSs are trained in cultural and behavioral competencies to better serve patients.

7. **Continuous quality improvement and innovation:** IDSs foster an environment that encourages professional growth and empowers employees to innovate. Strategic activities are often tested through pilot projects, and medical providers employ evidenced-based practices.

Impact of IDSs

By improving the performance of health care organizations, IDSs ultimately improve patient care. For example, IDSs:

- Kept health care costs down by working under fixed-price contracts to deliver health services.[6]
- Managed operational costs by developing disease-management programs to train other health care professionals in duties previously performed only by a physician.[7]
- Improved the quality of care by compiling comprehensive medical records and allowing physicians to share and access a patient's complete medical history.[8, 9, 10, 11, 12]
- Supported medication adherence and made tracking medications easier using EHRs.[13, 14, 15, 16, 17, 18]
- Reported greater job satisfaction among staff due to blending of professional cultures and increased cooperation, teamwork and communication with other agencies.[19, 20]
- Improved quality of care, in terms of clinical effectiveness.[21, 22, 23, 24, 25, 26, 27, 28, 29]

Your Hospital's Path to the Second-Curve Framework

Hospitals and care systems can evolve to varying levels of integration and find value in integration from their own vantage points, or organizational lenses (Figure 2).

Figure 2: Strategies for Health Care Transformation

Organizational Lenses

Hospital Care Delivery Organizations

Critical access hospital
Small/rural hospital
Safety-net health care system
Independent community hospital
Academic medical center
Multifacility health system
Specialty hospital

Nonhospital Care Delivery Organizations

Medical groups
Post-acute care
Health insurers

MASTER Organizational Capabilities

ANSWER Top 10 Strategic Questions

IDENTIFY Potential Paths

Source: AHA COR, 2014.

Hospital care delivery organizations include services traditionally offered within the four walls of the hospital, while nonhospital care delivery organizations include services delivered by ambulatory facilities, post-acute care organizations and health insurers. This report focuses on the potential paths for hospital care delivery but recognizes that many of today's hospitals also operate nonhospital care delivery components.

The following descriptions provide a broad brush in considering different hospital types, not to serve as a limiting factor but for dialogue regarding general hospital types.

Hospital Care Delivery Organizations

Critical access hospital
Critical access hospitals are Medicare-participating hospitals located more than 35 miles from the nearest hospital or more than 15 miles from areas with mountainous terrain or secondary roads, or they were certified as a critical access hospital before January 1, 2006, based on state designation as a "necessary provider" of health care services to residents in the area.[30] Critical access hospitals have no more than 25 beds for either inpatient or swing bed services. They provide 24/7 service with either on-site or on-call staff.

Small/rural hospital
The AHA identifies small and rural hospitals as having 100 or fewer beds, 4,000 or fewer admissions, or located outside a metropolitan statistical area. Rural hospitals provide essential health care services to nearly 54 million people, including 9 million Medicare beneficiaries.

Safety-net health care system
Safety-net health care systems provide care to low-income, uninsured and vulnerable populations.[31] They are not distinguished by ownership and may be publicly owned, operated by local or state governments or nonprofit entities.[32] In some cases, they are for-profit organizations. These health care systems rely on Medicaid, and to a lesser extent Medicare, as well as state and local government grants as variable sources of revenue for most of their providers.

Independent community hospital
Independent community hospitals are freestanding health care providers typically located in market areas with 50,000 or more residents.[33] They operate between 100 and 350 beds.

Academic medical center
An academic medical center is an accredited, degree-granting institution of higher education and can include hospitals with major or minor teaching programs.[34]

Multifacility health system
A multifacility health system is formed when hospitals undertake an organizational restructuring such as network affiliation or partnership with other hospitals.[35] These care systems have two or more general acute care hospitals and are the most common organizational structure in the hospital field; in fact, almost 200 hospital systems account for half of all hospitals and hospital admissions in the United States.[36]

Specialty hospital
Specialty hospitals are centers of care that are built for certain patient populations, such as children, or that provide a particular set of services, such as rehabilitation or psychiatric services.
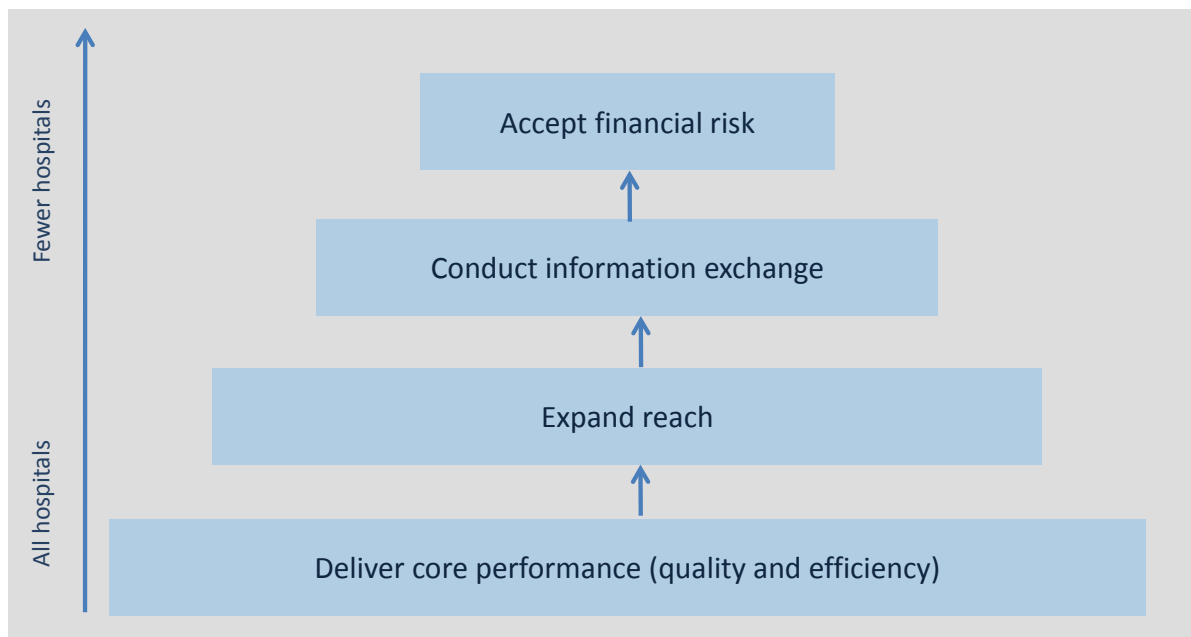
Nonhospital Care Delivery Organizations

Nonhospital care delivery organizations, such as post-acute providers, physician groups, home health agencies, hospice providers and alternate-site companies including ambulatory surgery centers, urgent care centers and dialysis companies, play an important role in the transformation of the health care field.

Organizational Capabilities

Assessing current organizational capabilities is key to understanding a health care organization's current level of integration and potential for further integration (see Appendix 1). This requires exploring and evaluating the current financial, clinical and operational risk tolerance, along with the organization's cultural underpinnings.

Regardless of a hospital's or care system's current or future level of integration, the organization needs to link its activities to its mission and value statement. To do this, hospitals and care systems need to deliver core performance and assess their potential for further capabilities, such as expanding reach, conducting information exchange and accepting financial risk (Figure 3).

Figure 3: Organizational Capabilities to Fully Integrate Care

Source: AHA COR, 2014.

Organizational capabilities are dependent on the type of integration model the hospital hopes to achieve. All hospitals and care systems must be able to deliver core performance—quality and efficiency. It is a foundational capability in order to succeed in the second curve of health care delivery. Few hospitals and care systems, because of size and scope, have the capability to expand their reach with populations and services and go beyond conducting information exchange as an additional capability. And even fewer can accept financial risk to deliver the best value to the patient population. Following are some specific examples needed for each capability.

Deliver Core Performance (Quality and Efficiency)

Develop strong organizational leaders
- Align executive leadership with the organization's mission and vision
- Empower staff for organizational change
- Identify transformational leaders

Increase organizational transparency
- Engage all stakeholders (i.e., employees, physicians, the community)
- Improve internal communication
- Report meaningful information to consumers
- Implement shared decision-making programs

Focus on performance and quality improvement
- Use clinical quality performance tools for outcome measures
- Develop quality improvement skills among clinical staff
- Measure clinical performance with evidenced-based tools
- Use consistent and thorough personnel performance measurement

Redesign care process
- Provide more team-based care throughout the continuum of care
- Leverage technology in all services

Expand Reach

Expand availability of health care services
- Engage and educate health care users by implementing patient and family engagement practices (Refer to the 2012 AHA Committee on Research report *Engaging Health Care Users: A Framework for Healthy Individuals and Communities* for strategies to engage health care users.)
- Implement outreach programs
- Promote patient accountability
- Deploy preventive health intervention
- Use evidenced-based practices
- Connect with community resources

Conduct Information Exchange

Use information systems
- Implement electronic health records
- Enhance health information system interoperability across sites of care
- Use existing data to facilitate analysis and reporting for process improvement and behavioral change
- Use predictive modeling for population health management
- Use data analytics for care management and operational management

Accept Financial Risk

Manage financial risk and use actuarial science for risk management
- Conduct health-risk assessments on defined populations
- Conduct a thorough due diligence process
- Expand financial planning and modeling

Experiment
- Use value-based payment
- Test care delivery models
- Assess risk tolerance

Top 10 Strategic Questions

To determine desired paths, hospital care delivery organizations need to address 10 strategic questions. Responses to each question provide an organizational assessment that leaders can use to choose an optimal path or a series of paths for transformation.

1. What are the primary community health needs?
2. What are the long-term financial and clinical goals for the organization?
3. Would the organization be included in a narrow/preferred network by a health insurer, based on cost and quality outcomes?
4. Is there a healthy physician-hospital organization (a business model that aligns physicians in private practice with hospitals and hospital-employed physicians)?
5. How much financial risk is the organization willing or able to take?
6. What sustainable factors differentiate the organization from current and future competitors?
7. Are the organization's data systems robust enough to provide actionable information for clinical decision making?
8. Does the organization have sufficient capital to test and implement new payment and care delivery models?
9. Does the organization have strong capabilities to deliver team-based, integrated care?
10. Is the organization proficient in program implementation and quality improvement?

Potential Paths

Paths toward Health Care Transformation

Assessing integration capabilities and answering strategic questions will help hospital and care system leaders determine potential paths that provide high-quality, affordable care. Depending on the value an organization seeks to create, one or more or a combination of these paths can be pursued:

1. **Redefine** to a different care delivery system (i.e., more ambulatory or long-term care oriented)
2. **Partner** with a care delivery system or health plan for greater horizontal or vertical reach, efficiency and resources for at-risk contracting (i.e., through a strategic alliance, merger or acquisition)
3. **Integrate** by developing a health insurance function or services across the continuum (e.g., behavioral health, home health, post-acute care, long-term care, ambulatory care)
4. **Experiment** with new payment and care delivery models (e.g., bundled payment, accountable care organization or medical home)
5. **Specialize** to become a high-performing and essential provider (e.g., children's hospital, rehabilitation center)

As Figure 4 illustrates, there is not a single transformational journey for hospitals. A comprehensive assessment may suggest a customized path or series of paths. For example, hospitals that choose to experiment with new payment and care delivery models have the option to later redefine, specialize, partner or integrate. Hospitals that choose to redefine after experimenting with new payment and care delivery models can either specialize or partner. Hospitals that choose to specialize can partner, and those who already chose to partner can integrate. The ultimate goal is not to fully integrate but to select one or more paths that best fit the goals and objectives of the organization.

Figure 4: Determining Paths toward Health Care Transformation
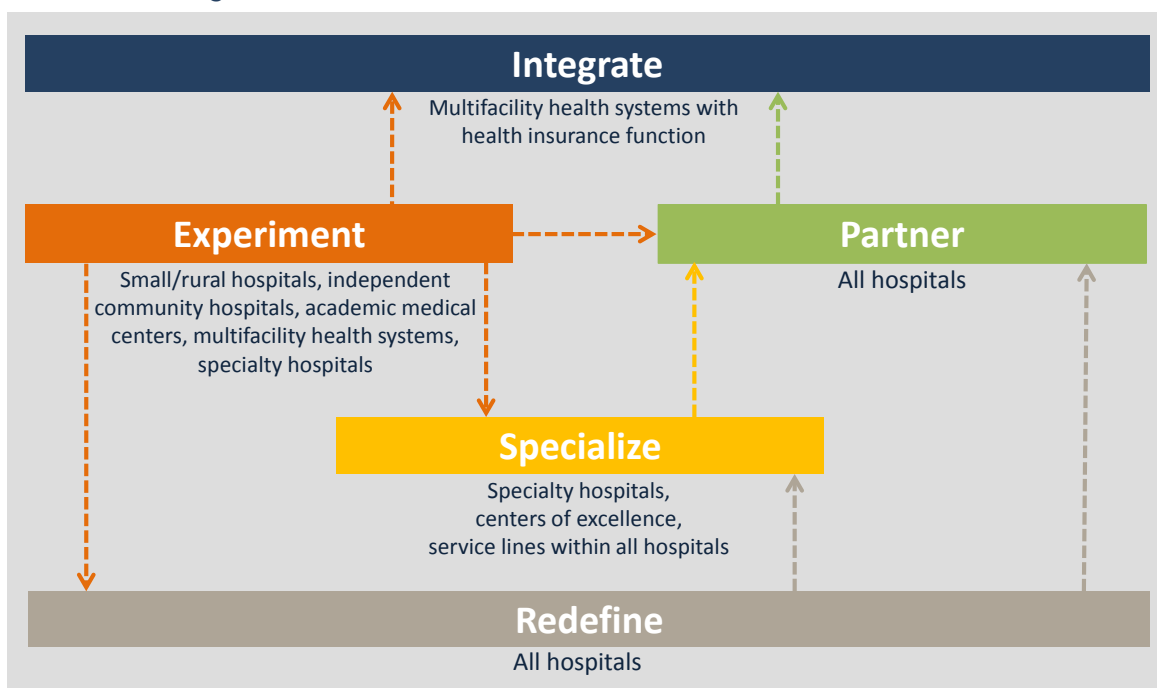
Source: AHA COR, 2014.

Guiding Questions

Once a path or series of paths has been identified, hospital or care systems must evaluate the viability of the desired transformation. This requires an honest assessment of organizational goals and needs, current capabilities and the ability to support and sustain the transformation.

The guiding questions in Table 1 facilitate organizational change across multiple dimensions. The goal of these questions is for hospital and care system leaders to reflect and gain new perspectives on the benefits and value of integration, study available options and set realistic and manageable expectations when considering organizational transformations. The last section of the table has guiding questions for each specific path.

Table 1: Guiding Questions for Health Care Transformation

Setting goals and establishing intent	
	What does the hospital or care system want to achieve in the long term for care delivery and operational performance? (e.g., revisit mission and vision, dramatically improve performance outcomes, significantly reduce operational costs)
Recognizing the realities of the health care environment	
	What is the impact of national health care reform on the organization? (e.g., emerging payment models such as bundled payments and accountable care organizations)
	Does the hospital or care system understand which efficiency and quality criteria are necessary to join a network or partner with another organization?
	What federal and state level impediments exist? (e.g., antitrust)
	What is the organization's contribution to reducing the total cost of care for the community?
Determining market needs	
	What are the current admission and ambulatory utilization trends? (i.e., are they decreasing, stable or growing?)
	Who are the current and future competitors and how are they evolving?
	What is the economic health of the hospital in relation to the community? (e.g., current market dynamics, patient demographics, long-term needs and available partners)
Determining community needs	
	What are the weaknesses of the existing data system to analyze population health?
	What are the community's population health needs?
	Is the community aware of the hospital's or care system's intent to transform?
	What assets can the hospital bring to improve the health of the population?
	What other community organizations can the hospital or care system collaborate with?
	How should the hospital portion out the limited funds dedicated to population health?
	How much should the hospital allocate to unfunded areas of need? (e.g., behavioral or mental health)

	Assessing financial status
	What are the organization's overhead expenses and how are they trending?
	Does the organization have a large amount of debt? (i.e., debt-to-equity ratio)
	Does the organization have debt agreements that affect organizational and corporate flexibility?
	What amount of financial dilution is acceptable in return for new organizational capability?
	What are the current and projected sources of revenue, profitability and cash flow, and how are these projected to change over time?
	What are the implications of the changing financial picture and market competition for the organization's mission, vision and strategy?
	What impact will declining inpatient utilization have on the organization?
	Assessing internal capabilities
	What are the organizational strengths (that can be utilized) and weaknesses (that can provide opportunities for growth)?
	What are the available assets and resources to the organization? (e.g., leadership, financial capital, workforce, etc.)
	How will the hospital cross-train employees and prepare them for future jobs?
	Assessing corporate culture
	Is the organization's workforce team oriented with a demonstrated history of collegial relationships?
	What is the relationship between the medical staff, management and other members of the care team?
	What is the organization's ability to resolve sensitive issues that affect clinical strategy? (e.g., credentialing, recruitment, hospital-based physician contracts)
	What is the organization's history with implementing change?
	Assessing facilities
	Are the current facilities designed for the future in terms of expansion or reconfiguration for different services?
	Managing risks
	How much risk is the organization willing to take? (e.g., financial, care delivery, operational and organizational culture risks)
	Is there tolerance for lower satisfaction and quality ratings?
	Developing a structure and process for implementation
	What is the time frame for implementing a potential path?
	Who is responsible for managing the process? (e.g., work group, independent consulting firm)
	Who will conduct and execute due diligence?
	Developing a measurement process
	How will the hospital or care system measure revenues and expenses for each clinical service?
	What are the organization's critical success factors?
	What are the organization's measurable milestones for the next one to three to five years?
	How will the hospital or care system measure the impact of integration? (e.g., use of assessment tools, scorecards and staff and patient evaluations)
	How will the hospital or care system monitor and adjust to environmental changes?

Guiding Questions for Specific Paths
Redefine to a different care delivery system that may be more ambulatory or long-term care oriented
Determining need
Is inpatient care the primary community health care need?
Under what conditions will inpatient care be available and where?
What discussions are needed with the community and its leaders?
Creating ambulatory or long-term care-oriented facilities
How will the hospital further develop ambulatory services?
How will the hospital economically design a facility that not only enhances patient experience but also creates brand recognition and customer loyalty?
How will the hospital develop satellite and neighborhood clinics that improve, support and sustain population health?
Building an infrastructure
Does the hospital have access to capital needed to expand or transform physical spaces?
Partner with a care delivery system
Organizational objective
Are there compelling reasons to partner?
What does the organization hope to achieve from the partnership?
Organizational advantages
What value does the organization provide to prospective partners? (e.g., opportunity for market extension, greater availability of primary care physicians)
What value does the prospective partner bring to the organization? (e.g., proportion of the patient population being served by the prospective partner)
Organizational impediments
What organizational issues need to be addressed before approaching a potential partner? (e.g., quality, safety, capital)
What board discussions need to take place for partnership consideration?
Criteria for selection
What services does a partnering organization bring to the table and how do they benefit the community?
What is the desired level of experience from a prospective partner? (e.g., number of hospitals in the current system, years of operation as a system)
What discussions are needed with the community and its leaders?
Identifying prospective partners
Are there attributes of a larger delivery system that the organization can benefit from? (e.g., financial health, brand, access to group purchasing and resources, financial stability, ability to access capital, refinancing of long-term debts with lower rates)
Is there a cultural fit with a potential partner organization?
Is there an agreed-upon business model that facilitates better health care outcomes and services?
Preparing to merge with the larger, regional delivery system
Have the regulatory risks been assessed?[37]
How will the workforce be managed?

Partner with a health plan for more at-risk contracting (shared savings, capitation)	
Determining need	
	What board discussions need to take place for partnership consideration?
	Does the organization have the scale and population size for greater at-risk payments?
Exploring options	
	Does the organization want to partner with payers or take on more financial risk?
	Which payer organizations are candidates based on services most attractive to patients, employers, the payer and organization?
	What are the attributes of the prospective health plan partner? (e.g., financial, brand, etc.)
	How does the prospective health plan partner compare to other insurers in the market?
	Is there an agreed-upon business model that facilitates better health care outcomes and services?
Experiment—medical home initiatives	
Determining capacity	
	Does the organization have strong physician affiliation to provide primary care?
	Is the current practice equipped to become a medical home? (e.g., sophistication of health information technology)
	Does the organization have the capability to deliver continuous, accessible, high-quality primary care? (e.g., multidisciplinary teams that actively participate in the continuum of care)
Experiment—bundled payment	
Determining need	
	Under what conditions should a bundled-payment model be applied?
	What data are needed to support bundled payment?
	What capabilities are needed to develop bundling inpatient and ambulatory payment and care delivery?
	What capabilities are needed to develop and manage a shared-savings ACO?
Exploring options	
	Should the hospital or care system contract with or acquire physician practices?
	What providers and services should be included in the bundled payment?
Setting up bundled payment	
	How will payments be risk-adjusted and set?
	How will expenses be measured and funds allotted?
	What expenses will constitute success and how will success be recognized?
Integrate to develop a health insurance function	
Determining capacity	
	What health insurance capabilities is the organization lacking? Is there opportunity to develop these capabilities or should partners be sought?
	Is there sufficient capital to meet infrastructure demands? (e.g., IT capabilities to manage financial transactions)
	Does the care system have a network of providers to attract enough employers and individual customers?
Assessing the market	
	What other health insurers are in the market and how do they compare?

	Creating a health plan
	How will the health plan develop competitive pricing?
	What are the goals of developing a health plan versus contracting with a health plan?
	How will claims be processed efficiently?
	How will the care system utilize direct access to clinical, claims and pharmaceutical data and lab results (that provide a full picture of patients and their incurred costs) to continually improve its health plan function and health care outcomes?
	What services does the organization need to provide a continuum of care?
	How will the hospital or care system align provider behavior to optimize financial and clinical care?

Specialize to become a high-performing and essential provider

	Evaluating clinical performance strengths and weaknesses
	Can the hospital or care system provide higher quality, more efficient specialized services than currently offered in the community?
	Does the hospital or care system have enough data and infrastructure support to assess physician quality and efficiency?
	Is there a shared commitment to standardize practices among physicians in the hospital?

	Assessing viability for expansion
	What scale and efficiency can the hospital or care system provide for specialized services?
	How does the hospital or care system compare to benchmark goals for quality, service and financial performance?

Source: AHA COR, 2014.

Factors Influencing Path Progression

Multiple factors contribute to how soon and how quickly hospitals and care systems can select a path and move forward.[38] Every market is different and there are many forces to consider, including:

- Changing payment system—Increasing pay for value by payers will necessitate a quicker move down the paths for hospitals and care systems.
- Degree of physician alignment—Communities with greater physician alignment with hospitals and care systems will mean a quicker move on the path(s).
- Health care needs of the community—Factors such as changing demographics can have a significant effect on health services of the community; more changes in services will push hospitals to move down path(s) quicker.
- Purchasers moving to new models—The focus and desire of purchasers to move to new payment models, such as direct contracting or narrow networks, will influence hospitals and care systems to move down path(s) faster.
- Providers in the market moving to new models—If there are a number of payment models being tested, such as bundled payments, shared savings and accountable care, hospitals and care systems will move faster down the path(s).

Regardless of the path chosen, providing safe, effective and high-quality care for patients is always the primary goal. Hospitals and care systems play a critical role in bending the cost curve and must actively engage in efforts to drive down costs by eliminating inefficiencies within the system, particularly health care services that do not benefit patient care. Making health care more affordable during this time of transformation presents challenges. Hospital leaders must aggressively pursue opportunities to reduce costs, while implementing changes that cater to patient and community needs.

Examples of Potential Paths

There are different paths and levels of integration, and many hospitals and care systems have moved or are moving toward them.

Redefine
Hospital care delivery organizations moving toward more ambulatory or long-term care

In May 2009, *Harrington Memorial Hospital,* based in Southbridge, Massachusetts, signed an agreement to take over the administration of *Hubbard Regional Hospital* (now Harrington HealthCare at Hubbard) in Webster, Massachusetts. Harrington Memorial Hospital eliminated the unprofitable inpatient department and transformed Hubbard Regional Hospital into a comprehensive outpatient facility that includes a full service emergency room, one of only two facilities in the state to successfully operate an ER without inpatient beds on site.[39, 40]

The emergency department at *St. Andrews Hospital* (now St. Andrews campus of LincolnHealth), Boothbay Harbor, Maine, had low patient volume, and the majority of patients admitted could be treated in an urgent-care center or by primary physicians more efficiently. To remain financially viable, in October 2013 the hospital closed its 24-hour emergency room and replaced it with an urgent-care center that is open for 12 hours each day of the week.[41]

Partner
Hospital care delivery organizations that have partnered with a care delivery system or health plan for greater horizontal and vertical reach, efficiency and resources for at-risk contracting

Advocate Physician Partners and *Blue Cross Blue Shield of Illinois* established a shared-savings contract to achieve the Triple Aim. The partnership led to the development of AdvocateCare.[42] AdvocateCare is an enterprisewide program that incorporates population health strategies across Advocate Health Care.

In October 2013, *Scottsdale Healthcare* and *John C. Lincoln Health Network* in Arizona formed a systemwide affiliation to create a new nonprofit health system, *Scottsdale Lincoln Health Network*.[43] The partnership is aimed at expanding acute and preventive services, improving care coordination, integrating health information technology and sharing best practices without merging assets that could implicate individual debt and obligated group.[44]

In Georgia, 29 hospitals, 14 health systems and approximately 2,000 physicians formed an alliance called *Stratus Healthcare*, the largest network in the southeastern United States. The alliance allows providers to collaborate while remaining independent and retaining local leadership.

In 2010, *O'Bleness Health System* and *OhioHealth System*, a larger care delivery system, signed a managed affiliate agreement. In June 2013, a memorandum of understanding was signed to begin the due diligence process for membership, which was completed in October. At the time of publication, O'Bleness Health System was in the final stage of becoming a full member of OhioHealth System.

McCullough-Hyde Memorial Hospital, a small, independent community hospital in Oxford, Ohio, is looking to partner with a major health system in Cincinnati. As the hospital explores potential partners, UC Health, Mercy Health Partners, TriHealth and the Christ Hospital were asked to formally outline affiliation options.[45, 46]

In June 2013, *Ohio State University Wexner Medical Center* formed an affiliation with *Mount Carmel Health System* to strengthen care delivery in central Ohio.[47] The agreement expands on an existing partnership between the two organizations and aims to explore opportunities to collaborate in clinical care, research and medical education.

In September 2013, seven health systems in New Jersey and Pennsylvania—consisting of more than 25 hospitals—formed an interstate alliance called *AllSpire Health Partners*.[48] The health consortium has a combined net worth of $10.5 billion. The alliance allows hospitals to pool their spending power, share expertise and innovative approaches, and pursue research projects.

Integrate
Hospital care delivery organizations that have integrated by developing a health insurance function or services across the continuum of care

Inova Health System, a nonprofit health care system in Northern Virginia, and *Aetna,* a health insurer, collaborated to establish the Innovation Health Plan.[49] The goal of the partnership is to improve the quality of care through expanded care coordination. Aetna supports Innovation Health Plan by providing the operational, sales, marketing, underwriting, care management and quality assurance and finance functions needed to operate the health plan. Meanwhile, Inova Health System provides care management, wellness and health prevention programs and the Signature Partners Network, a physician-led, clinically integrated provider network under development, which will be launched in 2014. Signature Partners Network is comprised of a select network of primary care physicians and specialists—all employed by Inova and community-based organizations—who serve as the value-based provider network for Innovation Health.

Rather than developing its own health plan, the *Florida Hospital Healthcare System*, based in Orlando, has partnered with *Health First of Rockledge* in Rockledge, Florida, to offer insurance products. The partners anticipate Florida Hospital will eventually acquire 49 percent of Health First Health Plans. This relationship gives Florida Hospital immediate expertise to sell health insurance and access data needed to identify treatment gaps.[50, 51]

In September 2013, *Catholic Health Partners* acquired *Kaiser Foundation Health Plan of Ohio* and its 200-person medical group practice and care delivery operations with *Ohio Permanente Medical Group, Inc.* in Northeast Ohio.[52]

Experiment
Hospital care delivery organization that has experimented with new payment and care delivery models

Hospital Sisters Health System in Springfield, Ill., launched its Care Integration Strategy in 2008. The strategy focuses on physician alignment using pluralistic models, including direct physician employment and clinical integration. The strategy also emphasizes the development of competencies. This facilitates evolution to more integrated care and population management using care delivery models, such as advanced medical home and chronic disease management, that encourage quality outcomes for patients.

Specialize

Hospital care delivery organization that has specialized to become a high-performing and essential provider

In 2012, *DaVita*, a provider of kidney care services, purchased *HealthCare Partners*, a physician practice.[53] DaVita's integration of the physician practice is a move toward an integrated delivery network that contracts a full spectrum of care and receives global capitation.[54, 55] This transaction positioned DaVita to participate in accountable care organizations and population health. It also allows DaVita to manage the care of kidney patients before reaching the end stage of the disease.

Case Studies

Several health care organizations have implemented and tested various integrated delivery care programs to improve care coordination, physician alignment, performance measures and patient outcomes. The case studies in this section describe successful integrated delivery programs that can be replicated by hospitals and care systems, regardless of their financial, clinical, operational or cultural level of integration.

- CareMore
- Health Quality Partners
- Hospital-at-Home Program (Presbyterian Healthcare Services)
- Program of All-Inclusive Care for the Elderly (PACE)
- ProvenCare (Geisinger Health System)

CareMore

CareMore is a health care provider that specializes in caring for Medicare Advantage patients. It has headquarters in Cerritos, Calif., and centers across the Southwest United States, with new facilities in Brooklyn, N.Y., and Richmond, Va. It is a wholly owned operating division of WellPoint.

Background
CareMore was established to improve the quality of geriatric care and eliminate the costs associated with lower quality. Frail and at-risk elderly patients represent a big portion of health care spending. CareMore focuses on its most at-risk patients to change the course of their disease. Its network of clinics monitors and treats chronically ill older patients to improve their health and reduce the need for costly medical care. Early interventions and preventive care, such as wireless scales and free rides to medical appointments, save long-term costs and reduce hospitalizations and surgeries.[56]

Intervention
CareMore founders developed the model with several elements of care coordination.[57] First, patients are assigned a nurse practioner who assists in managing chronic conditions and solving social/ environmental factors that contribute to poor health outcomes. Second, CareMore employs internal medicine physicians called "extensivists" who serve as hospital physicians, post-acute care providers and primary care physicians for the most at-risk members. Extensivists coordinate care and monitor individual patients throughout the care continuum. Third, to improve care and treatment compliance, CareMore provides free transportation service to get patients to and from their appointments. Health care professionals also conduct home visits to monitor a patient's weight, assess home accessibility and safety, ensure patients are taking their medications, etc. Fourth, CareMore promotes wellness through wireless monitoring of patients with congestive heart failure or hypertension. Patients are provided with wireless scales and wireless blood-pressure cuffs that transmit information back to the CareMore care center team.

Results
The approach at CareMore improved care and quality outcomes without increasing total cost: Hospitalization is 24 percent below Medicare average, hospital stays are 38 percent shorter, and amputations among diabetics are 60 percent below average.[58] While CareMore employs more staff members per patient than other companies, this preventive approach yields savings that reduce member costs, which are 18 percent below industry average.[59] Patient satisfaction for CareMore services is also high. According to a company survey, 97 percent of patients were very satisfied or somewhat satisfied with the health plan, and 80 percent of patients indicated that they would recommend CareMore to a friend.[60]

Lessons Learned
The success of the program is attributed to the physician-led culture and top-to-bottom commitment to patients. Physicians are provided with proper tools to effectively execute coordinated care, such as a unified electronic health record system.

The challenge for CareMore was financing replicas of the program model in local communities. Each replica has produced health outcomes similar to those at the original CareMore locations. However, the start-up costs of new locations required extensive investment, which has been curtailed in light of new CMS payment changes.

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Health Quality Partners

Health Quality Partners is a nonprofit health care quality research and development organization in Doylestown, Pa. Its aim is to improve population health outcomes through care system redesign and advanced care coordination.

Background
Studies show that 95 percent of Medicare costs are spent on patients with one or more chronic conditions; 78 percent of those costs are for patients with five or more chronic conditions.[61] In response, Health Quality Partners participated in a national demonstration project sponsored by CMS in 2002, and it developed a care management program that redefined care for the elderly and chronically ill. Because of the successes of the program, Aetna contracted with Health Quality Partners in 2009 to work with its members and primary care providers.

Intervention
Health Quality Partners enrolls elderly patients that have at least one chronic illness (from among: coronary artery disease, heart failure, diabetes or chronic lung disease) and hospitalization in the past year. Patients in the program are connected with a nurse case manager who monitors the patient's overall health, supports medication adherence, provides education and self-management coaching and follows up during care transitions from other health facilities. The type and frequency of contact from the nurse case manager varies according to changing patient needs and ranges from weekly to monthly. Most interactions (more than 60 percent) occur in person either as a one-to-one encounter or group program. This care management model uses a broad portfolio of evidenced-based interventions designed to reduce cardiovascular and geriatric risks for Medicare patients with chronic conditions.[62] For example, nurses promote physical activity, weight management, healthy diet, vaccinations, social engagement and home safety.[63] A data and analysis system allows rigorous monitoring of service delivery reliability per established performance specifications, which enables management staff to conduct timely root-cause analyses and take corrective actions as needed.

Results
The care management program has made a tremendous impact on care quality and cost. An independent study shows that the program reduced hospitalization by 33 percent and Medicare costs by 22 percent.[64] All-cause mortality was reduced 25 percent.[65] The CMS demonstration, from which these results were obtained, has been conducted as a long-term, prospective, randomized controlled trial—the most rigorous method of program evaluation.

Lessons Learned
One key element contributing to the success of the Health Quality Partners model is the continuous interaction and long-term relationship between nurse case managers and patients. The broad portfolio of interventions provided by the program and the rigor applied to ensure service delivery reliability are also key to the program's effectiveness. Ongoing, active collaboration with primary care, acute care and long-term care providers, as well as community organizations, patients and their families are another core element of the program. A nonjudgmental, supportive approach and a commitment to listen, understand and honor patient preferences and choices are main values the model promotes.

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Hospital-at-Home

Hospitals and care systems that adopted the Hospital-at-Home model provide hospital-level care to patients with acute medical issues in their homes.

Background
Bruce Leff, MD, along with a team of geriatric physicians and nurses from Johns Hopkins School of Medicine and Public Health, recognized that older patients experience adverse events while hospitalized. In 1995, they developed a care model, Hospital-at-Home, that provides safe and effective care in the patient's home.

Hospital-at-Home was developed to treat older adults with acute medical issues such as community-acquired pneumonia, congestive heart failure, chronic obstructive pulmonary disease and cellulitis. Hospitals and care systems that have adopted this model offer diagnostic tests and treatment therapies. Since its inception, the Hospital-at-Home model has been implemented in numerous sites throughout the country.

Intervention
In October 2008, Presbyterian Healthcare Services, a nonprofit health care system based in Albuquerque, N.M., introduced the Hospital-at-Home program to improve clinical outcomes, increase patient satisfaction and reduce costs. The program is offered to three patient populations in the area: (1) patients who arrive at the emergency departments of either the Albuquerque and Rio Rancho Presbyterian hospitals: Kaseman Hospital or Rust Medical Center; (2) patients who are referred from physician offices, urgent care and the health system's home health agency; and (3) patients who are transferred to the program from one of the hospitals.[66]

Patients with community-acquired pneumonia, chronic heart failure, chronic obstructive pulmonary disease, cellulitis and conditions such as nausea/vomiting/dehydration, complicated urinary tract infections and thrombosis and pulmonary embolism, are evaluated by physicians to determine eligibility for participation in the Hospital-at-Home program. Those who meet the criteria are given the option to be hospitalized or receive comparable care in the comfort of their homes. The program provides a range of medical care such as lab tests, ECGs, ultrasounds and X-rays at the patient's residence. From the program's inception to August 2013, 806 patients participated in the program. [67]

Results
In 2012, 348 patients were offered the option to receive care at home, and 323, or 93 percent of them, chose to participate in the Hospital-at-Home program.[68]

Patients enrolled in the program were more satisfied with their care. Patient satisfaction scores were 6.8 percent higher in comparison to similar patients who were receiving inpatient care at Presbyterian Healthcare Services (the comparison group consisted of 1,048 individuals).[69] As of July 2013, patient satisfaction scores for Hospital-at-Home patients were 97.9 percent.

Hospital-at-Home patients also had better or comparable clinical outcomes than the comparison group. They experienced zero falls versus 0.8 percent falls in the comparison group.[70] Hospital readmission within 30 days of discharge was also 0.3 percent lower and mortality rate was 2.57 percent lower for patients in the program.[71] Between 2011 and 2012, readmission rates were about 5 percent. Among Medicare Advantage and Medicaid patients with common acute care diagnoses, the Hospital-at-Home program achieved a 19 percent cost savings.[72]

Lessons Learned

Several critical factors contributed to the success of the Hospital-at-Home program at Presbyterian Healthcare Services.

First, the program has an integrated health plan, delivery system and medical group. This level of integration has allowed for interoperability of information systems and the ability to compare cost data across the health system.

Second, key players collaborated and were involved in the development and implementation process. This includes "clinical standards and orders for care delivery (from physicians), emergency department interfaces, billing and reimbursement process, coding, documentation, support-process development (such as intake, scheduling, medical records, auditing, and pharmacy), clinical quality and outcomes, communications and marketing, human resources and staffing model development, orientation and education, and policy development." [73] The ongoing support of high-level administration also contributed to the program's success.

Third, technical assistance from the Johns Hopkins School of Medicine and Public Health proved to be beneficial by shortening the implementation process.[74]

Lessons learned from implementing the Hospital-at-Home model led to the rapid development and implementation of a house-call program in April 2011.[75] Like the Hospital-at-Home model, the house-call program prevents avoidable hospitalizations and provides ongoing care to older adults with complex chronic illnesses in the comfort of their homes.

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Program of All-Inclusive Care for the Elderly (PACE)

PACE is a managed care program for dual eligibles that provides comprehensive long-term services and support for elderly patients throughout the United States. As of February 2013, there are 94 PACE programs operating in 31 states.[76]

Background
For 26 years, the PACE model has delivered a full spectrum of care to dual eligible patients, a complex and costly group of patients. It is also cost effective to both government payers and health care providers.

Intervention
The PACE program focuses on providing preventive care to help elderly patients live in their communities. The program serves individuals who are age 55 and over and is certified by their state to provide nursing home care. Organizations that participate in the PACE program partner with specialists and other providers to offer health care services in the home or community and PACE centers. The interdisciplinary team of health care professionals provides coordinated care and offers comprehensive services in the patient's home. In addition, patients have access to transportation services to and from a PACE center that offers adult day programs, medical clinics, occupational and physical therapies or medical appointments.[77]

Results
Across all PACE programs, studies show that there have been fewer hospitalizations and nursing home admissions, more contact with primary care providers, better health outcomes, higher quality of life and greater satisfaction with care providers.[78, 79, 80, 81, 82, 83, 84] These significant outcomes have enticed many hospitals and care systems to adopt the model, evidenced by its continued expansion throughout the country.

Lessons Learned
Three factors contributed to the success of PACE programs.[85] First, Medicare and Medicaid pay a fixed, combined, monthly amount to participating organizations regardless of services used by their patients. Therefore, participating organizations have flexibility to offer needed services. Second, PACE organizations partner with primary care providers and other health providers, such as nurses and physical therapists, to provide comprehensive and coordinated care in the home and community. Third, because participating organizations are responsible for the complete continuum of care and cost of services provided, there is a financial incentive to prevent hospitalization, unnecessary emergency room visits and premature nursing placements.

ProvenCare

Geisinger Health System in Danville, Pa., is a physician-led system that is part of the 2010 Premier Health Care Alliance's Accountable Care Collaborative.

Background

Geisinger Health System began looking for innovative ways to improve patient outcomes, service quality and care value to adapt to the changing health care environment. In 2006, the health system launched ProvenCare, a program that standardizes care in specific clinical areas and offers participating hospitals a flat rate for each procedure, motivating them to provide quality care.

Intervention

ProvenCare provides fixed pricing for certain procedures, with a 90-day care warranty for participating payers.[86] The fee is calculated at initial cost of the procedure plus 50 percent of follow-up costs over a three-month period.[87] ProvenCare also uses and enforces evidence-based standards in various procedures. For example, cardiac surgeons must follow a set of 40 guidelines. If there are reasons to deviate from the guidelines, surgeons are required to justify clinical decisions from an agreed-upon list of acceptable reasons.[88] This process provides doctors with flexibility in their practice. In addition, ProvenCare offers disease management. Patients with congestive heart failure, diabetes, hypertension and other chronic conditions are closely monitored and given goals to manage their disease.[89]

Results

The evidence-based standards of ProvenCare improved patient outcomes and reduced health care costs. In its first year of operation, hospital readmissions fell by 44 percent, complications decreased by 21 percent, and average hospital stays were reduced from 6.2 to 5.7 days for coronary artery bypass graft surgeries alone.[90] The program has been applied to other clinical areas, including elective percutaneous angioplasty, perinatal care and bariatric surgery.

Lessons Learned

The success of ProvenCare is attributed to three factors.[91] First, physicians are salaried and rewarded for performance. Second, electronic medical record systems have integrated physician, nursing and administrative services at Geisinger, which has reduced treatment duplication and improved care coordination. For instance, emergency room doctors that have access to a patient's EMR are able to better determine whether a patient should be admitted to the hospital. Meanwhile, a rheumatologist can use the EMR to identify patients who are at risk of osteoporosis and to initiate preventive measures. Third, doctors are required to follow evidence-based standards. The treatment pathways in place are designed to ensure the best patient outcomes while reducing treatment costs.

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Appendix 1: Assessment of Integration Capability

Assessing capabilities is key to understanding a health care organization's current level of and potential for integration. This requires exploring and evaluating the current financial, clinical and operational risk tolerance along with the cultural underpinnings of the organization.

Determining Current Level of Risks

Assessing Financial Risk

To assess the degree of financial risk, hospitals and care systems should evaluate arrangements with other providers and payers (Figure 5). Contractual agreements between providers and payers range from transactional costs with minimal financial risk to full accountability for all risk, such as capitation.

Figure 5: Degree of Financial Risk

Low	Moderate	High
Transactional costs	Risks within components	Full accountability to cost

Financial Risk

Source: AHA COR, 2014.

Transactional costs (low risk): A hospital or care system develops contractual agreements with payers to provide specific health care services at set costs.

Risks within components (moderate risk): A hospital or care system takes financial risk for specific components of care delivery, such as hospitals taking DRG payments.

Full accountability to cost (high risk): A hospital or care system has its own health plan or partners with a health plan to take accountability for the full cost of care for a defined population.

Assessing Care Delivery Risk

Assessing the degree of care delivery risk involves exploring relationships with internal and external health care providers (Figure 6). These relationships can range from hospitals and care systems that contract with various providers for pieces of the care continuum to hospitals and care systems that own and provide full service in the continuum of care.

Figure 6: Degree of Care Delivery Risk

Low	Moderate	High
A component of the continuum of care	Partnerships to deliver care	Full care accountability

Care Delivery Risk

Source: AHA COR, 2014

A component of the continuum of care (low risk): A hospital or care system subcontracts particular services and is not responsible for those services.

Partnerships to deliver care (moderate risk): A hospital or care system establishes partnerships with delivery organizations to provide services and share responsibility across the continuum of care (home health, post-acute, long-term, ambulatory, etc.).

Full care accountability (high risk): A hospital or care system provides services across the continuum of care through their own providers and is responsible for all services.

Assessing Operational Risk

To determine the degree of operational risk, hospitals and care systems can identify themselves as isolated systems that manage their own entity's performance objectives, as integrated systems that have shared performance goals across all system components or as someplace in between (Figure 7).

Figure 7: Degree of Operational Risk

Low	Moderate	High
Isolated systems	Emerging common systems	Integrated systems and standardization

Operational Risk

Source: AHA COR, 2014.

Isolated systems (low risk): Hospitals have operational systems—financial, human resources, information technology—that may be reliable but independent from other systems.

Emerging common systems (moderate risk): Hospitals operate systems that support their interconnectivity with partners.

Integrated systems and standardization (high risk): Hospitals have integrated systems that function across organizational components and partners, which reflect standardization and reduces variation.

Assessing Organizational Culture

The culture of a hospital or care system determines its ability to meet the challenges of evolving health care demands (Figure 8). Degrees of organizational culture can range from hospitals and care systems that are still developing a common culture to those that have defined their organizational culture and are highly reliable at delivering care efficiently. Leadership and governance complement organizational culture, ranging from an independent approach with multiple governance structures to systemwide governance aligned with the health care system's goals.

Figure 8: Degree of Organizational Culture

Low	Moderate	High
Developing common culture/ independent governance entities	Quality improvement culture/ developing systemwide governance	Adaptable, high-reliability culture/ system-based governance model

Organizational Culture

Source: AHA COR, 2014.

Developing common culture/independent governance entities (low risk): A hospital or care system is still defining its own common organizational culture and needs to experience multiple cycles of learning to become prepared in accepting and adapting to change. Organizational governance occurs at multiple levels and/or entities, with a loose structure and little communication between the levels or entities.

Quality improvement culture/developing systemwide governance approach (moderate risk): Hospitals and care systems have a disciplined quality improvement culture that is continuously focused on improving clinical outcomes, efficiency and patient experience. Governance is evolving to an aligned structure that is systemwide or streamlined in the organization.

Adaptable, high-reliability culture/system-based governance model (high risk): Hospitals and care systems exhibit a highly reliable culture focused on care that is safe, timely, efficient, effective, equitable and patient-centered. The governance structure is systemwide and strategically aligned with the health care organization's goals.

Appendix 2: Current Value-Driven Programs

The following is a list of current value-driven programs and models that are being tested and supported by [CMS' Center for Medicare and Medicaid Innovation](#).

Primary Care Transformation

- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration: Care coordination payments to FQHCs in support of team-led care, improved access and enhanced primary care services
- Multipayer Advanced Primary Care Practice Demonstration: State-led, multipayer collaborations to help primary care practices transform into medical homes

Bundled Payments

- Bundled Payments for Care Improvement initiative: Organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher-quality, better-coordinated care at a lower cost to Medicare.

Accountable Care Organizations

- Pioneer Accountable Care Organization Model: Experienced provider organizations taking on financial risk for improving quality and lowering costs for all of their Medicare patients
- Advanced Payment Accountable Care Organization Model: Prepayment of expected shared savings to support ACO infrastructure and care coordination

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