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Second Curve Road Map for Health Care

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In Partnership with AHA

Online survey tool accessible at:
http://www.hpoe.org/future-roadmap-1to4

Resources: For information related to health care delivery transformation, visit www.hpoe.org.

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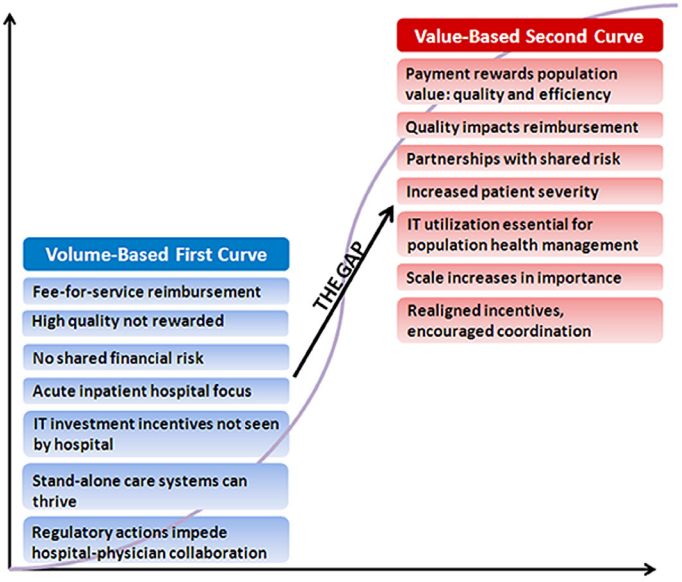
Second Curve Road Map for Health Care

Hospitals and health care systems face common challenges in transitioning to a health care delivery system characterized by value-based payment focused on outcomes, population health management and a patient-centered, coordinated care delivery approach. In 2011, the AHA *Hospitals and Care Systems of the Future* report (found at http://www.aha.org/about/org/hospitals-care-systems-future.shtml) identified ten must-do strategies for the hospital field to implement in order to survive and thrive in the transforming health care system.

Building off of health care futurist Ian Morrison's first curve to second curve shift, the AHA identified characteristics of the first curve (the volume-based curve) and the second curve (the value-based curve). The 2011 report outlined 10 must-do strategies, with four high-priority strategies required to be successful in the transformation from the first curve to the second curve. Hospitals and health care systems that are moving to the second curve use performance metrics to identify clinical, financial, cultural and process improvements; incorporate appropriate incentives; and evaluate results. In 2013, the American Hospital Association further defined the performance metrics for these 10 must-do strategies in the report, *Metrics for the Second Curve of Health Care* (found at http://www.hpoe.org/future-metrics-1to4).

Figure 1: First Curve to Second Curve



Source: Adapted from Ian Morrison, 2011.

This road map builds on both the 2011 and 2013 AHA reports to further detail each of the four high-priority strategies and create more specific metrics to evaluate progress toward the next generation of essential hospital management competencies. It will help you assess your hospital's progress in the transition from the volume-based first curve to the value-based second curve.

Completing the *Second Curve Road Map for Health Care* will enable hospital leaders to determine their current position and progress along the continuum toward meeting the second curve metrics. This information can provide your organization with guidance on the metrics that will be important for health care systems of the future, will enable you to assess potential gaps and provide a road map for planning future improvements within your hospital (or in affiliation with other partners).

The time frame for transitioning to the second curve will depend on your marketplace, but significant transformation across the health care field is expected to occur over the next three to five years. Some markets are moving more quickly toward the second curve, based on payer, competitor and other market pressures; others are moving more slowly. Moving too quickly could have a negative impact on margin or other operations as your organization shifts from volume-based reimbursement approaches to value-based payment approaches. Regardless of your market or where your health care organization falls on this continuum, it is important to strive for quality improvement and increased efficiency, while preparing for value-based payment approaches.

The AHA will use the collected data to identify operational gaps and create educational resources, including best practices and guides, to help hospitals and health care systems bridge these gaps.

Metrics for the four high-priority strategies below (bolded) are detailed in the *Metrics for the Second Curve of Health Care* report and this road map. Several preliminary metrics are also included for the additional six must-do strategies. The 10 must-do strategies are:

1. **Aligning hospitals, physicians and other clinical 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"

While completing this assessment, please refer to the 2011 *Hospitals and Care Systems of the Future* and 2013 *Metrics for the Second Curve of Health Care* reports, as each report explains metrics for the high-priority, must-do strategies for transitioning to the second curve. In addition, the 2013 report contains tables for each of the four high-priority strategies with metrics showing a general range of capabilities, which can help determine your current position and guide your answers.

You should respond to the survey questions on behalf of your hospital and where it is **currently positioned** on these metrics. If you are a leader of a hospital that is also part of a larger health care system, you may answer either from the perspective of your hospital or from the perspective of your health care system, but please indicate in the "Background Demographics" section from which perspective you are responding (hospital versus health care system level).

To take the survey online and to submit your data to AHA click here (http://www.hpoe.org/future-road-map-1to4). If you have any questions, please contact Thomas Duffy, Hospitals in Pursuit of Excellence program manager, at tduffy2@aha.org.

Instructions

The assessment has five sections. The first four sections are focused on the four highest priorities or must-do strategies. The fifth section includes evaluation metrics for six other important strategies for shifting to the second curve.

For each strategy, evaluation statements (or metrics) are provided to assess your hospital's current position. For example:

> 1) All of our hospital's or health care system's physicians are completely aligned across the entire care delivery spectrum, regardless of organizational structure (physicians could be employed, privileged, affiliated or contracted).

Not Applicable	No agreement	Minimal agreement	Moderate agreement	Strong agreement	Complete agreement
N/A	**0**	**1**	**2**	**3**	**4**
☐	☐	☐	☐	☐	☐

To complete the assessment, please answer all questions using a score of 0 to 4, or N/A, indicating your level of agreement with each statement. The assessment's total score range is 0 to 340 points, with higher scores indicating further progression toward second curve capabilities. At the end of the survey, your scores will be totaled and you will see a summary of your results compared to these categories:

0 – 136 = Limited transition toward the second curve

137 – 238 = Moderate transition toward the second curve; currently managing in the "gap"

239 – 340 = Generally operating in the second curve

When evaluating each statement in the survey, please refer to the scoring scale below. Indicate the degree to which you agree with each statement using a score of 0–4.

0 = no agreement

1 = minimal agreement

2 = moderate agreement

3 = strong agreement

4 = complete agreement

Background Demographics

Demographic Information	
Hospital name	
City	
State	
Bed size	
If part of a larger system, are you responding on behalf of your hospital or your larger health care system? • Please check one: ☐ Hospital or ☐ Health care system	

Strategy One: Aligning Hospitals, Physicians and Other Clinical Providers Across the Continuum of Care

Statement	Score (0–4 or N/A)
Scoring Scale: 0 = no agreement, 1 = minimal agreement, 2 = moderate agreement, 3 = strong agreement, 4 = complete agreement	
Percentage of aligned and engaged physicians	
1. All of our hospital's or health care system's physicians are completely aligned across the entire care delivery spectrum, regardless of organizational structure (physicians could be employed, privileged, affiliated or contracted).	
2. We are developing new physician alignment relationship strategies (e.g., physician-hospital organizations, clinical co-management, ACOs, employment or joint ventures).	
3. All of our physicians have financial interdependence with the hospital (i.e., joint financial success or risk is dependent on both the hospital and the physicians).	
4. All physicians affiliated or employed with our hospital are aligned with (and are champions for) our mission, vision and culture.	
5. All physicians affiliated or employed with our hospital are highly engaged, collaborative and participative in all major strategic initiatives.	
6. Improvements in physician engagement have been made that incorporate results from analysis of physician engagement survey data.	
7. Our physician recruiting efforts assess cultural fit including expected behaviors, values and mission (for all employed, privileged, contracted and affiliated physicians).	
8. Our physician contracts include a formalized "compact" or code of conduct with mutually agreed on behaviors, values and mission for all physicians (employed, privileged, contracted and affiliated).	
Percentage of physician and other clinical provider contracts containing performance and efficiency incentives aligned with ACO-type incentives	
9. We have a significant level of reimbursement risk associated with a bundled payment through a commercial health plan.	
10. We have a significant level of reimbursement risk associated with a bundled payment initiative through Medicaid.	
11. We have a significant level of reimbursement risk associated with a bundled payment initiative through Medicare.	

Statement	Score (0–4 or N/A)
Scoring Scale: 0 = no agreement, 1 = minimal agreement, 2 = moderate agreement, 3 = strong agreement, 4 = complete agreement	
12. Our hospital or health care system has or is developing affiliated, accredited medical homes with Medicare.	
13. Our hospital or health care system has or is developing affiliated, accredited medical homes with Medicaid.	
14. Our hospital or health care system has or is developing affiliated, accredited medical homes with a commercial ACO.	
15. All of our hospital's or health care system's payment contracts, payment models and compensation are linked to performance results (e.g., clinical outcomes, value-based care).	
16. We have implemented new payment models for acute care such as bundled payments, two-sided shared savings, partial or global capitation payments.	
17. We have implemented new payment models for non-acute care such as bundled payments, two-sided shared savings, partial or global capitation payments.	
Availability of non-acute services	
18. We have a full spectrum of health care services available across both acute and non-acute care (through ownership, partnerships or other affiliations).	
19. We are developing nontraditional partnerships to provide non-acute care for the population (e.g., payers, employers, community organizations, post-acute care affiliations).	
Distribution of shared savings/performance bonuses/gains to aligned physicians and clinicians	
20. We measure all clinical providers on performance results.	
21. We report feedback on physicians' and other clinical providers' performance against peers and benchmarks.	
22. All clinical providers across the entire spectrum of care share financial risk and rewards linked to performance.	
23. A large portion of our clinical providers have received a distribution of shared savings or performance incentives.	
Number of covered lives accountable for population health (e.g., ACO/patient-centered medical homes)	
24. Our hospital or health care system is participating actively in population health management initiatives for a defined population in chronic disease management.	
25. Our hospital or health care system is participating actively in population health management initiatives for a defined population in prevention and wellness programs.	
26. Our hospital or health care system is participating actively in population health management initiatives for a defined population in dental care.	
27. Our hospital or health care system has or is determining the threshold population size for participation in a medical home.	
28. We are able to measure the attributable population to be included in health management initiatives.	
29. A significant percentage of our hospital's or health care system's income and/or patients are covered by population health models such as ACOs or patient-centered medical homes.	

Statement	Score (0–4 or N/A)
Percentage of clinicians in leadership	
30. 30 percent or more of our hospital's or health care system's leadership roles (in active management positions) are filled by clinicians (e.g., physicians or nurse executives).	
31. A significant percentage of our hospital's or health care system's governance roles are filled by clinicians (e.g., physicians or nurse executives).	
32. Clinicians are leading the implementation of strategic, transformation initiatives through other organizational leadership positions (e.g., committee leadership).	
STRATEGY ONE SCORE	

Strategy Two: Utilizing Evidence-Based Practices to Improve Quality and Patient Safety

Statement	Score (0–4 or N/A)
Scoring Scale: 0 = no agreement, 1 = minimal agreement, 2 = moderate agreement, 3 = strong agreement, 4 = complete agreement	
Effective measurement and management of care transitions	
33. We have a fully implemented clinical strategy across the entire continuum of care to ensure seamless transitions and clear handoffs of responsibility.	
34. We utilize a multidisciplinary, team-based approach to ensure care coordination.	
35. We have fully implemented the use of case managers, health coaches and nurse care coordinators for chronic disease cases and follow-up care after transitions.	
36. We analyze all care transition data elements to evaluate the effectiveness of care transitions.	
37. All patient transitions are handled appropriately so transitions are safe and complete, have excellent communication and information exchange, and no one loses sight of the patient during the process.	
38. We implement interventions based on care transtion data results to improve the care transition process.	
Management of utilization variation	
39. We regularly measure, analyze and report on utilization variances.	
40. We evaluate the impact of evidence-based interventions.	
41. We identify specific physician results in a transparent manner when reporting on utilization variations.	
42. We reliably use evidence-based care pathways and/or standardized clinical protocols on a systemwide basis for at least 60 percent of patients.	
Reducing preventable admissions, readmissions, ED visits, complications and mortality	
43. We regularly report on all relevant data points on patient safety and quality (e.g., preventable admissions, readmissions, ED visits, mortality rates, complications, infections, falls).	
44. Based on timely patient safety and quality data analysis, we implement quality improvement interventions.	
45. We have observed positive results from our interventions to improve patient safety.	

46. We have implemented new chronic disease management care delivery initiatives to prevent future hospitalizations (e.g., proactive coaching to help change lifestyle behaviors, training on team-based disease management, working with nontraditional partners and community organizations).	
Active patient engagement in design and improvement	
47. We regularly use patient engagement strategies such as shared decision-making aids, shift-change reports at the bedside, patient and family advisory councils, motivational interviewing and/or health and wellness programs.	
48. We regularly measure and report on patient and family engagement.	
49. We have experienced an increase in patient and family engagement, including the effectiveness, use and uptake of our patient-centered strategies and tools.	
STRATEGY TWO SCORE	

Strategy Three: Improving Efficiency through Productivity and Financial Management

Statement	Score (0–4 or N/A)
Scoring Scale: 0 = no agreement, 1 = minimal agreement, 2 = moderate agreement, 3 = strong agreement, 4 = complete agreement	
Expense-per-episode of care	
50. We track expense-per-episode data across every care setting and across a broad range of episodes.	
51. We analyze our expense-per-episode data to understand the true cost of care for entire episodes.	
Shared savings or financial gains from performance-based contracts	
52. We measure, manage, model and predict risk using a broad set of historical data across multiple data sources (e.g., clinical and cost metrics, acute and non-acute settings).	
53. We have implemented a financial risk-bearing arrangement for a specific population (either as a payer or in partnership with a payer).	
54. We assess our ability to achieve long-term financial sustainability and scope required to succeed in value-based performance contracting (e.g., evaluating opportunities to achieve economies of scale through consolidation or joint ventures, or participating in affiliations/partnerships for virtual integration).	
Targeted cost-reduction and risk-management goals	
55. We have implemented targeted cost-reduction goals for the organization.	
56. We have implemented targeted risk-management goals for the organization.	
57. We have instituted process re-engineering and/or continuous quality improvement initiatives broadly across the organization (e.g., Lean/Six Sigma, Baldrige).	
58. We demonstrated measurable results from our process re-engineering or continuous quality improvement initiatives.	
Management to Medicare payment levels	
59. We currently project financial impact of managing to future Medicare payment levels for the entire organization.	

60. We have cut costs to successfully manage at future Medicare payment levels for all patients.	
STRATEGY THREE SCORE	

Strategy Four: Developing Integrated Information Systems

Statement	Score (0–4 or N/A)
Scoring Scale: 0 = no agreement, 1 = minimal agreement, 2 = moderate agreement, 3 = strong agreement, 4 = complete agreement	
Integrated data warehouse	
61. We have a fully integrated data warehouse, incorporating multiple data types for all care settings (clinical, financial, demographic, patient experience, participating and nonparticipating providers).	
62. We have a fully interoperable data warehouse, enabling seamless interface, connectivity and data exchange across multiple systems (acute and non-acute providers, participating and non-participating providers).	
Lag time between analysis and availability of results	
63. Our hospital or health care system provides real-time availability for all data and reports through an easy-to-use interface, based on user needs.	
64. We have advanced data-mining capabilities with the ability to provide real-time insights to support clinical and business decisions across the population.	
65. We conduct prospective/predictive modeling to support clinical and business decisions across the population.	
66. We have the ability to measure and demonstrate value and results/outcomes based on comprehensive data across the care continuum (both acute and non-acute care).	
Understanding of population disease patterns	
67. Our hospital or health care system possesses a robust data warehouse, including disease registries and population disease patterns to identify high-risk patients.	
68. We utilize a population health data warehouse to identify intervention opportunities and develop appropriate care programs.	
69. We have a thorough population health data warehouse that measures the impact of population health interventions.	
Use of electronic health information across the continuum of care and community	
70. Our hospital or health care system has a fully functioning electronic health record across all settings of care.	
Real-time information exchange	
71. Our hospital or health care system fully participates in a health information exchange.	
72. We utilize health information exchange data for quality improvement, population health interventions and results measurement.	
STRATEGY FOUR SCORE	

Additional Must-Do Strategies

Statement	Score (0–4 or N/A)
Scoring Scale: 0 = no agreement, 1 = minimal agreement, 2 = moderate agreement, 3 = strong agreement, 4 = complete agreement	
73. We have fully developed relationships with primary care services, post-acute services and other care organizations for fully integrated, coordinated care delivery across the entire care spectrum.	
74. We have a formal leadership education and/or development program for staff (employees, physicians and other clinicians).	
75. We engage staff on the organization's mission, vision and strategic priorities through education, communication and involvement in planning sessions.	
76. We have identified both short-term and long-term financial needs for IT capital projects and other innovation initiatives.	
77. We have accessed the short-term and long-term capital required for IT projects and other innovation initiatives.	
78. Our hospital or health care system has or is developing new types of contracts with payers focused on care delivery transformation.	
79. Our hospital or health care system has or is developing new types of contracts with payers focused on value-based financing approaches.	
80. Our hospital or health care system has or is developing new types of contracts with payers focused on population health management.	
81. Our hospital or health care system has or is developing new types of contracts with payers focused on patient engagement and experience.	
82. Most of our contracts with commercial health plans include clinical quality indicators.	
83. Most of our contracts with commercial health plans include patient experience indicators.	
84. Most of our contracts with commercial health plans include efficiency performance indicators.	
85. Our hospital or health care system regularly utilizes scenario-based planning along various dimensions and incorporates risk assumptions.	
ADDITIONAL STRATEGY SECTION SCORE	

TOTAL ROAD MAP SCORE	

0 – 136	= Limited transition toward the second curve
137 – 238	= Moderate transition toward the second curve; currently managing in the "gap"
239 – 340	= Generally operating in the second curve

Any additional comments?

If you would like to complete the online version of the survey and submit your answers to AHA click here (http://www.hpoe.org/future-roadmap-1to4).