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The Care Process Design System: An Organization's Systematic Approach to Value Generation and Accountable Care

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INTRODUCTION

The healthcare industry has become riddled with acronyms as many new structures of healthcare provider organizations have been developed, over the last few years, in response to the clinical and financial challenges that have bedeviled the industry. In fact, the creation of these new structures has been driven largely by healthcare reforms, such as the Affordable Care Act (ACA). The ACA specifically rewards the development of these new care models, through innovative changes in the reimbursement system and associated regulatory mandates for demonstrating quality and cost efficiency (i.e., value) as well as provider accountability for same.[1]

Accountable care organizations (ACOs), clinically integrated networks (CINs) and patient centered medical homes (PCMHs) represent examples of this phenomenon. These organizational entities differ in sponsorship and targeted population markets. They are similar, however, in their common purpose of delivering services that meet the growing consumer demand for reliably high quality and low cost. Moreover, these structures represent today's modern take on a not-so-novel form of healthcare delivery: the *integrated* care delivery system.

The dilemma faced by many hospitals and healthcare systems, however, is that organizational structure, branding, marketing, and even innovative incentive plans are not sufficient to render the significant changes needed within the front lines of the care delivery system. This is typically the area where providers, care practitioners, and medical staff are concerned. Simply put, organizing providers into new entities with novel acronyms on the door will not change the way those providers go about their business of delivering care to patients. Doctors, in particular, are creatures of habit, and they are also very good at responding to incentives, which for the most part still rewards them for practicing medicine in a manner to which they have become accustomed over their professional lifetimes: production-driven (or volume-driven) care delivery. Time and time

again, we are being told that the traditional, fragmented care delivery model is no longer sustainable. That change not only needs to occur but it is, frankly, imperative.

So, while conceptually the idea of moving from a volume to value production model may be easy to grasp, and there may be very good reasons to try and move the healthcare system in this direction, actually accomplishing this transformation on the front-lines of modern medicine is a very difficult task. In fact, in order to accomplish this change, a *systematic* approach to re-tooling the care delivery system will be needed and its value to healthcare organizations, particularly hospitals and physician practices, will be significant, for many hospitals have invested heavily in alignment strategies with physicians, such as employment, ACO formation, or CIN development. Likewise, many physician practices have gone to great lengths and expense to become recognized as a PCMH or even patient centered specialty practices. But what does practicing in one of these entities mean to the providers when they come to work tomorrow and see their first patient as a member of an ACO or a PCMH? How will their usual approach to care delivery have to change and, more importantly, how do you go about making it change?[2]

How will the usual approach to care delivery have to change and, more importantly, how do you go about making it change?

This is where the Care Process Design System (CPDS) comes into play. The CPDS explained herein will address the issue of re-tooling the care delivery system via key front-line individuals. It is important to note that the CPDS goes beyond the alignment and engagement stages of clinical integration (which are considered the preliminary, foundation-setting stages of integration) and describes a *system* for the transformation stage of clinical integration. This is where value production begins to occur.

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I. DRIVERS FOR THE CPDS

THE RISE OF VALUE

Value, defined as quality (or outcomes) per dollar of cost, has increased in relevance substantially over recent years. The rationale for this rise is that the inexorable rise in healthcare cost, coupled with the increase in government debt and the more recent downturn in the economy have combined to make cost control a major imperative in the US healthcare industry of the 21st century. No longer can providers of healthcare services simply pump out volume without regard to unit cost and expect someone to pay. Furthermore, this is true even in a fee-for-service (FFS) reimbursement model since, as further explained below, more and more consumer activism is driving less tolerance for cost shifting and higher premiums on the commercial side. Nonetheless, even as value-based payments increase in prevalence, FFS reimbursement will likely exist indefinitely.

The importance of demonstrating value-generation while producing volume is rather an unprecedented challenge for most healthcare providers.

The importance of demonstrating value-generation while producing volume is rather an unprecedented challenge for most healthcare providers today. Having nowhere to shift the costs, healthcare providers of all types finally will have to eliminate waste and inefficiency from their operations and bring prices more in line with reality and true costs of production. When and if value-based reimbursements, such as bundled payments, partial or global capitation, and shared savings plans, come to represent more than a small percentage of most markets, the providers will be ready to compete under these models, as well, but, even today, under a predominantly FFS reimbursement system, the CPDS is necessary and can play a vital role

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in helping organizations successfully maneuver through a very challenging time in the healthcare economy. Thereby, the CPDS is a tool for re-designing the care delivery model from being strictly volume-based to one that also generates value and integrates accountability measures for ensuring same.

COST AND CONSUMERISM

In addition to a demand for higher value in the US healthcare economy, there is also a rising tide of consumerism where patients are no longer willing to tolerate the costs shifts, lack of price transparency, and, indeed, total lack of connection between cost and price that is prevalent throughout the healthcare industry.

We have all heard stories of the $50 Tylenol and, unfortunately, the arcane nature of how prices are set, particularly within hospitals, make these anecdotes far too common. What is needed to combat this is a true understanding on the part of healthcare providers of the actual costs of providing the services they render to patients. Imagine an automobile manufacturer not knowing how much it costs to make one of their cars; now, imagine asking your local hospital how much it costs them to take out your gallbladder. Chances are, in the latter instance you will get a blank stare!

Up until now, the healthcare industry simply has had no need to actually know the true costs of the activities that they perform every single day--surgeries, patient visits to the doctor's office or hospital, X-ray procedures, etc. They have not needed to know these costs because they have been fortunate enough that payments have always covered the costs, and their profit margins have been preserved. Now that payments are being ratcheted down by government payers, and consumers are saying no to further cost shifts onto the commercial payers, providers must think about doing true activity based cost accounting. For perhaps the first time in history, providers have to know what their true costs of delivering services are so that they can price these services accordingly in order to weed out unnecessary costs and maintain profits.

The advent of so-called consumer-directed health plans with high deductibles and co-pays have also driven this rising tide of consumerism. Before, the average patient when presented with an exorbitant bill for a medical procedure, simply shrugged it off because "the insurance company will pay it;" now, the payment often will be coming out of the patient's pocket as he or she has to meet their high co-insurance or deductible. This is doing exactly what the health plans who designed these plans want, i.e., making patients think twice before they purchase healthcare services that they might not need (and the health plan might eventually have to pay for). It has also exposed the disconnect between healthcare pricing and true costs of production--especially as hospitals try to explain to consumers why a drug or a piece of medical equipment that they can buy in the local drug store for a fraction of the cost is so expensive when purchased from the hospital. Or, why the test or procedure they had in their private physician's office last year just shot up five- or ten-fold in price when that physician became a hospital employee six months ago. [3,4]

VALUE TRANSFORMATION AT THE BEDSIDE LEVEL

Between the government demonstrating that they can't tolerate healthcare costs approaching 20 percent of the gross domestic product (GDP) and consumers saying they won't continue to subsidize what the government refuses to pay hospitals and other healthcare providers, the moment of truth may have finally arrived. Healthcare services must somehow be systematically analyzed regarding their quality and costs. The question then becomes who is best qualified to do this and how does it happen?

Healthcare services must somehow be systematically analyzed regarding their quality and costs. The question then becomes who is best qualified to do this and how does it happen?

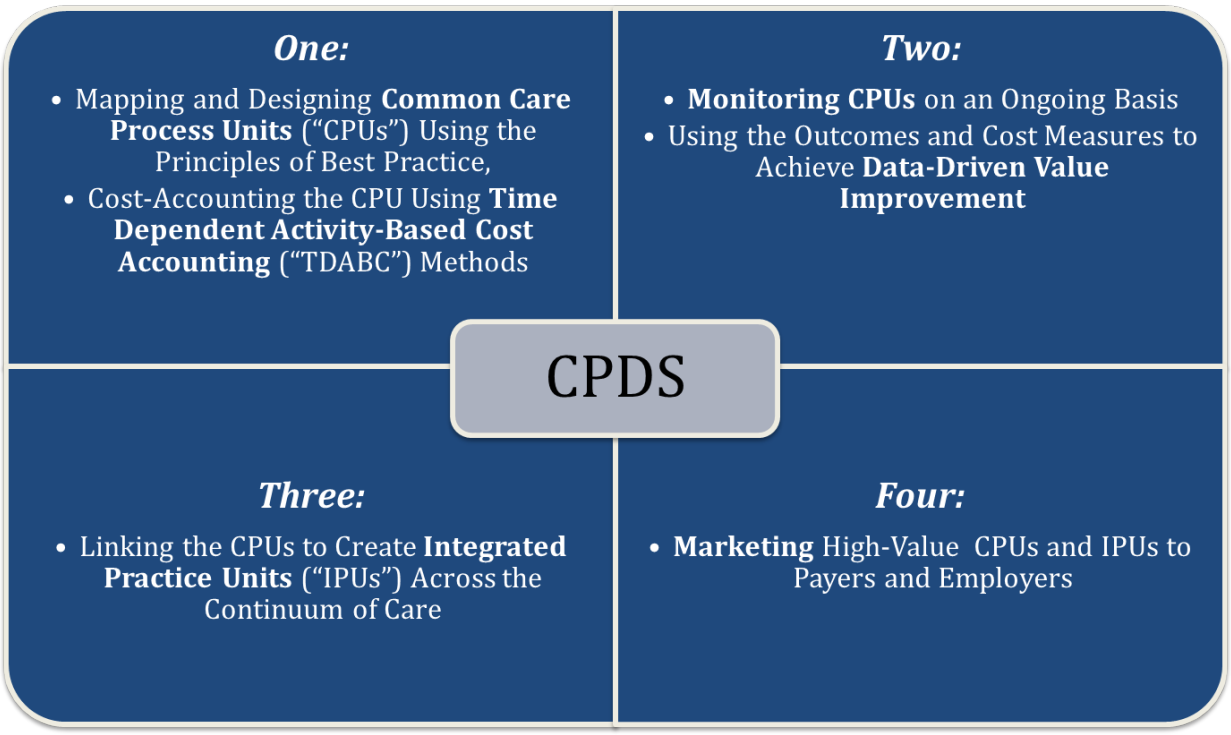
Historically, or at least for the last 50 years or so, this work has been done by the payers. With the creation of the Medicare system in 1964, we

had the first large scale attempt by a payer, in this case a government payer, to determine which costs they would legitimately cover related to services received by Medicare beneficiaries. Medicare cost reporting, to this day, probably represents one of the few examples of trying to use cost accounting to determine price. That is why, when all is said and done, the price point for all healthcare services will probably settle out somewhere around Medicare rates. Almost any chief financial officer (CFO) will tell you, however, that there are lots of flaws in the Medicare cost reporting system. Certainly, most providers would tell you that the commercial payers did no better when they tried to set capitation budgets back in the 80's and 90's for managed care products, which ended up forcing "gatekeepers" to withhold care from patients in order to eke out a profit from these arrangements. The promise of accountable care today is that quality metrics will be used alongside capitated budgets to avoid egregious practices such as this. But would it not be better if the budget was actually set by those who knew best what costs were necessary to assure quality and patient safety, i.e., the providers? This is one of the foundational elements of the CPDS. It is hoped that putting this system into place in enough organizations prior to the insurance industry or, even worse, politicians having an opportunity to financially or legislatively dictate care delivery standards will be a unique opportunity for healthcare professionals to step up and assume their rightful place in the system to determine what should and should not be included in the patient care processes that are used for the most common clinical conditions.[5]

II. THE CARE PROCESS DESIGN SYSTEM

CPDS COMPONENTS

Exhibit I: Basic Components of the CPDS



As illustrated by Exhibit I above, the CPDS has four main components. While the subsequent sections explain each component in greater detail, it is important to note that these four parts signify interdependent pieces of the puzzle that, when executed effectively and applied consistently, create a system that allows for care delivery transformation. The primary intent is to develop a model that is both responsive to the existent and upcoming changes in healthcare and beneficial for the organization in multiple ways.

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THE CPDS AS A SYSTEM

As mentioned on numerous occasions above, the CPDS has been developed to be a system, as opposed to a temporary project or initiative. Inherently, the CPDS represents a critical mental and cultural shift away from the "normal" care delivery process to one that is anchored by the principles of alignment and (clinical) integration. Simply put, the CPDS model necessitates that the organization has already established a strong provider base that is tied (both to the organization and to one another) via the same values, goals, and objectives, with the patient being at the center of them all. The primary reason for this prerequisite is because, once in place, the CPDS will be a permanent part of the organization. This is to say that the CPDS will be the basis for the future of the organization's care delivery process and will serve as the backbone for the organization's brand and market recognition.

By its very nature, the CPDS model has been designed to advance systematically the value proposition.

By its very nature, the CPDS model has been designed to advance systematically the value proposition. As the market and industry continue to sharpen the spotlight on value, the CPDS will allow the organization to differentiate itself in the marketplace as a high-value producer of healthcare services. It will not be unique to how one service or the other is delivered, but rather will be the system by which the organization *designs, monitors, and improves* the value of all its services once the CPDS is fully implemented.

The CPDS is adaptable to multiple types of organizations (i.e., hospitals, specific service lines, physician practices, ancillary service providers, post-acute providers, etc.). It is applicable to both a fee-for-volume or a fee-for-value based reimbursement model, where systematic design of care processes that produce reliably desirable outcomes for quality

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and cost is needed. More importantly, it is arguably the optimal system for organizations in a combination reimbursement market (i.e., both FFS and FF-value), which is likely to be the dominant payment arrangement for most parts of the country over the next three to five years. As will be discussed later in this document, the CPDS factors in the importance of production and, thus, operates in a manner that derives volume through value through such things as the creation of more cost effective care process units.

THE CPU

The major focus of the CPDS is the care process unit or CPU. A CPU is an isolated process or procedure that is frequently used to care for the most common clinical conditions. The idea behind choosing the most applied CPUs versus the most expensive (although, they may be one and the same in certain instances), is to trim down the aggregate costs of the CPUs of greatest volume. For example, a CPU may be something as simple as an office visit for a diabetic patient or as complex as a total joint replacement for a patient with severe degenerative arthritis. Needless to say, the CPU will vary by specialty and even can differ by organization type. Nonetheless, it is imperative that each CPU has a well-defined start and stop point. It may involve a process of care such as care of a medical condition over a period of time or a procedure such as a surgical intervention.

The CPUs will incorporate industry "best practices." To assure this happens, the processes and procedures will incorporate evidence-based guidelines derived from the scientific literature, the knowledge and experience of the clinical providers practicing within the CPU, and, finally, input from actual patients. These patients will be asked to participate on the care design teams and assist with the mapping out and designing of their own care processes.

Mapping out of a CPU is similar to creating a patient care flow diagram for a very specific process or procedure. While the exhibit below illustrates an example of a mapped CPU at a very high-level, the most useful CPUs are those with much more detail included.

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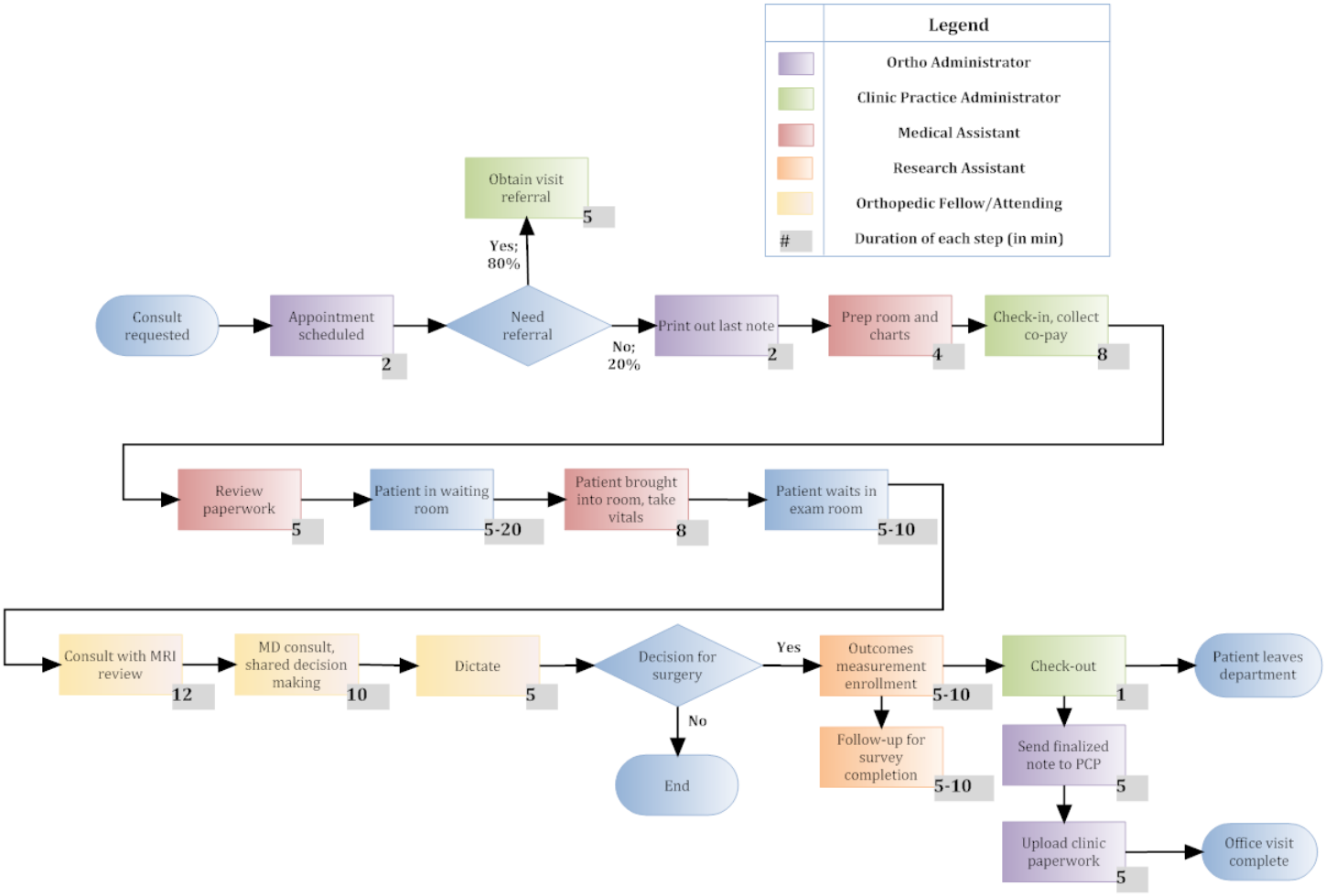
Exhibit II: Example of a High-Level CPU for a Surgical Ortho Procedure[6]



THE IPU

The IPU (or integrated practice unit) is a series of care process units that are related to a common clinical condition and brought together in order to better provide a coordinated care experience for the patient across the care continuum. An example of an IPU might be the multiple processes of care that would be experienced by a patient with chronic congestive heart failure. This patient might see a primary care physician who would manage their other co-morbidities and do the basic management of their heart failure (HF). We could call the primary care office visit for this patient HFCPU1. Next, this patient might be seen in a dedicated heart failure clinic by a nurse practitioner, overseen by a

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cardiologist. We would call this HFCPU2. Continuing on, the patient may require hospitalization for decompensation of his heart failure by the adult hospitalist group, and we could call this HFCPU3. Finally, the patient may reach the point where he needs a left ventricular assist device (LVAD) implanted as a bridge to heart transplantation, and the LVAD procedure would be HFCPU4. Stringing HFCPU1-4 together, we could come up with a HFIPU, unique for this type of patient, and better determine how to design this IPU, measure its outcomes and overall costs, again, with an improved value proposition for the payer and patient.

Exhibit III: Example of a High-Level IPU for Congestive Heart Failure

As can be seen, the number of CPUs and IPUs are almost endless, and that is another reason the CPDS is a system and not an initiative. Any organization implementing this model will find it to be a way of conducting business and not a simple "one and done" project. That being said, the CPDS can be thoroughly internalized and embedded into the organization and does not require outside support once the initial training and education in its operation is complete over a matter of months.

III. THE KEY PLAYERS

THE CPDS DESIGN TEAMS

The CPDS system development will function through multi-disciplinary design teams made up of physician leaders, clinical and non-clinical experts, financial experts (trained in time-dependent, activity-based cost accounting), process and performance improvement experts

(trained in Lean process care mapping techniques), and patients who have previously undergone the process or procedure under design. Each CPDS design team will be tasked with mapping and embedding "best practice" guidelines into the CPU, relating their experience with the process to the cost accounting experts, who can use the TDABC method to determine a case rate (dollars/minute for the process) and selecting outcomes measures for the CPU that they believe will best reflect the goals of the clinical process under consideration. The end result of this collaborative effort will be a compilation of individual CPUs and associated performance measures and metrics that are representative of the most commonly utilized care processes of the organization.

As physicians generally are considered the "controllers" of cost, it makes sense for them to serve as the champions for change, especially when clinical guidance is of utmost value throughout this process.

This integrative approach to establishing the CPUs ensures that all relevant parties are engaged in the transformation process. This is not merely for driving satisfaction from patients and providers who feel involved in their care or their work, respectively (although their satisfaction is a crucial focus area), but also for creating representative and meaningful CPUs that can then be enhanced by financial and operational experts to be cost effective and guided by best practice standards.

In most instances, the CPDS design team will consist of individuals within the organization, and rarely will necessitate that the facility hires or contracts new team members just for this development process. Further, as more and more entities engage in clinical integration/quality improvement efforts, participation in the CPDS design team certainly can be incentivized. This likely will be of particular importance for physician leaders. As providers generally are considered the "controllers" of cost, it makes sense for them to serve as the champions for change, especially when clinical guidance is of utmost value throughout this process.

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PHYSICIAN LEADERS[7]

The physician's roles and responsibilities on the design team will consist of:

- ***Leading the team***. In the sense of making sure the team keeps their focus on the big picture of moving toward value production (i.e., quality/cost), if the physician on the team does not endorse this concept, then it is highly unlikely that the other members of the team will follow and fully engage in the activities at hand. Similar to a "lead by example" approach, physician champions are expected to be the most rooted by the goals and objectives of a fully integrated, value-centric, transformative care delivery model so that they can guide their team members in reforming the clinical and some non-clinical aspects of the business of healthcare.
- ***Lending expertise***. The physician will need to strike a balance between contributing his or her knowledge and experience with the process under consideration and ensuring that others have the opportunity to contribute their thoughts and ideas to the design phase of the team's work. The physician can dominate this phase easily; therefore, it will be very important for the physician to understand the need to allow everyone on the team to contribute. The *integrated* delivery system and the CPDS, particularly in the early development stages, necessitate a collaborative approach to be fully functional and sustainable. While the clinical aspect will require significant buy-in from providers and physician champions, the other key components and stakeholders of healthcare must not be overlooked.
- ***Practicing data-driven value improvement***. Possibly the most important role for the physician will be to monitor the outcomes of the process over time and adjust practices on a continuous basis to assure that value (quality per unit of cost) remains high. In this way, the process becomes a learning laboratory, and steps in the care process that would otherwise never be subjected to a

randomized controlled clinical trial can be objectively evaluated as to their efficacy and efficiency.

PROCESS MAPPING

While many hospitals and other healthcare organizations are now hiring fully-trained experts in Lean process engineering, the CPDS design teams will only require someone to be capable of mapping out the key steps in the process using a modified Lean process mapping technique. This technique can be taught to most clinical and even non-clinical healthcare workers in a short period and should not be looked at as a major obstacle in implementing this system.

Simply put, the main objective for a Lean process mapper is to identify, via a prescribed methodology, the key steps in a CPU so that outlying" steps may be extracted from the overall, standardized process without compromising efficacy. By removing these steps, whether they are duplicative or just unnecessary, efficiencies likely will be achieved, and certainly the cost structure will decrease.[8]

TIME DEPENDENT, ACTIVITY-BASED COST ACCOUNTING EXPERTS

Unlike the process mapping described above, this methodology does require some familiarity with activity-based cost accounting, and most business analysts and others in healthcare financial departments can easily perform this work. It also does not require purchasing expensive cost accounting software systems. Large hospital systems have done this by hand using Microsoft Excel spreadsheets.

The main idea here is to apply a methodology that factors in the true costs of care (on a small, per CPU scale), as opposed to using more nebulous and, thus, less beneficial forms of cost accounting such as ratios of costs per charge or labor RVUs.[9] Rather, the TDABC method allows for a more accurate and useful methodology (because it is broken down by cost per time) for estimating the direct resource demands of a particular CPU, as well as identifying inefficient or unprofitable processes. This information will not only be of value

for the CPDS/CPU mapping/IPU development, but also can serve as important intelligence for strategic and operational considerations such as budgets and pricing of services.[10]

PATIENTS

Lastly, it cannot be emphasized enough just how incredibly important it is for the patients to be a part of the CPDS design teams. True patient-centered care cannot be designed without the input of those who have experienced care from this perspective in recent times. All efforts should be made to seek out and involve patients in the design process on an ongoing basis, if at all possible.

The healthcare organization that puts the CPDS into place will become a true learning organization constantly accumulating knowledge about how to create higher and higher value within each process and for each patient.

IV. ADDITIONAL COMPONENTS

BEST PRACTICE/EVIDENCE-BASED DESIGN

It is commonly misunderstood that healthcare delivery includes only practices that are supported by the scientific literature. The truth is that the vast majority of clinical care is driven by provider preference, habit, or simply "that's the way we've always done it" – not by rigid scientific study.[11] Further, as mentioned above, many of the practices in question will never be subjected to a randomized clinical trial. Accordingly, the quality and cost outcomes data measurements obtained through the CPDS will provide a way of studying the process designs; and, using objective information to determine what works and what doesn't as an ongoing iterative process continues under the direction of each physician leader. Slowly but surely this will create hundreds, if not thousands, of bedside/exam room learning laboratories. Therefore, the healthcare organization that puts the CPDS into place

will become a true *learning organization* constantly accumulating knowledge about how to create higher and higher value within each process and for each patient.

When setting up each process as to its starting point or original iteration, it is also important to remember that the input from the clinical and non-clinical content experts will not be evidence-based in the strictest sense. A broader definition of evidenced based, however, which takes into account both the scientific literature as well as the provider's experience and the patient's point of view, will be used in the CPDS. For reasons outlined above, this method is felt to provide a more complete way of capturing "best practices" for inclusion in the care design process.

THE ROLE OF HEALTHCARE INFORMATION TECHNOLOGY

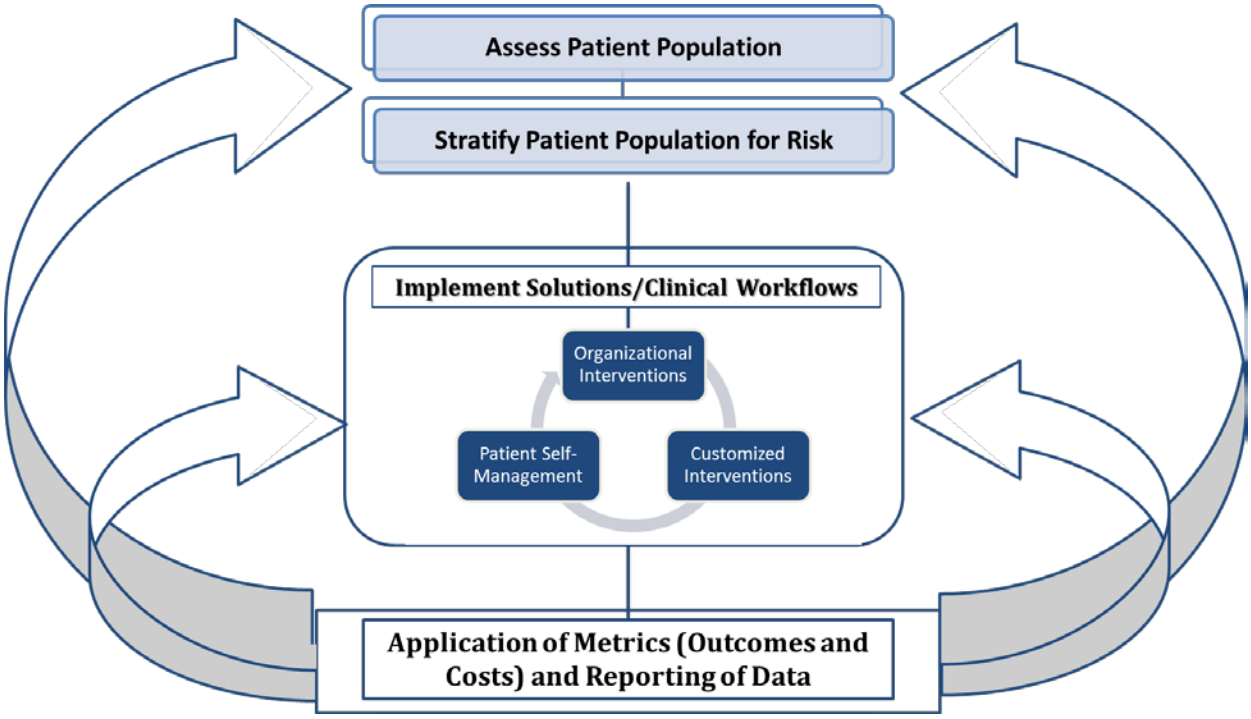
By the time the organization has begun to consider the CPDS model, it is assumed that their clinical integration infrastructure has already been established or is well underway. This is to say that the CPDS will rely heavily on a robust information technology (IT) platform, which is a requisite for all CINs. As such, the CIN's IT infrastructure will allow the organization to have the following six capabilities that will lend to its ability to carry out population health management functions:

1. Continuous assessment and monitoring of patient populations
2. Application of clinical filters to enable risk stratification based upon assessments
3. Application of clinical workflows (best practices) to implement interventions based upon risk level and evidence-based medicine
4. Generation of data based upon configured metrics (outcomes and costs)
5. Reporting and sharing of data among all providers and care practitioners involved
6. Improvement of the care delivery system and/or intervention based upon analysis of data

As illustrated below and previously noted, organizations undertaking CPDS development will strive to become true "learning" organizations. Here, the information flow of quality and cost measures within the clinical delivery system is fed back to providers via

continuous feedback loops and used to drive on-going performance improvement and enhanced delivery of value to the healthcare consumer. The knowledge gained from this system will then be used to expand the "evidence base" of medical science.

Exhibit IV: Care Continuum Feedback Loop



Once CPUs/IPUs have been finalized and established, they can be "mapped" in as workflows into the organization's HIT system and supported using tools such as computerized order sets and decision support systems. The CPDS will also ensure that the multitude of data that is acquired (and moreover, legally required by law to be gathered) is being used in a meaningful and impactful way for continuously improving the care process and delivery system of an organization. Moreover, measures for tracking provider performance and regulatory compliance can also be interfaced into the HIT platform to enhance further the reliability and security of the system.

V. THE VALUE OF A VALUE-BASED CPDS

DERIVING VOLUME THROUGH VALUE: MARKETING OF CARE PROCESS AND INTEGRATED PRACTICE UNITS

As described above, CPUs can be linked together to create larger IPUs across the care continuum. These IPUs will provide patients with a seamless and coordinated care experience and will help to correct the frequent frustrations typical of today's far too fragmented healthcare system. In addition, these IPUs can be marketed as "bundles" to payers or employers looking to reimburse under a bundled payment methodology. This will allow organizations adopting the CPDS an advantage over other providers in a competitive marketplace, who are not organized to provide services in this fashion.

The business of healthcare is undeniably moving toward the business of population health management. Through the capabilities afforded to an organization via the CPDS, adopters are likely to experience a competitive advantage within its market. Purely by being a true value-generating organization with a system that allows it to demonstrate its cost effectiveness to patients and payers alike via the wealth of information it garners, CPDS adopters will likely be more apt to capture a greater share of the market. In negotiating contracts, they will enjoy enhanced leverage (particularly for value-based contracts), set competitive prices that are guaranteed to cover costs (due to the TDABC approach), and enter into contracts for innovative services such as population health management. Moreover, as patients become more educated as to the "new" wave of care delivery (and thus, pickier consumers), they may be more willing to seek care from establishments that can prove its ability to provide value. In turn, these organizations will realize a rise in volume.

Most observers agree that FFS reimbursements are likely to drop for hospitals and healthcare systems over the next few years. Therefore, it would be wise to mitigate these drops in reimbursement and likely increases in expenses by implementing the CPDS. This

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will help hospitals and physician practices maintain operating margins by lowering their cost structure and doing so in a way that does not sacrifice quality or patient safety. Furthermore, these entities will no longer have to enter into FFS negotiations blindly (i.e., without knowing their true costs of delivering line item services within a fee-for-service system). This knowledge will be especially valuable as margins for error at the negotiating table decrease.

Finally, for hospitals, the CPDS will avoid the revenue losses that are bound to if readmissions or hospital acquired conditions, such as hospital acquired infections range above targeted thresholds.

If and when value-based reimbursements become more the norm, the CPDS will provide organizations with the knowledge necessary to set prices accurately for bundled or capitated payments and to mitigate the risks inherent in providing population health management services. The name of the game in population health management will be market share and the CPDS will position players to win that game every time.[12]

PATIENT AND PROVIDER SATISFACTION

Perhaps the most important benefits that the deployment of the CPDS will bring to adopters will occur in the clinical realm. Compared to prior care experiences, patients will be better served with more reliable production of high quality clinical outcomes, improved coordination of care across the continuum, and the ability of the providers to bring enhanced knowledge to the bedside or into the exam room. Also, note that this clinical benefit will not be theoretical but will be proven through the accurate measurement and reporting of true outcomes as opposed to process compliance measures, which most patients find meaningless.

The providers also will find much to like about the CPDS. Most physicians, for instance, were originally motivated to enter their chosen profession because of a deep interest in the science of medicine and a sincere desire to help those in need. Unfortunately, many such

well-motivated individuals have been frustrated after working in systems that don't reliably apply cutting edge science to the care environment or who are unable to measure the actual difference they make in people's lives. The CPDS will allow them the opportunity to change this and, in the process, attract the best and the brightest to work within facilities using the CPDS. In fact, this ability to enhance provider satisfaction may also lower labor costs by offering intangible benefits to employees, which many will consider equal to higher pay.

GETTING STARTED

So, where should an organization start on their Care Process Design System transformation journey? Coker has found that the CPDS is best implemented on a focused basis, around the most common processes and procedures used for the most frequently seen clinical conditions. The model is applicable to both the inpatient or outpatient location and can apply to multiple targeted population groups or population health management in general.

Furthermore, the CPDS will require minimal cost to implement on a small scale and incremental basis. In addition, implementation costs can be covered easily by projected shared savings from care process design projects.

Once in place at the service line level or individual practice or unit level, most providers will want to spread the system into other areas and then throughout the organization in order to transform their entire operation into a value based production model.

Regardless of where it starts or how fast it spreads, this is the operating system that will transform clinical care delivery as we know it today. High quality at low cost will demand a different way of doing business for healthcare providers, and there is much still to learn. The CPDS can make it easier for those willing to begin.

CONCLUSION

Whether we realize it or not, the future of healthcare is already here. As hospitals and physician groups strategize responses to the rapidly changing times and declining

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reimbursements, the traditional care delivery model becomes increasingly obsolete. Undeniably, healthcare is undergoing a major cultural shift where value, patient-centeredness, and population health management are reigning elements, even in a predominantly production-based environment. Thus, as providers align and integrate, whether in partnership with another group or amongst themselves, they will need to place a key focus on the actual care delivery process.

For an organization truly to be considered a clinically integrated, value-based organization, it must have in place a *system* that can provide its consumers with high quality and low cost care, demonstrate its ability to generate value, hold its providers accountable for their performance, and gather and apply information in a manner that promotes population health management, as well as process/outcomes improvement. The CPDS offers all of these capabilities and more, making it just the system a progressive organization needs to develop a sustainable, affordable, and valuable care delivery model that can ultimately facilitate its long-term success.

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