Introduction

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The United States is committed to moving its healthcare system from a volume-based reimbursement method to one centered on value. By 2018, the Centers for Medicare & Medicaid Services (CMS) will have shifted 50 percent of its payment methodologies to "pay for value," with 90 percent of its payment programs tied to some form of quality measures. Commercial payers are following CMS's lead. Amy Oldenburg, vice president of network and product strategy accountable care solutions at Aetna, estimates that 75 percent of Aetna's spending will be absorbed by some form of value-based payment by 2020 (Gruessner 2016).

Thus, time is short as healthcare organizations transform their care and business models in an effort to provide value-based services that can meet key benchmarks for clinical and business outcomes (particularly concerning cost of care). But what will get us there? Certainly not the traditional twentieth-century models. Their stand-alone hospitals providing primary and secondary service areas with both employed and self-employed physicians (who work through productivity-based contracts) are on the decline.

The stand-alone hospital must evolve into a coordinated and integrated delivery system that can leverage the facility as a cost center intended to treat the seriously ill and injured. Organizations must build a new ambulatory infrastructure whose purpose is to prevent patients from resorting to the hospital, emergency department, and physician's office. Doctors must be fully aligned and integrated with

large healthcare systems so that they can work in collaboration with management and other healthcare facilities, working toward common clinical and business goals. Hospitals will be part of clinically integrated delivery systems that include patients and their families in their homes, schools, home health agencies, health clubs, freestanding imaging centers, inpatient and outpatient rehabilitation facilities, nursing homes and other long-term care facilities, post-acute care facilities, and more. This spectrum of facilities will be tied in with health information exchanges, employers, Medicaid and other state-supported programs, and the federal government (CMS); they will require the support of clinical and business analytics with access to a data warehouse covering the whole enterprise. With these elements in place, healthcare systems can work with large payers toward mutual, value-based goals and objectives.

Contracts with all parties will need to be dynamic, transparent, and shared. These measures will ensure that all parties are working together to achieve the objective of better health outcomes at a reduced cost.

This book describes the fundamental operational components that all healthcare organizations must share to achieve success in this rapidly emerging world. The specific structure of each organization will differ based on local market and payer conditions and the availability of resources across widely diverse geographic, political, and economic regions. Each chapter describes a component or building block integral to the rapid transformation of a volume-based "sickness" industry into a value-based "health" industry. The following are short descriptions of the chapters.

CHAPTER 1: A HEALTHCARE VISION FOR THE NEXT-LEVEL HEALTHCARE ENTERPRISE (JON BURROUGHS, FACHE)

This chapter articulates the compelling economic, clinical, and political mandate to redesign the healthcare enterprise and describes the

new models necessary to move the traditional model toward prevention and population health.

CHAPTER 2: SUSTAINABLE CHANGE IN HEALTHCARE: LEADERSHIP FOR THE TWENTY-FIRST CENTURY (TOM ATCHISON)

Forging ahead in a radically altered business model requires new leadership and management skills. The top-down style of the twentieth century will be replaced by collaborative executives able to guide change in a complex matrix management configuration. Such leaders bring stakeholders together, helping them to envision collaboration and supporting overarching strategies that benefit broader constituencies. Hospital executives will evolve into *healthcare* executives who oversee clinically integrated networks of largely ambulatory facilities and resources. The personal traits of such leaders must evolve as well, with direct control replaced by influence, vision, and collaboration. This chapter examines the characteristics of effective contemporary leaders and the leadership skills that are essential in the twenty-first century.

CHAPTER 3: GOVERNING THE FUTURE OF HEALTHCARE SYSTEMS (JAMES E. ORLIKOFF)

Governance models for integrated systems are significantly different from those for stand-alone hospitals. As healthcare enterprises become increasingly complex and interconnected, novel governance competencies will be in high demand. Governing members are required to have greater skill, commitment, and knowledge of the healthcare sector. These advantages will enable them to partner effectively with management and medical staff, improving quality and financial outcomes. This chapter covers emerging governance

models and analyzes the fundamental competencies required to govern effectively in the twenty-first century.

CHAPTER 4: THE EVOLVING ROLE OF THE PHYSICIAN, NURSE, MEDICAL STAFF SERVICES PROFESSIONAL, AND ORGANIZED MEDICAL STAFF (JON BURROUGHS, FACHE; KATHLEEN BARTHOLOMEW; AND MARY A. BAKER)

As healthcare becomes more patient centered, lower-cost providers will be patients' primary contact point with their healthcare systems. Physicians will take on coordination and oversight roles, delegating responsibility for direct, routine services and documentation to others while overseeing the management of larger populations for whom they will be held accountable according to specific, measurable outcomes. The boundaries between physician, nurse, medical staff services professional, and healthcare executive will blur as clinical professionals gain increasing operational and financial experience and assume greater management responsibilities. The organized medical staff will shift from being an entity that once functioned like a protective professional guild to more dynamic units capable of moving with management through ever-accelerating change in an agile and collaborative way.

CHAPTER 5: STRATEGIC PLANNING FOR THE FUTURE HEALTHCARE ENTERPRISE (JOHN M. HARRIS AND DAN GRAUMAN)

As strategic, operating, and business plans become more adaptable to accommodate unforeseeable change, the ability to plan will require different skills. Analytics shared among healthcare enterprises, payers, regulators, and patients will alter the dynamic of healthcare planning, which will evolve to include the integration and alignment of key

stakeholders. This chapter looks at the new ways in which healthcare organizations will plan for an increasingly transformed future.

CHAPTER 6: MODELS AND COMPETENCIES FOR CLINICAL INTEGRATION (JON BURROUGHS, FACHE; AND CARL COUCH)

Clinically integrated networks (CINs) take many forms, ranging from accountable care organizations to acute care episode–bundled-payment projects. This chapter explores the various models of clinical integration and the fundamental operational components and competencies necessary for any successful CIN, regardless of its structure. It will also discuss the Baylor Scott & White Quality Alliance, one of largest and most successful ACOs in the United States, as an example of the complexities of a well-designed, clinically integrated enterprise.

CHAPTER 7: TAKING THE SERVICE LINE TO THE NEXT LEVEL IN THE TWENTY-FIRST CENTURY (WILLIAM VANASKIE, FACHE)

One of the fundamental building blocks of any clinically integrated network is the service line, or horizontally integrated clinical institute. These units involve multiple clinical disciplines coming together, through aligned contracts, to develop evidence-based approaches to managing high-volume or variable-risk conditions. Service lines are often governed and managed collaboratively through dyad or triad models of physician–nurse–executive oversight to manage overarching organizational initiatives. This chapter explores the success factors for service lines, regardless of operational structures, and how they can support more consistent clinical and business outcomes.

CHAPTER 8: HEALTH INFORMATION MANAGEMENT FOR THE TWENTY-FIRST-CENTURY HEALTHCARE ENTERPRISE (LEE PIERCE, MIKE HARMER, BRENT HEATON, LONNY NORTHRUP, NAVEEN MARAM, AND SID THORNTON)

Like finance industries, population health requires the seamless transmission of information throughout the world—from the patient to all key healthcare personnel and institutions. This seamlessness requires a series of tools within, between, and beyond clinical enterprises, including

- electronic medical records (internal and interorganizational),
- multi-institutional health information exchanges,
- customized patient portals,
- clinical and business analytics with decision alerts to key stakeholders, and
- enterprise data warehousing.

These elements must be connected via global systems that readily interface and provide superb interconnectivity. Intermountain Healthcare has one of the largest and most sophisticated health information management systems in the world, and this chapter summarizes the fundamental components necessary for sharing and transmitting information throughout any clinically integrated delivery system.

CHAPTER 9: MANAGING ACTUARIAL RISK (STEVEN JOHNSON)

Clinical and business analytics provide real-time, predictive, actionable information that enables healthcare enterprises to

optimize value by managing clinical outcomes while minimizing costs. One of the overarching purposes of predictive analytics is to manage actuarial risk for defined populations of covered lives. The question of using internal versus outsourced talent is of less importance than the skill with which an organization can implement this component of its model. Steven Johnson, who oversees a sophisticated health plan, discusses how to manage actuarial risk generically and how to apply these skills to manage insurance products that will be an essential part of any effective healthcare system of the future.

CHAPTER 10: BEST-PRACTICE EVIDENCE-BASED MANAGEMENT THAT MINIMIZES COSTS AND OPTIMIZES OUTCOMES (JON BURROUGHS, FACHE; AND STEVE BERGER, FACHE)

One of healthcare's contemporary strategies is to employ evidence-based management of labor and supply chains for higher-quality healthcare at a fraction of the cost. This goal requires the adoption of clinical and business analytics that use real-time and predictive information, enabling a smaller number of managers to gain greater control over operational processes. This chapter examines healthcare organizations' best practices, used to achieve significantly lower costs while optimizing quality and safety.

CHAPTER 11: OPERATIONAL BUILDING BLOCKS AND SUCCESS FACTORS FOR POPULATION HEALTH (JON BURROUGHS, FACHE)

Population health represents the rationalization of healthcare resources for risk-stratified subpopulations of covered lives. Operational elements of population health include the following:

- Palliative care for patients with life-threatening conditions
- Disease management for patients with complex, chronic conditions
- Post-acute care and ambulatory disease management following discharge for acute care services
- Retail medicine for healthy individuals with minor, acute, episodic problems
- Ongoing access to e-health platforms and customized healthcare management systems and solutions for the healthy majority

This chapter covers the key operational elements of each of these services, describes their contributions to the well-being of defined subpopulations, and discusses the ways in which they will optimize healthcare outcomes and minimize costs.

CHAPTER 12: CREATING A HIGH-RELIABILITY ORGANIZATION FOR THE TWENTY-FIRST CENTURY (KATHLEEN BARTHOLOMEW; JOHN NANCE; AND JON BURROUGHS, FACHE)

High reliability, along with the elimination of non-value-added variation, is essential to optimal outcomes and constitutes a fundamental public expectation of all healthcare organizations. Sustaining a culture of safety is even more challenging in a clinically integrated network, in which traditional hospital strategies are implemented throughout the network. Contractual performance expectations for all collaborative partners and care providers add a layer of complexity. This chapter discusses the approach that organizations must take to link all venues of care while keeping in sight goals such as excellent outcomes and the elimination of preventable harm.

CHAPTER 13: BUILDING A CULTURE OF SERVICE EXCELLENCE FOR THE TWENTY-FIRST CENTURY (JAKE POORE)

As healthcare continues to become standardized and commoditized, service will be the great differentiator between competent and outstanding healthcare organizations. It is currently a leading indicator of optimized clinical and financial performance. Traditional, hospital-based tactics will no longer be enough—clinically integrated networks span the entire continuum of care from home health care to community-based ambulatory settings to long-term care facilities. To optimize service delivery for all populations throughout the enterprise, collaborative at-risk contracts will include the expectation of systemwide best practices for service.

CHAPTER 14: LEGAL CHALLENGES FOR CLINICALLY INTEGRATED NETWORKS (BRIAN BETNER AND MICHAEL GREER)

Innovative healthcare models will create new and unique legal, regulatory, and accreditation challenges as care shifts from inpatient settings to accommodate more complex and innovative integrated structures. Chapter 14 discusses these developments, along with the traditional issues surrounding price fixing, antitrust regulations, civil monetary penalties law, the Health Insurance Portability and Accountability Act, the corporate practice of medicine, state requirements, insurance regulations, the Stark law, the antikickback statute, fraud and abuse, and the False Claims Act. As healthcare becomes increasingly regulated and managed by international, federal, state, and accreditation organizations, legal challenges will become more pressing for leaders.

CHAPTER 15: INTERMOUNTAIN HEALTHCARE: AN EVOLVING INTEGRATED DELIVERY SYSTEM (JON BURROUGHS, FACHE)

This chapter chronicles and celebrates an innovative organization willing to pioneer new models for clinical integration in order to provide cost-effective healthcare to defined populations. Intermountain Healthcare is one of several organizations that has chosen to become a positive outlier by forging unique links between its clinical and business enterprises. We look at this organization in greater detail and explore some of the factors that define its status as a leader in innovative, clinically integrated models.

CONCLUSION (JON BURROUGHS, FACHE)

This postscript sums up the key learnings from *Essential Operational Components for High-Performing Healthcare Enterprises* that will enable all healthcare organizations to pursue an up-to-date model to catalyze success in the new pay-for-value world.

REFERENCE

Gruessner, V. 2016. "Private Payers Follow CMS Lead, Adopt Value-Based Payment." Health Payer Intelligence. Published October 17. https://healthpayerintelligence.com/news/private-payers-follow-cms-lead-adopt-value-based-care-payment.