As health reform continues throughout the country, we have seen a lot of confusion about what constitutes a High-Performing Health System™, and why these systems should be incentivized. Because our members are on the cutting edge of health care quality and innovation, AMGA decided to take a leadership position in defining a High-Performing Health System™ to educate legislators, insurers, and the public on the unique attributes of these systems and to aid provider organizations in their efforts to improve patient care.

A provider entity is considered a High-Performing Health System™ if it can demonstrate that it is conducting the following activities:

**Efficient Provision of Services**
The provider entity successfully manages the per capita cost of health care, and improves the overall patient care experience, and the health of their respective populations.

**Organized System of Care**
The provider entity includes a multispecialty medical group or other organized system of care and:
- Provides a continuum of care, including prevention and ambulatory care, for a population of patients;
- Is integrated or has partnerships with other care sites, which may include, but not be limited to, acute care hospitals, long-term acute care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, home health agencies, ambulatory surgery centers, and hospices to provide the appropriate care setting for each patient's needs;
- Includes physicians who are the principal leaders of all clinical programs and medical care and share responsibilities for the non-clinical aspects of governance, administration, and management; and
- Assumes accountability for coordination across transitions in care.

**Quality Measurement and Improvement Activities**
The provider entity conducts quality measurement and improvement activities across sites of care and between patient visits to improve the health and outcomes of populations, including:
- Preventive care and chronic disease management for targeted groups of patients;
- Ongoing patient outreach programs, such as patient registries, to improve the health of those populations;
- Participation in continuous learning, such as collaboratives, and the conduct of benchmarking on utilization rates and patient outcomes with other peer groups;
- Use of research and/or other mechanisms, such as applied data analytics, to validate clinical process and outcomes data to determine effectiveness;
- External reporting and transparent internal reporting on clinical outcomes, variability, and timely performance improvements; and
- The conduct of patient experience surveys which would be made publicly available.

**Care Coordination**
The provider entity uses a team-based approach that supports collaboration and communication among the patient, physician, and licensed or certified medical professionals who are working at the top of their field across medical specialties and health care settings to improve the patient’s well-being. This activity shall include:
- A single plan of care across health care settings and across health care providers who furnish care to the patient; and
- Shared decision making which is a collaboration between the patient and health care provider that empowers the patient in the decision-making process; and provides the patient with objective information concerning: (1) the risk or seriousness of the disease or condition to be prevented or treated; (2) available treatment alternatives; and (3) the costs and benefits of available treatment alternatives.

**Use of Information Technology and Evidence-based Medicine**
The provider entity meaningfully uses interoperable information technology, scientific evidence, and comparative analytics to:
- Aid in clinical decision making and improve patient safety;
- Help monitor patients and track preventive services; and
- Aid in the prescribing of prescription drugs.

**Compensation Practices That Promote the Above-listed Objectives**
The provider entity uses compensation structures that provide incentives to physicians and licensed and certified medical professionals to improve the health and outcomes of populations. These compensation practices may include, but not be limited to, incentives that are affiliated with:
- Patient experience; or
- Quality metrics, such as chronic disease measures and prevention compliance within a physician’s managed population.

**Accountability**
The provider entity assumes shared financial and regulatory responsibility and accountability for successfully managing the per capita cost of health care, improving the overall patient experience, and improving the health of their respective populations.
Efficient Provision of Services
- Manage per capita cost of care
- Improve patient care experience
- Improve health of populations

Quality Measurement & Improvement Activities
- Preventive care & chronic disease management
- Patient outreach programs
- Continuous learning & benchmarking
- Research to validate clinical processes & outcomes
- External & transparent internal reporting
- Patient experience surveys

Compensation Practices
- Incentivize improved health & outcomes of populations
- Affiliate with patient experience or quality metrics

Accountability
- Shared financial & regulatory responsibility & accountability for efficient provision of services

Use of IT & Evidence-based Medicine
- Meaningfully use IT, scientific evidence, & comparative analytics
- Aid in clinical decision making
- Improve patient safety
- Aid in the prescribing of Rx

Care Coordination
- Team-based approach with team members working at the top of their field
- Single plan of care across settings & providers
- Shared decision making

Organized System of Care
- Continuum of care provided for populations
- Integrated or has partnerships
- Physicians as principal leaders of medical care
- Shared responsibility for non-clinical activities
- Accountable for care transitions

High-Performing Health System™