Transformation to Value:
A Leadership Guide

CHANGING STRATEGY AND CULTURE

Who We Are

The **Health Care Transformation Task Force** (Task Force) is an industry consortium that brings together patients, payers, providers, and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system. We are committed to rapid, measurable change from volume of services to value of care, both for ourselves and our industry. To achieve this, we commit to have 75 percent of our respective businesses operating under value-based payment arrangements by 2020.

Introduction

The transformation from fee-for-service to value can be highly challenging, even for the most sophisticated health care organizations. The process of transformation requires strong leadership, well-defined strategic and operational plans, appropriate resources, and exceptional commitment and ongoing dedication at all organizational levels. Despite the importance of value transformation, there are few public resources that provide strategic guidance and examine broader trends in organizations' transformation experiences.

The Health Care Transformation Task Force (Task Force) has created a *Dimensions of Health Care Transformation Framework* (Framework) to help health care organizations assess their transformational maturity along the value-based payment and care continuum. The structure of the Framework provides the foundation for a series of interviews with provider and payer organizations that are deeply engaged in the transition to value. These interviews offer insight into the process of transformation: the decisions that organizations must make as they move along the value continuum, the options available to them and their consideration of alternative approaches, the rationale for particular decisions, and the subsequent results of those decisions.

Shared learnings related to changing organizational strategy and culture, as well as new structure and investments that organizations have put in place to facilitate their transition to value, are captured in this report. The report presents this information in a consistent way: (1) common approaches; (2) varying approaches; and (3) lessons learned.

The transformation to value is a long and risky process. There is no clear roadmap to success, and each organization has unique needs and resources. Further, it will not be possible to fully assess the impact of the changes that organizations have made for several years yet to come. Rather than identify industry best practices for delivery system change, the approaches described below illuminate a broader plan for success. In some instances, there is significant alignment on the path forward; in others, the organizations interviewed diverge in their approaches. Together, these findings paint a detailed and diverse picture of the path to transformation to help guide organizations as they embark on their own journey to value.

Changing Strategy and Culture

In the first dimension of the Framework, Task Force members articulated three key components that either impact, or are impacted by, strategy and culture change. Those components are (1) Organizational Structure; (2) Governance; and (3) Executive and Clinical Leadership. The Framework provides examples of the types of questions that organizations should use to evaluate their progress toward strategy and culture transformation.

Dimensions		*Concept* *Execution* *Sustainability*
Strategy and Culture	*Organization*	What is the formal organizational structure, and what are the roles of organizational participants? What partners are needed? Are there benefits to using a separate corporate structure or entering into joint ventures?
	Governance	How does governance define the value-based care proposition, and how does governance establish the organization's commitment to "cultural reengineering" around person-centered care? How are consumer priorities identified and achieved? How are performance metrics defined?
	Executive and Clinical Leadership	How does executive and clinical leadership plan, execute, and evaluate the cultural reengineering plan? What other strategic priorities are necessary for execution? What performance metrics are established to review progress?

When the Framework was created, culture change was highlighted by Task Force members as a key to successfully transforming to a value-based organization. Leaders in payer, provider, and purchaser organizations alike underscored the integral nature of successfully changing the culture within all levels of an organization to support value-based payment and care delivery. The enormity of that task was not lost on any of these leaders, as they also noted that successfully transitioning to a culture of value is one of the biggest challenges and hurdles to successful transformation. As most organizations then went on to point out in the interview process, culture change involves buy-in across an entire organization (i.e., clinicians, executives, administrative staff, and affiliated partners). This necessitates an overarching vision for transformation, dynamic and experienced leaders, and an appropriate level of organizational integration and local leadership buy-in to successfully transition within each market. These high-level assumptions and themes are borne out in the detailed analysis below.

Organizational Structure

Common Approaches

Independent of the overarching organizational configuration, virtually all organizations interviewed have implemented a structure that aims to achieve a balance between the standardization needed across an organization to facilitate high-quality and consistent care, and the customization needed to address organizational and population health needs across varied markets, regions, and lines of business. This generally involves close collaboration with clinical staff and leadership in specific localities who are closer to patients and market dynamics. These local leaders often adopt centralized resources and modify them for their specific markets, but still have overarching accountability to centralized leadership for the cost and quality of their markets. This balance of local and centralized leadership encourages a more rapid and successful adoption of new processes and structures than a purely centralized approach, while still enabling local markets to benefit from the knowledge, resources, and economies of scale that come with larger organizations. Likewise, centralized organizations can benefit from the knowledge of local markets and translate shared learnings to other markets.

"These very different market dynamics are variations upon a theme," noted one interviewee. "We have to quickly identify what that theme is to maintain system consistency, [then] implement and tailor the program to what the market's needs are."

EXECUTIVE; LARGE, SINGLE-STATE PROVIDER ORGANIZATION

Also common among many interviewees was the importance of aligning with partners and providers who share the organization's broader goals in achieving the desired structure and outcome, and who have the capacity to help build that vision.

"When picking partners…I think the alignment is more than just what assets either party would contribute, but definitely that culture and the vision and the fit of where we want it to be intentionally. That was so huge for us."

EXECUTIVE; LARGE, SINGLE-STATE PROVIDER ORGANIZATION

"When picking partners…I think the alignment is more than just what assets either party would contribute, but definitely that culture and the vision and the fit of where we want it to be intentionally. That was so huge for us."

EXECUTIVE; LARGE, SINGLE-STATE PROVIDER ORGANIZATION

Varying Approaches

Organizational approaches to value-based payment transition fall along a continuum. On one end, an organization may develop parallel structures within their organization, where the new value-based payment infrastructure is separated from the current fee-for-service business, usually with the intention of merging these efforts over time. On the other end is a fully integrated value-based structure that forms the basis of the entire organization's payment and care delivery models. Hybrid structures fall somewhere in between, where value is integrated into the care and payment for certain populations or lines of business, but does not permeate an entire organization.

The organizations interviewed do not predominantly fall into any one of these categories, but rather represent this organizational continuum. Organizations that decided to pursue a parallel value-based care structure generally cited greater return on investment, stronger potential for change, and the need for a "learning laboratory" as reasons for segregating their fee-for-service from their value-based practices or lines of business. On the other end of the spectrum, organizations that pursued a fully integrated structure indicated a desire to provide seamless and consistent care, the need for effective oversight, and interactions and interdependencies across an organization that warrant a centralized approach.

A national nonprofit system moves toward care delivery integration

The path to transformation is a learning process, and after years of implementation of value-based programs, one organization is moving away from "parallel structures" and toward a more structurally integrated system of care delivery.

At the outset, this health system emphasized transformation over integration. Recognizing the variability across the many markets in which its hospitals are located, and the need to support and work within that market-specific context (e.g., geographic location, population, clinical profile, partner/competitor dynamics) the health system leadership decided to build accountable care organizations in various regions, allowing the ACOs to organically adapt and cater to local market dynamics, with the intention of integrating down the line.

The transformation experience of this organization, so far, has helped the leadership realize that there isn't enough "persistence, experience, leadership, and management" at the local level to guarantee continuity in management across the broader organization. While there's a recognition that local management and an understanding of local markets is critical to success, so too is standardized infrastructure, standardized metrics, and a centralized management structure that allows each region to integrate with the health system. The organization has thus concluded that ACOs have "many interactions and interdependencies that warrant a central approach," and is transitioning to a more integrated care coordination network.

This health system learned a couple important lessons throughout this process that may advise other organizations in their transformation journey. First, the development of market-specific value-based organizations is a heavy lift; in retrospect, having an established infrastructure that could be replicated, generally, in various markets could have smoothed, and sped up, the process of transformation. In a similar vein, the organization has come to realize more acutely that "value-based purchasing arrangements are all synergistic," and that centralized management and coordination of all value-based purchasing arrangements provides a foundation for widespread success.

The interviewees differ not only in the type of value-based care structure, but also in the pace with which they adopt (or encourage the adoption of) value. Some leaders noted the importance of a slow transition to value, which allowed more time to develop and mature the necessary organizational structure, while others emphasized a more rapid-yet-deliberate transition to fully capitated risk. Those emphasizing a slower transition to value were sensitive to the ability of smaller, less experienced organizations to take on downside risk. They therefore emphasized small gains in quality of care and value-based care delivery capabilities. The organizations supporting a more rapid transition to full capitation emphasized the value for providers in bringing on a partner with experience and awareness of the hard work required to set up a new structure:

"There are four key factors. One, that the premise actually really works. Two, that when people get it, they want to move ahead way faster. It's just helping them understand where it needs to go. Three, that it needs incredible diligence and hard work. Four, that it takes a year to actually get a delivery system ready to do this. You have to invest for a year in building for implementation a year later."

EXECUTIVE; NATIONAL PROVIDER PARTNER ORGANIZATION

Finally, interviewees differed in their value approaches by organizational type. Payers tended to have a large book of value-based programs operating simultaneously, often encompassing a broad spectrum and many different markets. Providers tended to have fewer types of value-based models, but size and geographic dispersion appeared to play a role in the scope of diversity of programs.

Examples of Value Initiatives by Organization Type

Organization Type	Value Initiative
National Health System	• Accountable Care Organization • Bundled Payments • Risk-Based Contracts (Medicare Advantage)
National/Multi-State Payer	• Accountable Care Organization • Episode-Based Payment • Global Risk • Hospital Pay for Performance • Partial Physician Capitation • Patient-Centered Medical Home • Specialty Pay for Performance (Cardiology and Orthopedics)
National Provider Partner	• Accountable Care Organization • Bundled Payment • Full Capitation • Provider-Sponsored Health Plans • Risk-Based Contracts (Medicare Advantage)
Regional Health System	• Accountable Care Organization • Bundled Payments • Direct Purchasing • PACE • Risk-Based Contracts (HMO and PPO)

Examples of Value Initiatives by Organization Type, Cont.	
Regional Federally Qualified Health Center	• Accountable Care Organization • Patient-Centered Medical Home • Risk-Based Payer Contracting
Single-State Payer	• Patient-Centered Medical Home
Single-State Provider	• Accountable Care Organization • Bundled Payments

Lessons Learned

In pursuing a new organizational structure that facilitates the transition to value, there are a few key lessons expressed by the interviewees. First and foremost is that the path to transformation is long and difficult. A number of organizations interviewed admitted to underestimating the time that value-based payment and care delivery implementation would take, and just how arduous organizational transformation would be. To that end, leaders in the organizations interviewed noted that it is important to set realistic expectations around what clinical outcomes, financial savings, and overall transformational progress can be made in a given year – and not to overinvest initially in costly resources.
Instead, leaders suggested maintaining focus on the transformation process and the goals of value-based care and organizational culture change, which are to improve quality of care for patients and lower the cost burden of health care across the country.

"So basic IT is necessary, basic analytical capability is necessary, but people should resist the temptation to spend too much money and too much time worrying about that and keep their eye on the ball of making sure patients' lives are affected…and clinical care is delivered differently."

EXECUTIVE; LARGE, NATIONAL NONPROFIT HEALTH SYSTEM

Further, in order to achieve a malleable, successful, and sustainable value-based payment and care delivery infrastructure, many organizations emphasized the importance of obtaining continued input and feedback from staff and participants at all levels of the organization, and setting realistic goals.

"So basic IT is necessary, basic analytical capability is necessary, but people should resist the temptation to spend too much money and too much time worrying about that and keep their eye on the ball of making sure patients' lives are affected…and clinical care is delivered differently."

EXECUTIVE; LARGE, NATIONAL NONPROFIT HEALTH SYSTEM

"It really is just a lot of personal time and energy to talk about why we think this is important. And of course, eliciting feedback, and then trying to build the systems and supports that will make the walk the walk and the talk the talk as closely aligned as possible."

EXECUTIVE; REGIONAL FEDERALLY QUALIFIED HEALTH CENTER

Governance Structure

Common Approaches

Similar to the balance needed within an overarching organizational structure, interviewees identified a need for both centralized and local governance structures that oversee the value-based portfolio. Importantly, this puts a premium on strong leadership structures and good communication between local and executive decision-makers. A number of organizations employ governance and management structures such as "dyads," duos consisting of a clinician and an administrator who work jointly to make decisions, and/or governance structures consisting of a central board and market-level boards with similar compositions. These governance structures facilitate formal decision-making processes at both the market and central level that are critical to ensuring the success of complex, multi-pronged value transformations.

"The organization is organized around geographic regions led by a physician-administrative dyad. In this manner, services are tailored to meet the needs of each region, but the objectives that promote value-based care are consistent across all regions. We have dyads at every level, at the central level, at the regional level, and then in each delivery group." If you're going to get big, you need to have delivery groups around local communities in 5- to 10-mile radiuses that own that community and delivery system."

EXECUTIVE; NATIONAL PROVIDER PARTNER ORGANIZATION

Using dyads to transform provider organizations: One partner organization's perspective

In helping transform provider organizations into value-based systems, partner organizations have specific, evidence-based strategies that they utilize. For one organization, the dyad structure has helped meet transformation goals and objectives.

First, the dyad structure helps promote regional leadership while maintaining consistency across the organization from a centralized point of governance. In the organizations that this partner works with, the dyads consist of a physician lead and an operational lead who must work together to merge the clinical voice (objectives, experiences, outcomes) with the value-based payment management experience and broad organizational know-how of the "operator."

The dyad structure also helps to promote adoption of a culture of value by holding regional dyads accountable for clinical results, quality metrics, and overall cost of care for that region. The partner organization helps to set up dyads at every level of care (i.e., central, regional, community care delivery centers). Each regional dyad coordinates with a high-risk dyad that oversees care for the high-needs population in that region, and then reports to the president in that specific market.

In addition, several organizations are subject to governance requirements under their value-based agreements with the federal government. Organizations that participate in federal value-based programs such as the Medicare Shared Savings Program are legally required to abide by governance requirements established by HHS. This includes establishment of certain boards and committees and appointment of specific leadership roles. In addition, Federally Qualified Health Centers (FQHCs) are subject to federally mandated organizational structures and governance features. For example, by federal mandate, fifty percent of the governing board of an FQHC must be made up of patients who receive their care at the organization.

Varying Approaches

While many of the organizations interviewed shared the common approach of a joint central/regional governance structure, there was wide variation in how much control was maintained at the central versus regional level. Some organizations relied primarily on centralized governance for decision-making, preferring to maintain consistency in program roll-out with as-needed modifications for different markets and patient populations. Others preferred to govern primarily at the market level, with centralized administrative and IT functions. A number of organizations were in the process of retooling their governance structures; some were creating new integrated governance structures to better facilitate shared learnings across markets. Payers in particular appeared to be consolidating programs and streamlining their governance structures:

"We are in the process of consolidating…And because it's a large organization, we didn't try and bring it all together at once. We're slowly consolidating programs."

EXECUTIVE; MULTI-STATE PAYER

The value in streamlining, this same payer noted, was consistency and reduced duplication across initiatives:

"We realized that we had to centralize some of the functions just so that we could do the same thing and do it well for all of our plans."

For one provider organization, streamlining the governance structure was a top-down approach intended to promote consistency across markets and regions. However, while the organization streamlined their service lines and aligned them with specific care models, it maintained site-based management and accountability, allowing upper and middle management to develop value-based programs.

"The board doesn't belong in operations. The board belongs in understanding our strategy, making sure we're financially sound, making sure that our quality is positive, and that we have the right structures in place."

EXECUTIVE; SINGLE-STATE PROVIDER ORGANIZATION

"But naturally, you tend to get some siloing; you don't get opportunities for as much natural coordination as you would like. Now what we're doing is putting those pieces together to create a more integrated care coordination network for patients that we are accountable for across the entire system."

EXECUTIVE; MULTI-STATE PROVIDER ORGANIZATION

Lessons Learned

A number of organizations, especially those actively undergoing changes to their governance structures, expressed concern about information siloes resulting from complex governance and organizational structures. One hospital executive articulated it this way:

"But naturally, you tend to get some siloing; you don't get opportunities for as much natural coordination as you would like. Now what we're doing is putting those pieces together to create a more integrated care coordination network for patients that we are accountable for across the entire system."

EXECUTIVE; MULTI-STATE PROVIDER ORGANIZATION

Another lesson learned was the importance of developing governance structures and tools that are flexible, scalable and replicable to avoid unnecessary time and resources on restructuring. For example, developing an oversight process that is centralized but still allows for natural market variation. One interviewee noted that his organization had decided to seize momentum and build out its value business in flight, but in hindsight could have initially developed a more comprehensive structure:

"Our feeling was that the learning curve is not on the technical side. It's on the market facing side and the market location side. And so we thought it was important to get going in each market. Now it would have been nicer if we had a better-established infrastructure that we had stamped out. Looking back, maybe we could have done more of that."

EXECUTIVE; NATIONAL PROVIDER ORGANIZATION

Role of Executive/Clinical Leadership in the Cultural Engineering Plan

Common Approaches

As noted above, most organizations interviewed hold the assumption that a standardized vision of progress driven by experienced leaders is key to systematic culture change and value-based transformation. Leadership plays a pivotal role in the success (or failure) of most systemic transformations; in value-based transformation especially so because of the many complex moving parts and political perils of changing how providers practice and receive reimbursement for care. It is also important to acknowledge that executives at the organization and the clinical and managerial leadership in each market hold distinct, but often equally as important roles in facilitating transformation.

Executive Leadership

Among the organizations interviewed, strong leadership emerged as a unifying theme. In particular, interviewees almost universally stressed the importance of hands-on communication from the highest echelons of management to reinforce the importance of value-based care transformation. To that end, interviewees highlighted the need for visionary, dedicated, and experienced leaders to drive transformational change for an organization. While organizations noted the need for strong leadership and dedication to value at all levels of the organization, interviewees attributed early progress and success in value-based payment and care delivery to leaders at the top of the organization who were forward-leaning and steadfast in their pursuit of value.

Maintaining momentum also emerged as a key factor in successful transformation. Interviewees stressed the importance of leadership in keeping the organization focused on value, even after the initial "honeymoon" phase – and sustaining that momentum across a broad group of leaders, staff, and clinicians.

"Our next phase, continuous improvement, is to ensure that the leaders who have made the decisions, who are endorsing and supported the program, are able to spend time with the local leadership and governance people to convey that. And it's not just their hospitalists or their hospital-based physicians. It really is quite a huge physician community that we're talking about."

EXECUTIVE; SINGLE-STATE PROVIDER ORGANIZATION

Clinical Leadership

In many organizations, executive leadership worked together with market-level clinical leaders to develop and execute on a shared vision of transformation. According to one executive,

"The presence of local leadership in each geographic region has been critical. Ensuring that providers in each region felt they had a voice and had the opportunity to weigh in on decisions was essential to generating the desired level of participation and cohesion."

EXECUTIVE; REGIONAL HEALTH SYSTEM

Just as leadership is critically important to value transformation, so is buy-in from all levels of an organization, and specifically local clinical leaders. Because value-based care requires input and coordination from many different operational and clinical areas, ensuring that leadership, staff, and clinicians are in lockstep on the importance of value and the steps to achieve it can mean the difference between success and failure.

"I think it's because the COO and the director of care management came together, mapped out the work plan, and really just hit the pavement and communicated it to their staff, as well as through the medical hospitalists and the medical community-at-large.

Each of our markets fell on a spectrum of least engaged to most engaged. The data is indicative of that. The ones who are probably most engaged produced our best success stories. And the ones that were not as engaged did not see as much success."

EXECUTIVE; SINGLE-STATE PROVIDER ORGANIZATION

Varying Approaches

While strong leadership was a common theme among the organizations interviewed, these organizations varied significantly in leadership style. Some larger providers and payers took a more top-down approach, with a centralized vision and leadership style; this tended to be more popular in employed hospital/physician models and payer contracting approaches with direct lines of accountability and risk, and also among organizations pursuing specific federal models such as MSSP ACOs that require very explicit leadership structures. Others took more of a partnership approach through mechanisms such as joint venture arrangements; this approach was more prevalent among payers involved in co-branding value products with local health systems, and in consulting/technology companies that pair specific value expertise with provider organizations.

Among consulting partners, there was also significant variation in leadership style. Some primarily supported a model of "teach-to-independence," with a goal of providing organizations with the leadership tools and resources necessary to eventually pursue value-based care on their own. Others employed a model of ongoing support, where they provide the leadership, tools, and resources (including personnel and technology) so provider organizations do not need to build them internally. Both approaches require strong communication and synchronous leadership between the partner organization and provider client to be successful.

"What we try to do is teach people to fish, teach organizations. Now, we have managed some care management programs for organizations, but we've done it on an interim basis. And then we help them build it. And we have all the templates, job descriptions, models, staffing ratios. And so we'll go in and help them build their own care management program."

EXECUTIVE; NATIONAL PROVIDER PARTNER ORGANIZATION

Another difference among organizations was the style of leadership communication. In provider organizations where staff and physicians are mostly employed, organizations placed strong emphasis on the importance not just of having a shared vision (as was a point of commonality among most organizations), but also of communicating and discussing that shared vision with clinical leaders to ensure that all levels of the organization are aligned around the shared goal.

"We do a lot of environmental work. And we talk about changing environment and we talk about the changing financing of health care. We go through the implications. We talk about changing provider compensation to align to these changes."

EXECUTIVE, FQHC

For organizations with more of an indirect model, such as affiliated provider organizations and some payers, higher leadership communication appeared to be more concretely messaged around data. For example, one high-performing ACO leader encouraged physician participation through regular sharing of analytics and cost data. While these approaches are not necessarily mutually exclusive, messaging appears to be nuanced by leadership style, audience, and cultural environment.

Finally, there were multiple organizations interviewed that highlighted the need to not only coordinate with clinical leadership and incentivize the movement to value (either through a shared vision or sharing of cost and quality data), but also let those on the front lines of care delivery drive and design the care model.

"Traditional leadership structures, in which physicians were given a 'seat at the table' but not at the forefront of decision-making, proved no longer able to drive the kind of system redesign and sustainability necessary in this rapidly changing environment. Physicians involved in patient care saw firsthand the changes that would yield the largest benefits to patient care. Thus, it was logical to put them in positions to design, modify and approve process change."

EXECUTIVE; REGIONAL HEALTH SYSTEM

"Traditional leadership structures, in which physicians were given a 'seat at the table' but not at the forefront of decision-making, proved no longer able to drive the kind of system redesign and sustainability necessary in this rapidly changing environment. Physicians involved in patient care saw firsthand the changes that would yield the largest benefits to patient care. Thus, it was logical to put them in positions to design, modify and approve process change."

EXECUTIVE; REGIONAL HEALTH SYSTEM

Lessons Learned

One key lesson learned was the importance of establishing effective communication early on, particularly with vendors and partners. Especially when partner organizations are brought on early in the process to help providers transform, ensuring that there is clear direction from leadership and open lines of communication is essential. One participant articulated the cultural challenges of working with a new company, and the importance of finding a strong fit:

"The biggest lesson that we learned is making sure that the partnership is something that aligns as a fit, both culturally and vision-wise, because had it not been for that, I don't know that we would have been as successful. Like any partnership, it was rough from the onset. You're introducing new players, new stakeholders, and particularly with this engagement, with them being the conveners, and us being the episode initiators – so really had to be listening to each other and communicating well."

EXECUTIVE; MULTI-STATE PROVIDER ORGANIZATION

Another lesson shared among multiple interviewees was the underestimation of the length of time and resources required to truly shift an organization toward value. One health system recalled that it had explored options to acquire all inpatient and ambulatory care facilities in its network to improve the ability to drive value, but rejected the "go-it-alone" strategy due to time and resource constraints.

"Over time it takes everybody to be on the same page pushing the rock in the same direction. And, of course, that starts with senior leadership, executive and physician and non-physician. But it really takes a lot more knowledge and education and data and feedback and really getting everybody on the same page. My observation over time is that we've been very, very good and very successful in our old models of care. And part of this change really took time and education and continued reinforcement of the principles that we're trying to achieve with it."

EXECUTIVE; REGIONAL HEALTH SYSTEM

Finally, some organizations noted the importance of bringing patients more readily through the transformation process:

"I think bringing along the patients in this understanding and expectation is another piece that doesn't always get front and center. We talk about being patient-centric, but many times we buffalo them with our own terminology and thought process so they're not quite sure what we're calling them for."

EXECUTIVE; MULTI-STATE PROVIDER SYSTEM

Conclusion and Implications

The journey to value is complex, resource-intensive, and highly individualized. What works well in one scenario may not translate well to another. Although there is no "one size fits all" for value transformation, there are many lessons to be drawn from the experiences of organizations that have achieved success in value. The interviews described here, and the Dimensions of Health Care Transformation Framework on which they were based, provide a framework and knowledge base for leaders to draw from as they make strategic and cultural value decisions.

Recommendations for organizations embarking on the value journey

Provider 	• Seek a balance of local and central oversight that is best suited for your organization. Build in a process to identify areas for optimization and quickly make changes. • Actively involve staff and clinicians in the process of organizational transformation. Offer appropriate education, resources, and outlets for expressing concerns. • Identify and engage value "champions" at all levels of the organization to maintain momentum for change. Ensure that leadership is actively connected across the organization to "connect the dots" between operational change and the end goal of value.
Payer 	• Find opportunities to collaborate with high-performing providers. Form partnerships with organizations that have shown that they can already successfully take on risk for their patients. • Conduct market assessments to determine where value-based programs are most likely to succeed, and which programs will be most successful. Capitated arrangements, for example, may not be appropriate in markets where fee-for-service remains dominant.
Partner 	• Meet your provider clients where they are. Not all organizations are ready to move to dual-sided risk arrangements or full capitation. Ensuring that clients are able to start where they are comfortable, even if it means participation in less risky arrangements, could mean the difference between failure and long-term success. • Make sure the partnership is a good cultural fit. Taking care to ensure that both organizations are aligned on values, goals, and expectations will save time, money, and stress.

Detailed Methodology

The Task Force created the Dimensions of Health Care Transformation Framework to assist health care leaders as they design and implement their transition to value. The Framework is built on the collective experience and wisdom from member organizations that are at the vanguard of value-based payment and care delivery. It reflects questions that change leaders should ask themselves in building out a transformation strategy. The Framework was developed from a series of working sessions with the Task Force Path to Transformation Advisory Group, consisting of Task Force members, over a period of several months.

The Task Force used the Framework dimensions to craft an interview guide for members. Task Force staff sought participation from members of the Path to Transformation Advisory Group. Members had the option of participating via phone or through a written response to the interview guide. In total, the Task Force conducted interviews with 12 member organizations, corresponding to over 20 hours of interviews, and received four written responses. The breakdown was as follows:

- 3 payers (two national, one regional)
- 9 providers
- 3 partners (guide providers through value transformation)

Following interview transcription by a professional transcription service, the transcripts and written responses were qualitatively coded using Dedoose, an online coding platform, to highlight and organize key themes among member experiences and observations across each dimension. Task Force staff also completed a summary analysis to enable comparison of approaches and results for similar member organizations. All quotes in this report draw from these interview and written transcripts.

Acknowledgments

This is a product of the Health Care Transformation Task Force under the leadership of the Path to Transformation Advisory Group. The Path to Transformation Advisory Group is comprised of Task Force members who are dedicated to identifying issues and challenges that impact the path to value transformation. The Advisory Group addresses both internal operational challenges of moving toward broad adoption of value and external, atmospheric meta-issues that challenge transformation efforts for health care organizations.

Health Care Transformation Task Force Leadership

Francis Soistman
Executive Vice President and President of Government Services
Aetna

Stuart Levine
Chief Medical and Innovation Officer
agilon health

Farzad Mostashari
Founder & CEO
Aledade, Inc.

Shawn Martin
Senior Vice President, Advocacy, Practice Advancement and Policy
American Academy of Family Physicians

Peter Leibold
Chief Advocacy Officer
Ascension

Warren Hosseinion, MD
Chief Executive Officer
ApolloMed

David Terry
Founder & CEO
Archway Health

Marci Sindell
Chief Strategy Officer and Senior Vice President of External Affairs
Atrius Health

Dana Gelb Safran, Sc.D.
Chief Performance Measurement & Improvement Officer and
Senior Vice President, Enterprise Analytics Performance Measurement & Improvement
Blue Cross Blue Shield of Massachusetts

Kevin Klobucar
Executive Vice President, Health Care Value
Blue Cross Blue Shield of Michigan

Gary Jacobs
Vice President, Strategic Partnerships
CareCentrix

Carlton Purvis
Director, Care Transformation
Centra Health

Gaurov Dayal, M.D.
Executive Vice President, Chief of Strategy & Growth
ChenMed

Susan Sherry
Deputy Director
Community Catalyst

Colin LeClair
Chief Development Officer
ConcertoHealth

Kevin Sears
Executive Director, Market & Network Services
Cleveland Clinic

Sowmya Viswanathan
Chief Physician Executive Officer
Dartmouth - Hitchcock

Elliot Fisher
Director for Health Policy & Clinical Practice
Dartmouth Institute for Health Policy and Clinical Practice

Shelly Schlenker
Vice President, Public Policy, Advocacy & Government Affairs
Dignity Health

Mark McClellan
Director
Duke Margolis Center for Health Policy

Chris Dawe
Vice President
Evolent Health

Frank Maddux
Executive Vice President for Clinical & Scientific Affairs: Chief Medical Officer
Fresenius Medical Care North America

Angelo Sinopoli, MD
Vice President, Clinical Integration & Chief Medical Officer
Greenville Health System

H. Scott Sarran, MD, MM
Chief Medical Officer, Government Programs
Health Care Service Corporation

David Klementz
Chief Strategy and Development Officer
HealthSouth Corporation

Richard Merkin, MD
President and Chief Executive Officer
Heritage Development Organization

Anne Nolon
President and Chief Executive Officer
HRH Care Community Health

Leonardo Cuello
Director
National Health Law Program

Debra Ness
President
National Partnership for Women & Families

Martin Hickey, MD
Chief Executive Officer
New Mexico Health Connections

Kevin Schoeplein
President and Chief Executive Officer
OSF HealthCare System

David Lansky
President and Chief Executive Officer
Pacific Business Group on Health

Timothy Ferris
Senior Vice President, Population Health Management
Partners HealthCare

Jay Desai
Founder and CEO
PatientPing

Danielle Lloyd
Vice President, Policy & Advocacy
Premier

Joel Gilbertson
Senior Vice President
Providence St. Joseph

Christopher Garcia
Chief Executive Officer
Remedy Partners

Kerry Kohnen
Senior Vice President, Population Health & Payer Contracting
SCL Health

Richard J. Gilfillan, MD
Chief Executive Officer
Trinity Health

Judy Rich
President and Chief Executive Officer
Tucson Medical Center Healthcare

Mary Beth Kuderik
Chief Strategy & Financial Officer
UAW Retiree Medical Benefits Trust

J.D Fischer
Program Specialist
Washington State Heath Care Authority