HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

INTEGRATION IN A REFORM ENVIRONMENT

STRATEGIES FOR SUCCESS

As the nation moves toward healthcare reform, collaboration among stakeholders across the care continuum, particularly between physicians and hospitals, will be critical. Learn key strategies for executing an effective integration strategy, based on findings from HFMA's 3rd-Annual Thought Leadership Retreat, interviews with key stakeholders, and discussions from HFMA's National Advisory Councils.

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Integration in a Reform Environment:
Strategies for Success
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MESSAGE FROM HFMA PRESIDENT AND CEO

DEAR COLLEAGUES:

As our nation moves toward healthcare reform, physician integration will be critical to hospitals' ability to drive evidence-based improvements in quality of care, reduce costs, and protect an organization's financial viability—skills that will be particularly important in a reform environment. During HFMA's September 2009 thought leadership retreat on payment reform, healthcare leaders from across the country identified physician integration as one of four key competencies that are essential to a healthcare organization's success under healthcare payment reform.

HFMA has identified seven key competencies that should be addressed in executing an effective integration strategy. Recently, HFMA interviewed representatives from 12 leading provider organizations to explore how these competencies can best be developed by healthcare organizations in a reform environment. This report addresses key strategies for promoting integration between hospitals and physicians—strategies that could help hospitals better position themselves for success on the cusp of major payment change.

HFMA would like to thank the healthcare leaders who contributed their insights on how providers can best execute an effective integration strategy. The action steps in this report will help hospitals better position themselves for success on the cusp of major payment change—and enhance their ability to meet the needs of the communities they serve.

Sincerely,

Richard L. Clarke, DHA, FHFMA
President and CEO
Healthcare Financial Management Association

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HFMA'S PAYMENT REFORM PROJECT

HFMA recognizes that changing the current healthcare payment system is key to achieving the nation's overall health goals of wellness, high-quality care, access to care and other societal benefit, and financial stability. In September 2007, HFMA held a retreat titled "Building a Better Payment System" to get input from a cross section of payment system stakeholders and identify principles that should guide changes to the current system. Arising from that retreat was the paper *Healthcare Payment Reform: From Principles to Action.* The paper identified the guiding principles of quality, alignment of incentives, fairness/sustainability, simplification, and societal benefit. The paper further identified a number of payment techniques that could support the principles and included feedback from industry stakeholder groups about how these techniques might be received in the industry.

In September 2008, HFMA brought together a group of healthcare executives to examine the actions that providers would need to take to support various approaches to payment reform and followed up that retreat with research to see how leading provider organizations are preparing for reform. The result was the paper *Healthcare Payment Reform: A Call to Action,* which shows the key competencies that provider organizations will need to succeed under payment reform that is emerging from the federal government and throughout the country.

HFMA's most recent healthcare payment reform retreat, "Payment Reform: Leading the Way to Change," held in September 2009, brought together healthcare executives from key provider organizations across the country to review HFMA's findings on payment reform and develop a consensus on general assumptions about the future of healthcare reform. A paper based on the discussions during this conference, *Healthcare Payment Reform: Accelerating Success,* was published by HFMA in March 2010.

In late 2009 and early 2010, HFMA interviewed healthcare leaders from 12 systems across the nation to gain insight on one of the key competencies identified as being critical to accelerating success under reform: integration. This paper is the result of those interviews as well as insights from HFMA's 2009 retreat on payment reform, discussions from HFMA's National Advisory Councils, and HFMA research.

HFMA will continue to help its members and others involved in healthcare finance to succeed as healthcare reforms designed to build a sustainable and effective health system are implemented.

Get project news, insights, and strategies at www.hfma.org/paymentreform.

EXECUTIVE SUMMARY

As the nation moves toward healthcare reform, one of the key strategies that healthcare providers should deploy to succeed in a reform environment is integration. Collaboration among stakeholders across the care continuum, especially between physicians and hospitals, will be critical.

Physician integration—which involves changes in core practices to produce better coordination and overall outcomes—requires a closer relationship among providers than does physician alignment—which involves contractual relationships, limited employment of needed specialties, joint ventures, and similar relationships. During the most recent thought leadership retreat on healthcare payment reform held by the Healthcare Financial Management Association (HFMA) in September 2009, integration was one of four key competencies identified by representatives from leading provider organizations as being critical to healthcare organizations' success under reform.

There is an art to achieving integration, collaboration, and engagement between hospitals and physicians. To break this art into its key components, HFMA has identified seven key competencies that should be addressed in executing an effective integration strategy.

Market awareness. A clear view of the market position of each of the component organizations involved in the integration process is essential. Having a clear view of a healthcare organization's market position involves more than just analyzing reams of market statistics.

Goal setting. Setting realistic goals based on a sound vision, organizational capabilities and an assessment of the organization's market and customer base is key to the success of an integrated organization. Aligned goals also facilitate process improvement. It is critical that these goals be translatable into concrete actions and measures.

Structure. The type of structure chosen for an integrated system should best complement the traits of the system's local market. Although the selection of a specific structure is not a sure determinant of success for an integrated system, it is critical to ensure that the structure that is chosen is a good fit with the organization's local market.

Physician leaders/champions. Developing key physician leaders/champions who have a high level of credibility with physicians and other providers will be critical to producing the changes necessary to create a sustainable healthcare industry, particularly in an era of reform.

Technology/data sharing. The development and sharing of credible data related to utilization, cost, and quality will be essential to making informed decisions on system composition, processes, and incentives.

Compensation/incentives. Hospitals should establish the right set of incentives to drive alignment with rank-and-file medical staff and mitigate revenue redistribution issues, particularly as the focus of care shifts from specialists to primary care physicians.

Engagement/cultural blending. Culture should be an important determinant of the type of integration structure adopted by an organization. Integrated systems should take these steps to shape a common culture that embraces high-quality, low-cost care.

To explore how healthcare organizations can best develop these seven competencies in a reform environment, HFMA interviewed representatives from 12 leading provider organizations. This white paper addresses key strategies these providers identified for promoting integration between hospitals and physicians—strategies that could help hospitals better position themselves for success on the cusp of major payment change.

Evidence shows that hospitals with a high degree of physician integration are better able to drive evidence-based improvements in quality of care, reduce costs, and protect an organization's financial viability. These skills will be particularly important in a reform environment.

Going forward, HFMA will continue to draw on the lessons learned from leading organizations to identify better practices related to the competencies of integration, pricing, risk management, and achieving value.

1. INTRODUCTION: THE IMPORTANCE OF INTEGRATION IN A REFORM ENVIRONMENT

As the nation moves forward toward healthcare reform, one key strategy that should be deployed by healthcare providers to succeed in a reform environment is clinical integration. Collaboration among stakeholders across the care continuum, especially between physicians and hospitals, will be critical.

Physician integration—which involves changes in core practices to produce better coordination and overall outcomes—requires a closer relationship among providers than does physician alignment—which involves contractual relationships, limited employment of needed specialties, joint ventures, and similar relationships. During the most recent thought leadership retreat on healthcare payment reform held by the Healthcare Financial Management Association (HFMA) in September 2009, "Payment Reform: Leading the Way to Change," integration was one of four key competencies identified by representatives from leading provider organizations as being critical to healthcare organizations' success under reform.

Evidence shows that hospitals with a high degree of physician integration are better able to drive evidence-based improvements in quality of care, reduce costs, and protect an organization's financial viability—skills that will be particularly important in a reform environment. Consider the following statistics.

Reduced costs. Total physician and hospital spending for patients in their last two years of life who received care in integrated delivery systems were 24 percent and 2 percent less, respectively, than spending for care in less-integrated settings (Sterns, J.B., "Quality, Efficiency, and Organizational Structure," *Journal of Health Care Finance,* Nov. 14, 2007).

Improved quality. Medical groups affiliated with a hospital, health plan, or health system were significantly more likely to score in the top quartile on care management and health promotion indices than were non-affiliated groups (Shortell, S.M., et al., "An Empirical Assessment of High-Performing Medical Groups: Results of a National Survey," *Medical Care Research and Review,* August 2005).

Enhanced financial health. Integrated health systems score better on a several indices of financial performance, including operating margin, productivity, and staffing per occupied bed, than organizations that are not part of integrated systems (Shortell, S.M., Gillies, R.R., and Anderson, D.A., "The New World of Managed Care: Creating Organized Systems," *Health Affairs,* Winter 1994).

The exhibit below shows that affiliated systems tend to have higher operating margins and return on total assets and lower ratios of FTEs to occupied beds than organizations that are not part of affiliated systems. Additionally, there are positive credit implications for hospitals that achieve true physician alignment, according to a recent report released by Moody's Investors Service (*Transforming Not-for-Profit Healthcare in the Era of Reform,* Moody's Investors Service, May 2010). (See the sidebar on page six for positive and negative credit implications of integration.)

However, today's hospitals face a number of barriers to true alignment with physicians, and many are approaching integration cautiously by employing physicians as a first step toward integration (*Transforming Not-for-Profit Healthcare in the Era of Reform,* Moody's Investors Service, May 2010). Healthcare leaders remember all too well the failed attempts of many hospitals to rush to integrate with physicians in the 1990s as a response to capitation. These organizations often struggled to make the arrangements work because the arrangements lacked strategic focus and the necessary management infrastructure. As a result, hospitals overpaid for physician practices that in many cases didn't contribute value to the core business goals of their organizations. Once these practices were purchased, organizations lacked the proper structures and processes to align economic incentives between hospitals and physicians, mitigate revenue redistribution between physicians, and foster the free flow of clinical and financial data. These problems in combination made it very difficult

COMPARING FINANCIAL INDICATORS OF AFFILIATED SYSTEMS AND NON-AFFILIATED ORGANIZATIONS

Operating Margin	2004	2005	2006	2007	2008
System	2.96	3.44	3.47	3.57	2.29
Non-System	1.83	2.29	2.41	2.12	0.72
Return on Total Assets	**2004**	**2005**	**2006**	**2007**	**2008**
System	4.22	4.82	4.94	5.23	3.07
Non-System	2.77	3.41	3.83	3.88	1.62
FTEs / Occupied Bed (CMI Adjusted)	**2004**	**2005**	**2006**	**2007**	**2008**
System	4.05	3.84	3.98	3.53	3.52
Non-System	4.06	4.03	3.98	3.92	3.95

Source: Almanac of Hospital Financial and Operating Indicators, 2010, Ingenix.

for healthcare systems to generate a positive financial impact from physician integration activities. In fact, most systems reported losing tens of thousands of dollars annually for each physician added to the system.

Other barriers to integration identified by participants in HFMA's 2009 thought leadership retreat include:

- Difference in cultures/lack of trust
- Different perspectives (physicians versus administrators)
- Technologies that are not interoperable
- Cost of implementing effective technologies to integrate decisions and care information
- Lack of capital
- Low community support/board support

There is an art to achieving integration, collaboration, and engagement between hospitals and physicians. To break this art into its key components, HFMA has identified seven key competencies that should be addressed in executing an effective integration strategy:

- Market awareness
- Goal setting
- Structure
- Physician leaders/champions
- Technology/data sharing
- Compensation/incentives
- Engagement/cultural blending

To explore how these seven competencies can best be developed by healthcare organizations in a reform environment, HFMA interviewed representatives from 12 leading provider organizations. This report addresses key strategies identified by these providers for promoting integration between hospitals and physicians—strategies that could help hospitals better position themselves for success on the cusp of major payment change.

CREDIT IMPLICATIONS OF PHYSICIAN ALIGNMENT

Positive credit factors include:

- Gains in market share and scale that lead to greater pricing leverage, moving the hospital toward the goal of being a "price setter" rather than a "price taker"
- Greater revenue recognition from strategies that focus on central business office functions
- Potential for substantial expense savings for larger systems through consolidation and centralization of support services
- Elimination or reduction of competition through acquisition
- Increase in outpatient revenues through outpatient growth strategies, which may have higher returns and margins

Negative factors include:

- Integration risk when merging different cultures or medical staffs
- Time lag between investment costs and revenue realization
- Costs associated with more investment in information systems to improve revenue cycle management
- Difficulty in sustaining revenue growth once the easier gains from internal processes are achieved

Source: Transforming Not-for-Profit Healthcare in the Era of Reform, Moody's Investors Service, May 2010.

2. KEY COMPETENCIES FOR INTEGRATION: TAKING A CLOSER LOOK

Payment reforms that shift the economic incentives in the reimbursement system from volume-based to value-based will require physicians and hospitals to successfully integrate. For hospitals to remain financially viable under this new payment paradigm, physician leadership for quality improvement efforts, such as projects to develop evidence-based standardized care protocols, will be critical. Additionally, physician participation in projects designed to increase the efficiency of hospitals will be essential to reducing the costs of providing care.

However, in spite of the advantages highly integrated organizations enjoy, they remain the exception rather than the rule. Although hospital ownership of medical groups increased by 25 percent from 2003 to 2008, it remains low at less than 20 percent (the Medical Group Management Association reports this figure at 10 percent ["Integrated Delivery Systems," *MGMA Connexion*, January 2010], while the U.S. Bureau of Labor Statistics estimates this figure at 19 percent [*Occupational Outlook Handbook 2010–11 Edition*]). Additionally, the prevalence of other vehicles that could serve as a step toward full integration has steadily decreased. In 2008, only 18 percent of hospitals had physician hospital organizations, down from 29 percent in 1998 (*TrendWatch Chartbook*, American Hospital Association, 2010).

As changes brought about by reform drive hospitals to integrate with physicians, it is important to understand the lessons of the 1990s—and to work toward developing key competencies that will support the success of integration initiatives today.

Both participants in HFMA's 2009 thought leadership retreat as well as representatives from leading healthcare organizations who were interviewed for this report agree: There is little debate about whether closer integration among providers is necessary. The imperative to increase quality and lower cost renders arguments to the contrary moot. But, for integration to be successful, incentives should be clearly aligned, and providers should enhance efficiency through efforts to reduce redundancy and waste. The key question is how to achieve the goals of integration.

During interviews with representatives from leading healthcare organizations, the following strategies were identified as critical to a hospital's efforts to more closely integrate with physicians.

Market awareness. A clear view of the market position of each of the component organizations involved in the integration process is essential. The healthcare marketplace involves complicated interactions of stakeholders across the entire spectrum: patients, physicians, insurers, employers, and government. All of these stakeholders have their own points of view regarding the value that an integrated system brings to the market.

Having a clear view of a healthcare organization's market position involves more than just analyzing reams of market statistics. These data are only the starting point for understanding the needs and wants of customers. Other key questions to answer include:

- Who are your customers, and what do they need/want/prefer?
- How well do we satisfy customers versus our competitors?
- Which customer segment(s) should you target?
- How will our game-changers impact competitors and other external constituencies?
- How is our organization perceived by the segment's constituents?
- What externalities are shaping the demand for services in your market?

Answering these key questions can give organizations a powerful view of the nature of their markets. One key tool to use is a behavioral segmentation analysis. This tool can help clarify the customers in the market and provide a clear view of the types of customers the organization should focus on and how to get there.

Organizations should determine which market data and measures are most indicative of trends in the primary and secondary markets of the organization. This decision making on which measures represent the "critical few" is essential to avoid data overload and maintain the focus of the organization's managerial bandwidth. These key indicators should be selected recognizing the specific market condition and market position of the organization. Once this market view is established, strategies should be developed to produce actions in response to market needs—and to monitor the deployment of these strategies. These strategies might include starting a new service line, dropping an existing service, acquisition of a physician practice, changing a marketing focus, or opening negotiations with a payer.

One question HFMA posed to the healthcare leaders who were interviewed for this report was whether their organizations' market awareness came from a "bottoms-up" approach, with knowledge flowing to senior leaders through the organizations' component entities, or whether market data were captured through a "top-down" approach, with centralized staff responsible for developing market

SAMPLE CUSTOMER SEGMENTATION

	Cardiac High Touch	Cardiac Service Follow Up & Follow Through	Cardiac Rate Sensitive	Cardiac High Tech
Characteristics	• Focus on nursing care and other non-clinical services • Little info on medical care • 40% Medicare	• Follow recommendations of primary care physicians • Service to referring physicians critical	• High deductible plans or uninsured • Need clinical decision support tools	• Look for market leading technology and practitioners • Well informed on medical care issues • Ages 50 to 65
VOC	**"I want to be well cared for"** • Nursing care • Quality of food • Comfort of room and bed	**"I want to know what is happening with my patients"** • Service, billing & collection excellence • Program dashboards	**"The lowest rates get you volume"** • Shop for best rate • Need transparency on prices	**"I'll choose my provider based on best performance and technology"** • High-tech approaches • Review quality stats
Solutions	• Dedicated unit • Room comfort program • Six Sigma projects on nursing care issues	• Use clinical systems to tighten linkages to referring physicians • Six Sigma projects to improve processes	• Review and publish rates • Provide information on clinical efficacy	• Monitor clinical quality indicators • Invest in technology

Source: Healthcare Payment Reform: From Principles to Action, Healthcare Financial Management Association, 2008.

intelligence and driving action. The responses indicated that both approaches were used by the health systems and that the CFOs were equally satisfied with the results. Neither approach was considered to be predominant.

During interviews, one integrated health system stood out for taking action to align its structure to the market. The system is located in a relatively rural setting, with little prospect for future population growth, low growth in demand for services offered by the system, and difficulties attracting physicians to the market area. With this market assessment in mind—and also, given the likely path of future reimbursement methodologies—the organization has embarked on a transition to a clinic-based model that calls for employment of its physician base. This tactic will allow the health system to recruit the right mix of physicians to the area and to align tightly with physicians to increase quality and lower costs. With this position as a high quality/low cost provider of services, the system is trying to secure managed care contracts that would appropriately compensate them for the investment in these services.

Goal setting. Another key to success as an integrated organization is setting realistic goals based on a sound vision, organizational capabilities and an assessment of the organization's market and customer base. It is critical that these goals be translatable into concrete actions and measures.

Goal setting and performance monitoring provide the roadmap and feedback that is crucial for improving the value of care delivered by healthcare organizations. Without tightly aligned goals and clearly defined performance metrics, it is unlikely that physicians and hospitals will have the common motivation and information they need to work together to improve the quality and efficiency of the care they deliver.

As noted in our prior white papers on payment reform, HFMA believes that highly centralized organizational structures often are able to set common goals that effectively align physician and hospital objectives around performance improvement. Culturally, aligned goals create a common cause that both hospital administrators and physicians can rally around. Aligned goals also facilitate process improvement. Component hospitals that show strong performance against a given metric can share their knowledge with the organization as a whole, speeding improvements across the system.

In an ideal model, broad improvement mandates are established by the organization's executive team with substantial involvement and oversight from the board of directors. In a multi-hospital system, these mandates are then passed down to the system's component facilities. Individual component organizations are then given the

flexibility to set their goals and develop an execution plan in a manner that reflect both the broader organization's objectives and conditions in the local market. In a single hospital that is seeking stronger alignment with physicians, the lines of communication may be simpler, but the importance of ensuring that the goals are widely communicated and well understood by all stakeholders is no less critical.

To balance this delicate tension and create the disciplined learning environment that drives performance improvement, many of the organizations interviewed by HFMA use the goal setting and monitoring principles similar to those embedded in General Electric's (GE's) strategic planning process. GE's planning cycle involves an annual analysis, now dubbed the Growth Playbook, that includes detailed analyses of trends in the marketplace, customer problems, the company's market position and product mix, and competitor intelligence. Based on this annual analysis, GE develops detailed operating and strategic plans for achieving business growth goals, deciding whether growth targets are to be achieved through organic expansion of the existing lines, development of new products and services, or acquisition of another company. This provides a clear roadmap to achieving the growth targets set by the company, and allows performance against these goals to be monitored easily and clearly.

DEVELOPING KEY PHYSICIAN LEADERS/ CHAMPIONS WHO HAVE A HIGH LEVEL OF CREDIBILITY WITH PHYSICIANS AND OTHER PROVIDERS WILL BE CRITICAL.

As goals based on the organization's strategic plan are communicated, leaders should partner with physicians to translate the goals to determine what is "uncomfortable but achievable," as one healthcare leader who was interviewed stated. Special attention will need to be paid to the time frame for achieving short-term and long-term goals, particularly as incentives embedded in physician and hospital payment systems move from volume-based to value-based. This shift will not occur overnight, nor will it occur at the same time in all healthcare markets. Management teams will need to monitor the organization's goals to ensure that the organization's goals and the time frame for achieving goals is appropriate as the reimbursement environment evolves.

One large system that was interviewed has set clearly established goals for clinical integration. The organization's goal begins with a clear definition of clinical integration as "a structured collaboration among … physicians and … hospitals on an active and ongoing program designed to improve the quality and efficiency of health care. Joint contracting with fee-for service managed care organizations is a necessary component of this program in order to accelerate these improvements in health care delivery." This goal has been translated into a set of strategies around clinical integration, including optimization of clinical outcomes, enhancing the patient experience, creating a culture of committed physicians, and funding. Then, specific clinical integration measures upon which everyone within the organization is evaluated were developed based on the strategic focus areas for the organization. Thus, the goal setting process has been a powerful unifying force for the integrated system.

Physician leaders/champions. Developing key physician leaders/champions who have a high level of credibility with physicians and other providers will be critical to producing the changes necessary to create a sustainable healthcare industry, particularly in an era of reform. But what makes a "credible leader" credible? And how can healthcare organizations foster effective physician leadership?

Healthcare leaders have long understood that activities that improve quality and reduce cost sustainably require effective physician leadership, which is why physician/hospital integration is crucial in the face of healthcare reform. As one of the CFOs interviewed by HFMA stated, "It's hard for me to tell a physician that his quality is lacking or that his costs are higher when compared with his peers. However, if one of the physician's colleagues who understands the business carries that message to the physician, real change can be effected."

Effective physician leadership has three prerequisites. First, organizations should ensure they have the right types of physicians placed throughout the organization. Then, they should select a compensation structure for employed physicians, and appropriate payment to non-employed physicians for non-clinical services, that is aligned with the outcomes the organization is trying to achieve. Finally, a management infrastructure should be established that allows physician leaders to engage with clinicians and staff to proactively improve quality and enhance efficiency throughout the organization.

Across the nation, healthcare organizations are trying to increase the numbers of physician leaders at all levels. Many of the systems HFMA spoke with are actively working to ensure that each component facility has a chief medical officer who is a key contributing member of the executive team. A similar effort is underway at the service-line level within these facilities. Effective physician leaders at lower levels in the organization are crucial to improvement efforts as they not only serve as examples for peers, but also can

actively coach underperformers and drive adoption of recognized best practices. Additionally, many organizations are using leadership positions at the department and service-line level to prepare physicians for senior leadership roles. However, success in both driving change and grooming the next generation of senior leadership depends on having the right raw talent.

How can healthcare organizations identify potential physician leaders? It's important to look for physicians who understand that the current healthcare model is unsustainable and believe hospitals need to focus on improving the value of care delivered. Those interviewed for this report also stressed the need for these physicians to have strong leadership, communications, and collaboration skills as well as an "intellectual interest" in the administrative challenges of running a hospital. One healthcare system that has developed a particularly strong framework for developing physician leaders looked for physicians who:

- Are many years from retirement
- Possess an ability to use data and integrate it into performance improvement strategies
- Have credibility with their colleagues (many organizations require physicians leaders at all levels to maintain a clinical schedule—albeit a reduced clinical schedule—in addition to administrative duties)
- Possess the "soft skills" necessary to successfully execute policy

There was no clear consensus on whether it was better to hire physician leaders into the organization or develop them in-house, as both approaches have advantages. Hiring externally allows the organization to tap into new ideas and experiences, while homegrown leaders possess a deep understanding of a hospital's operations and issues. Many hospitals and health systems are recruiting physician leaders both inside and outside their organizations due to the sheer number of leadership roles they need to fill.

Once physician leadership roles are filled, several of the organizations interviewed by HFMA invest significant resources in continuing development activities. Some, like Spectrum Health in Grand Rapids, Mich., choose to do this in-house during two-day "boot camps" where a cross-functional team of hospital executives guides physicians through case-studies based on real situations from across the health system. Other organizations interviewed provide their physician leaders with external opportunities for development, such as the opportunity to take part in GE's healthcare fellowship program.

However, although developing a base of physician leaders with the right characteristics is necessary to achieve integration, strong physician leadership alone is not sufficient to drive the alignment necessary to improve the value of care provided by an organization. The right environment needs to be cultivated as well.

Technology/data sharing. It is frequently said what gets measured gets done. The development and sharing of credible data related to utilization, cost, and quality will be essential to making informed decisions on system composition, processes, and incentives.

Key questions to ask include the following:

- In relation to the goals discussed earlier, what data are necessary to build an effective integrated relationship?
- What are the barriers to obtaining and sharing this information?
- What standards or benchmarks will be used?
- How will the data be used to foster effective discussions and transform data in knowledge that will be useful to the integrated entity?

Once goals are established at all levels, metrics that best measure progress should be identified. Generally, using nationally agreed upon metrics and definitions will aid an organization in making comparisons with other organizations. A clear definition of the metric should be established at the outset to minimize confusion and foster understanding among all stakeholders. To make the data easily accessible, a common dashboard or scorecard should be created to present the data in a consistent fashion that can be readily recognized and used by anyone in the organization.

Each function or department that contributes toward attainment of goals should have specific, measurable targets. For each given function, process, or department, one individual who is well respected in the given area should be charged with ensuring that all targets are met. Performance should be reviewed frequently to determine the effectiveness of strategies and tactics employed to achieve the organization's goals. At Cleveland Clinic, the organization's CEO, CFO, COO, chief medical officer, and director of human resources meet weekly to conduct this review. A similar meeting occurs at each level of the organization, with staff who represent various functions and departments taking part.

Compensation/incentives. Even with strong physician leadership, hospitals should establish the right set of incentives to drive alignment with rank-and-file medical staff and mitigate revenue redistribution issues, particularly as the focus of care shifts from specialists to primary care physicians.

Compensation policies and economic incentives are powerful tools that can be employed to align incentives

and foster change. But how can healthcare organizations establish integrated goals amenable to compensation/economic incentives? And how should organizations tailor compensation/economic incentives to stakeholders and ensure that major goals are accomplished?

Although the compensation methods used by organizations whose leaders were interviewed for this report varied, almost all of the participants we interviewed were moving to a relative value unit (RVU)-based compensation packaged that included a performance bonus based on metrics that are weighted to reflect strategic priorities. Common priorities included quality/outcome improvement, cost efficiency, financial performance, patient satisfaction, and organizational "citizenship." Although the bonuses for any individual metric group may only account for a small percentage of compensation, those interviewed by HFMA believe these bonuses are strong motivators for physicians.

One of the systems interviewed had a very detailed bonus compensation structure that was well aligned with the organization's goals of increasing quality and efficiency. The program utilized 116 measures, which included metrics in the areas of clinical effectiveness, efficiency, utilization of technology, patient safety, and patient experience. The breadth of the metrics used by this organization is of particular interest, since they extend well beyond basic productivity. These measures were converted into a physician-specific score that was used to determine annual bonus payments. The incentive funds were divided into two separate pools, with 30 percent of funds allocated to the physician practice groups and 70 percent allocated for direct distribution to the physicians. The group portion was allocated to the physicians practicing in the group based on three performance driven tiers. These incentives have proven successful in driving major improvement in quality and efficiency across the system.

Additionally, the organizations interviewed by HFMA for this report are compensating both their employed and community physicians for non-productive but value-added work, such as participation in performance improvement projects. For these activities, employed physicians receive an hourly rate based on historical productivity. Compensation for community physicians is developed using available benchmarks for each specialty.

Physician alignment with the hospital's value improvement goals requires a conducive environment to occur. Even with this type of environment in place, performance improvement doesn't occur in a vacuum. Management infrastructure should be developed to provide the consistent feedback necessary to guide the organization's efforts. An effective management infrastructure is actually a "three-legged stool." Its legs consist of technology, shared information that is generated from collected data and packaged in an easy to use fashion, and business support staff that help physicians understand and effectively use the information to improve performance.

The technology component of an effective management infrastructure requires an electronic health record (EHR) that is implemented across the organization in a manner that allows for fast and flexible querying. An EHR system provides the foundation for performance improvement by collecting patient care data, facilitating care coordination, and hardwiring clinical protocols into the system. Physicians should be heavily involved in the design and implementation of an organization's EHR system and the clinical protocols that are embedded into it. To drive adoption of EHR systems among medical staff, physician training is critical. Bon Secours Richmond Health System, based in Richmond, Va., suggests that physician training

SAMPLE COMPENSATION STRUCTURES USED BY ORGANIZATIONS INTERVIEWED

System 1

Base: 65 percent of Medical Group Management Association benchmarks

Bonus/Other: Up to 20 percent available

- Driven by scorecards based on financial results, quality, volume, and patient satisfaction
- A second-tier bonus available based on volume, but is capped to minimize inappropriate utilization

System 2

Base: 80 percent based on RVUs

Bonus/Other: Up to 20 percent available

- Driven by scorecards based on quality (40 percent), innovation (10 percent), talent development (10 percent), growth (15 percent), and financial performance (25 percent)
- The organization creates a pool of funds to offset lost specialist revenue due to decreased utilization of services resulting from improved primary and preventative care

System 3

Base: Compensation 100 percent base salary

Bonus/Other: No bonus

- All physicians receive a one-year appointment
- An annual evaluation process determines whether the appointment is renewed
- Tenured department heads have been removed

be flexible and convenient to maximize participation. To reinforce learning and minimize frustration with the EHR system once it was implemented, Bon Secours also developed physician "super users" who were readily available to provide support for their peers during the first month after the system went live.

But capturing the data in an EHR alone is not sufficient to drive performance improvement. Advanced clinical and financial decision support tools are necessary to transform raw data into information that can guide quality and efficiency improvement decisions. Cleveland Clinic's business intelligence system features feeds that are updated every 30 minutes, allowing easy access to organizationwide information on items such as transfers and supply utilization. These continual updates allow for real-time performance monitoring and management.

As healthcare reform gets underway, the need for more advanced financial decision support systems also will increase. The financial decision support systems currently used by many healthcare organizations are insufficient, those interviewed told HFMA, and provide insufficient flexibility and detail to manage financial performance under value-based reimbursement systems to be adopted under payment reform. As the nation moves toward value-based reimbursement, the ability to "micro cost" specific components of healthcare services and use the data to determine metrics such as per-member/per-month cost will be necessary to manage performance.

Organizations interviewed by HFMA combine clinical and financial information to identify opportunities for improvement within the hospital. However, for improvement to occur, the information must be trusted by physicians and easy for them to use.

Credible data also are necessary to drive process improvement. "Every meeting will be about the data until the physicians have faith in the data," one healthcare leader told HFMA. "Only once you clear that hurdle can progress be made." Although finance doesn't create the raw data, the finance department is widely viewed by clinicians as the keeper of data. As such, it is finance's responsibility to work collaboratively with physicians to frequently review the raw data feed. When errors are identified, it is important for finance professionals and other healthcare leaders to acknowledge the errors and quickly correct mistakes. Doing so will preserve the credibility of the data—a prerequisite for the information to be useful for the organization.

LEADING ORGANIZATIONS ARE PAIRING PHYSICIAN LEADERS WITH BUSINESS LEADERS TO CO-MANAGE DEPARTMENTS OR SERVICE LINES.

Data that hold the highest interest for physicians and that are likely to drive improvement meet three criteria.

- The data must be aligned with performance improvement goals and targeted at the appropriate level of the organization. For example, Catholic Healthcare West, which has hospitals in California, Arizona, and Nevada, provides metrics on quality, variation, and financial performance that are customized to meet the needs of specific specialties and service lines. The data can be provided at the physician level for individual performance benchmarking or can be used for analysis at any level of the organization.
- The data must be provided in a timely fashion. Most organizations are refreshing their data on a monthly basis and providing scorecards to physicians quarterly. However, the healthcare leaders interviewed for this report widely acknowledged that quarterly scorecards are not sufficient. "The problem with quarterly reporting is that as physicians make adjustments to the way in which they practice, they want the instant gratification of seeing improvement and identifying new opportunities," one interviewee commented. To accommodate this need, many of the organizations represented in this report are planning to provide physicians with monthly performance data.
- The data must be presented in a concise format that is clearly explained and easily understood. Additionally, physicians must have immediate access to a resource person who can answer questions about the data and discuss strategies for improving quality and cost efficiency. This capability requires a dedicated business support staff.

To provide this type of support, leading organizations are pairing physician leaders with business leaders to co-manage the operations of a department, service line, hospital, or health system. This arrangement alleviates the need to find physician leaders who also have masters degrees in business administration or healthcare administration while ensuring that each department has the financial expertise and analytical and decision support capabilities required to drive performance improvement.

Engagement/cultural blending. The CFOs interviewed for this report frequently cited culture as an important determinant of the structures they have ultimately adopted. The concept of a prevailing local healthcare culture or prevailing set of practices is coming under more scrutiny, whether in Atul Gawande's article "The Cost Conundrum" (*The New Yorker,* June 1, 2009), which describes a regional propensity for physician ownership of healthcare facilities and high-tech care in McAllen, Texas, one of the most

expensive healthcare markets in the nation, or the focus on culture during the "How Do They Do That? Low-Cost, High-Quality Health Care in America" conference sponsored by the Institute for Healthcare Improvement, The Brookings Institution, The Dartmouth Institute, and others. Deliberations at the 2010 conference were primarily focused on the role of culture and "collective community sense" in determining cost and quality performance in the local markets represented.

How can integrated systems shape a common culture that embraces high-quality, low-cost care? One of the healthcare leaders interviewed pointed to the importance of consistency of application of system goals across all parts of the organization, both clinical and non-clinical. As the organization where this leader works has moved toward integration, it has shaped a cadre of non-clinical leaders who can adopt an integrated view rather than work as adversaries with physicians. Similarly, the ability of clinical leaders to embrace the collaborative model is an important component in determining whether these professionals will have a leadership role in the integrated system.

The power of a strong brand also was cited as a benefit in the transition toward integration. Those systems with very strong brand identities—in most cases, strong cultural traditions for high-quality patient care and innovations in teaching and research—reported that they found it easier to be more tightly engaged with new clinical and non-clinical staff. As one CFO expressed, "The concept of putting the patient first is at the center of everything we do." This is an easy concept to grasp and rally around—and it is this type of simple, overarching theme that tends to unify every member of an organization and builds a shared sense of culture.

Finally, a close partnership between members of the executive team, with the whole group strongly embracing the shared goals of the organization, was found to be effective in leading an organization toward integration. As Albert Schweitzer, MD, a physician, theologian, missionary, and humanitarian, once said, "Example is not the main thing in influencing others. It is the only thing." The ability of senior leaders to lead by example and collaborate well with others throughout the organization appears to be a bigger key to system success than unique management structures. The reporting relationships described by the organizations interviewed by HFMA generally traditional in terms of the hierarchy of the organization and the way in which departments are organized. This reinforces the importance of selecting leaders based on performance and fit with the cultural values of the system. It also demonstrates the importance of a collaborative spirit among leaders in the organization.

KEY STRATEGIES FOR SUCCESSFUL INTEGRATION: A CHECKLIST

Market awareness. A clear view of the market position of each of the component organizations involved in the integration process is essential. Having a clear view of a healthcare organization's market position involves more than just analyzing reams of market statistics. Key questions to answer include:

- Who are your customers, and what do they need/want/prefer?
- How well do we satisfy customers versus our competitors?
- Which customer segment(s) should you target?
- How will our game-changers impact competitors and other external constituencies?
- How is our organization perceived by the segment's constituents?
- What externalities are shaping the demand for services in your market?

A behavioral segmentation analysis can help hospitals clarify the customers in the market and provide a clear view of the types of customers the organization should focus on.

Goal setting. Setting realistic goals based on a sound vision, organizational capabilities, and an assessment of the organization's market and customer base is key to the success of an integrated organization. Aligned goals also facilitate process improvement. It is critical that these goals be translatable into concrete actions and measures.

- Set common goals that effectively align physician and hospital objectives around performance improvement.
- Share successes in component hospitals with the system as a whole. Doing so will speed improvements across the system.
- Ensure that broad improvement mandates are established by the organization's executive team, with substantial involvement and oversight from the board of directors. Then, give component organizations the flexibility to set their goals and develop an execution plan in a manner that reflect both the broader organization's objectives and conditions in the local market.

(Continued)

KEY STRATEGIES FOR SUCCESSFUL INTEGRATION: A CHECKLIST *(continued)*

Structure. The type of structure chosen for an integrated system should best complement the traits of the system's local market. Although the selection of a specific structure is not a sure determinant of success for an integrated system, it is critical to ensure that the structure that is chosen is a good fit with the organization's local market.

- Maintain a high level of centralized control over management and financial decision making.
- Be mindful of the speed of change.
- Understand and communicate the impact that these changes will have on all of the organization's key stakeholders.
- Consider how vital management functions will be established and maintained as the system is integrated.

Physician leaders/champions. Developing key physician leaders/champions who have a high level of credibility with physicians and other providers will be critical to producing the changes necessary to create a sustainable healthcare industry, particularly in an era of reform.

- To identify potential physician leaders, look for physicians who understand that the current healthcare model is unsustainable and believe hospitals need to focus on improving the value of care delivered.
- Develop leaders who have an "intellectual interest" in the administrative challenges of running a hospital.
- Potential physician leaders also should:
  - Be many years from retirement
  - Possess an ability to use data and integrate it into performance improvement strategies
  - Have credibility with their colleagues
  - Possess the "soft skills" necessary to successfully execute policy

Technology/data sharing. The development and sharing of credible data related to utilization, cost, and quality will be essential to making informed decisions on system composition, processes, and incentives.

- Each function or department that contributes toward attainment of goals should have specific, measurable targets.
- For each given function, process, or department, one individual who is well respected in the area should be charged with ensuring that all targets are met.
- Performance should be reviewed frequently to determine the effectiveness of strategies and tactics employed to achieve the organization's goals.

Compensation/incentives. Hospitals should establish the right set of incentives to drive alignment with rank-and-file medical staff and mitigate revenue redistribution issues, particularly as the focus of care shifts from specialists to primary care physicians.

- Consider a relative value unit-based compensation packaged that included a performance bonus based on metrics that are weighted to reflect strategic priorities.
- Also consider compensating physicians for non-productive but value-added work, such as participation in performance improvement projects.
- Provide credible data to physicians in a concise format that is clearly explained, timely, and easily understood. These data should be aligned with performance improvement goals and targeted at the appropriate level of the organization.
- Pair physician leaders with business leaders to co-manage the operations of a department, service line, hospital, or health system.

Engagement/cultural blending. Culture should be an important determinant of the type of integration structure adopted by an organization. Integrated systems should take these steps to shape a common culture that embraces high-quality, low-cost care.

- Apply system goals consistently across all areas of the organization, both clinical and non-clinical.
- Develop a cadre of clinical and non-clinical leaders who can adopt an integrated, collaborative view in working with physicians.
- Create a strong brand identity for the organization with a theme that is easy for every member of the organization to grasp and rally around (such as putting the patient first in all that the organization does). Doing so will help to build a shared sense of culture.
- Encourage a close partnership between members of the executive team, with all members embracing the shared goals of the organization.

3. STRUCTURING AN INTEGRATED HEALTHCARE SYSTEM

In the article "Creating Accountable Care Organizations: The Extended Hospital Medical Staff" (Fisher, E., et al., *Health Affairs,* Dec. 5, 2006), the authors summarize the need for physician-hospital integration as follows: "Many of the deficiencies in U.S. health care are reflections of the disjointed and poorly coordinated care that patients receive as they move across settings and among providers: more frequent and flawed care transitions, failures of communication, and errors. Current organizational forms, payment methods, and regulatory and quality assessment systems reinforce this fragmented system. Because most patients receive their care within the context of a local delivery system comprising physicians and the hospital where they work, the hospital and its extended medical staff provide a natural organizational setting within which to improve the overall experience of care. Policy initiatives should be judged at least in part on the degree to which they strengthen accountability and collaboration at the level of the hospital and its medical staff."

Studies have shown that the "local delivery systems" the authors refer to in this article are as varied as the markets that these systems serve. The consensus of the thought leaders at HFMA's 2009 retreat "Payment Reform: Leading the Way to Change" is that there is no predominate integration structure being put into place by healthcare organizations. Rather, providers are adopting structures that best complement the traits of their local markets. This assertion was borne out in interviews with some of the leading integrated systems in the country. Although it appears that the selection of a specific structure is not a sure determinant of success for an integrated system, it is critical to ensure that the structure that is chosen is a good fit with the organization's local market.

Virtually all of the healthcare leaders who were interviewed by HFMA indicated that their organizations have a high level of centralized control over management and financial decision making. As one CFO expressed, "Our administrative office functions as a management company, not a holding company." This stands in contrast to the integration experiences of healthcare organizations in the 1990s, when many of the integrated systems were formed as loosely affiliated groups of operating entities. Although the approach avoided the difficult work of integration, such as combining cultures and reducing redundant governance structures, it also presented challenges in achieving cost savings and improving quality of care, since the component organizations were free to pursue their own strategies. Today, even those systems that had initially begun as loosely affiliated systems are transitioning toward tighter control, with nearly all of the leaders of integrated organizations who were interviewed indicating centralizations of major management functions and extensive utilization of shared services.

Of the organizations that were studied for this report, one in particular demonstrates the importance of market forces in determining the right structure for integration. This organization appears to have the most distributed control and management structure of those studied, and describes itself as "a loose federation of hospitals" rather than a highly integrated healthcare system. The health system's CFO attributes this structure to the lack of competition in the health system's local markets, resulting in significant market power accruing to its component organizations. The CFO estimates that it may take as long as 10 years for the healthcare organization to evolve into a more tightly integrated system, but speculated that significant changes to the nation's payment system or other major changes in financial performance could accelerate such change.

Others who were interviewed by HFMA agreed that the pace of integration could be heightened by changes to the nation's payment system or declines in an organization's financial performance, with many citing poor financial conditions as the "common cause" around which both physicians and hospitals could rally.

Among the organizations studied for this report, the approach to physician-hospital structures was split: Nearly half of the organizations indicated that they had adopted physician-lead clinic structures, with the remainder employing some physicians in key roles, but also relying on community physicians for support. Many of the systems that are using a clinic model structure have long histories and strong brand recognition; their use of the clinic structure is a significant component of their strength and their ability to innovate. It remains to be seen whether integrated systems can choose to adopt a physician-lead clinic structure and move rapidly toward implementation to create the level of strong alignment and collaboration that will be necessary to ensure future success.

One hospital studied by HFMA for this report has chosen to pursue implementation of a physician-lead clinic structure. This hospital has a clearly articulated plan that is

based on its view of trends in their market as well as the long-term evolution of payment systems and healthcare reform. A significant aspect of this hospital's plan focuses on employing the "right" mix of physicians, which for this organization means a heavy emphasis on primary care physicians. The hospital's CFO describes this approach as "putting primary care physicians at the front of the bus and having a well-oiled managed care machine that only refers patients to specialists when patients truly need a more specialized level of care."

The hospital's focus on primary care does present unique challenges for the organization, since hospital revenues are likely to decline as hospitalizations for ambulatory sensitive conditions are avoided. Also, since payment systems at the local and national level have not fully evolved to reflect this shift to a primary care focus, systemwide revenues may be soft as well. Specialty care physicians in the community are also likely to oppose this transition, since their volumes may soften due to enhanced coordination of primary care services.

How is the hospital mitigating these challenges? First, it is developing a shared culture that embraces the vision the hospital has for its integrated system. For this hospital, a shared culture begins with a board that is committed to the transition toward integration and a close-knit team of senior leaders who can effectively shape and communicate the system's vision and values. Physicians and hospital personnel alike are expected to demonstrate these values in their work if they are to continue working with the hospital. To ease the impact of shifts in revenue for its medical staff, the hospital has committed to sheltering the physicians as much as possible from the initial financial impacts of system formation and to transition from "bottoms up" goal setting to corporate-defined goals over a three-year period. The organization's compensation structures also include significant use of bonus payments based on demonstrated alignment with and execution of the organization's goals. Finally, the hospital is working with national and local payers to negotiate new contracts that will better align with the hospital's new focus on primary care. It remains to be seen whether this multipronged approach will prove successful in providing the level of alignment and collaboration needed for future success, but it appears to be a promising framework.

The process of transforming models of physician-hospital integration is not without significant risks. The experience of Alegent Health, based in Omaha, in attempting to transform its physician-hospital model is very instructive. During the course of Alegent Health's transformation toward a more employment-centric integration model, relations soured between the system and independent physicians. These relations reached a low point in October 2009, culminating in a vote of no confidence in and subsequent resignation of Wayne Sensor, the CEO of Alegent Health.

In an interview with *HealthLeaders* magazine, Sensor stated, "Our physicians didn't necessarily feel a need for the change (to an employed model) in that reimbursement hasn't largely changed, and that provides great understanding of where they're coming from. That said, they largely supported that vision, but they have to understand what that means when the rubber hits the road. If you're affecting physicians' practice of medicine and, in some cases, incomes, that creates tremendous tension and anxiety" ("Lessons from Wayne Sensor's Fall at Alegent Health," Oct. 30, 2009). Some of the key lessons shared by Sensor include being mindful of the speed of change, creating a sense of urgency to change even if the market forces have yet to materialize, and understanding and communicating the impact that these changes will have on all of the organization's key stakeholders.

THE PROCESS OF TRANSFORMING MODELS OF PHYSICIAN-HOSPITAL INTEGRATION IS NOT WITHOUT SIGNIFICANT RISKS.

Whether to consolidate multiple fiduciary boards during the process of integration also is an important issue for healthcare organizations to consider. It is easy to assume that having independent directors at the component level would add to the complexity of coming to a consensus on strategic and tactical plans for the integrated system as a whole. The majority of systems studied by HFMA for this report had consolidated their boards to a single entity or had maintained separate board structures that incorporated overlapping directors who served on more than one of the boards. The latter approach reduces the total number of directors involved in board planning and oversight functions and streamlines decision making.

On the flip side of this approach, one could argue that centralizing board structures severs an important link between the component organizations and the communities they serve. This is an important concern that needs to be taken into account by the centralized governance and management structures of the integrated system. For example, the presence of community leaders on boards of local hospitals has long been an important part of helping to establish these hospitals' vital roles in their communities. The community presence of a local hospital is important to activities as diverse as philanthropic fund raising, securing

a line of credit at the local bank, and ensuring the success of volunteer programs at the hospital. Integrated systems may need to implement focused community outreach programs to maintain the important link between providers and the communities they serve.

How does the consolidation of multiple fiduciary boards take place? HFMA discussed this issue at length with one large integrated system. The impetus for integration at this organization was the need for a financial turnaround among a loosely affiliated set of component organizations. A new senior leadership team was brought in to improve performance. The new senior leaders soon realized that the presence of boards of directors at each of the component organizations would significantly impede the speed at which the turnaround could be accomplished. With that in mind, these leaders set about collapsing the board structure at each of the component organizations. Ultimately, the system consolidated 10 independent boards into a single, systemwide board within 21 months. According to the CFO for this system, the speed at which the organization's senior leadership team set about achieving this goal was one of the primary reasons for its success in consolidating the board structure, as the rapid pace of change did not allow time for opposition to coalesce around this issue.

IT IS IMPORTANT TO CONSIDER HOW VITAL MANAGEMENT FUNCTIONS WILL BE ESTABLISHED AND MAINTAINED AS THE SYSTEM IS INTEGRATED.

This organization's strategy sounds remarkably similar to a classic turnaround scenario where long-term structural change must be balanced with short-term "wins" to ensure that everyone stays engaged with the process and moves toward the common goals. Clearly, the poor financial performance of the organization was a significant rallying point for everyone within the organization, and senior leaders used their mandate to improve performance in wielding significant power to consolidate and strengthen the level of integration.

In adopting an integrated delivery approach, it is also important to consider how vital management functions will be established and maintained as the system is integrated. In smaller systems without broad geographic dispersion, the maintenance of these efforts may be quite easy, but such maintenance becomes geometrically more difficult as the system grows and spreads. Intimate knowledge of the market may be lost as senior leadership is consolidated, and significantly more resources may need to be expended in ensuring compliance with the system's goals and values.

For example, one integrated system studied by HFMA for this report adopted a fairly rigorous planning, goal setting, and monitoring approach to address the problems caused by growth of the integrated system and the size of the system. This organization's approach is not unlike that of an industrial company, where some planning and goal setting is done at the component level and business plans are presented to corporate leadership on an annual basis. Planning at the component-entity level for this system is completed within frameworks for profitability, capital spending, quality, and other measures set at the corporate level. Corporate leaders review each component organization's business plans, challenge assumptions, and approve or modify the goals and budgets contained in the plan. These plans are then presented to and approved by the system's board of directors on a consolidated basis. This approach—not unlike the highly praised planning cycle and management calendar used by GE—ensures maximum utilization of talent and market knowledge at the component level, provides an annual forum for discussion of markets and performance, and establishes an ideal framework for monitoring ongoing performance against business goals.

None of the system leaders interviewed by HFMA for this report mentioned significant regulatory barriers that have impeded their organizations' development or are stifling future growth or structures. There is broad speculation in the healthcare industry that many of the regulatory and legal frameworks around provider integration will need to change as payment systems evolve toward bundled payments and other reimbursement structures that will require closer alignment between providers. In fact, as part of Medicare's acute care episode (ACE) demonstration project, the U.S. Secretary of Health and Human Services was given the authority to waive the federal law that prohibits hospitals from paying physicians to reduce or limit patient services. It was believed that this move would help in allowing gainsharing, which is likely to be integral to the success of new bundled payment structures. It's not clear whether there will be any permanent alterations in the regulations that shape provider relations. On the one hand, policymakers recognize the benefits of provider integration; on the other, they fear that excessive integration will eliminate competition and boost pricing power. The Federal Trade Commission's (FTC) recent actions regarding Roanoke, Va.-based Carilion Clinic's acquisition of outpatient imaging and surgical services, and the FTC's opposition to the acquisition of Prince William Hospital in Manassas, Va., by Inova Health System in Falls Church, Va., may well signal stepped up scrutiny of integration efforts.

4. MOVING TOWARD COLLABORATIVE HEALTHCARE DELIVERY

The challenges involved in transforming the healthcare industry's care delivery systems are huge. It is critical that ways to foster collaboration between providers and between functional areas of expertise within provider organizations are explored and developed, particularly as healthcare reform and payment reforms are implemented. Although integrated systems can provide an excellent framework to support such collaboration and nullify some of the negative impacts of our reimbursement policies, integration is not the only way to achieve collaboration among providers, nor is the formation of an integrated system a guarantee that effective collaboration and engagement will take place.

It is clear from interviews conducted by HFMA that there is an art to achieving true integration, collaboration, and engagement between providers. Softer skills, such as an organization's ability to hire and groom effective physician leaders and to build a shared culture, will be critically important in developing an integrated environment—one that involves changes in core practices to produce better coordination and overall outcomes. Effective collaboration among stakeholders across an organization—particularly between providers and physicians—will be key to the successes that will improve the value of care that an organization provides and protecting the long-term health of the organization.

CFOs interviewed by HFMA for this report identified the ability to find and nurture physician leaders as key to the success of their organizations. Although other traits were noted as important, the presence of an effective physician leader is a key enabler of many of these traits. For instance, physician leadership is essential to the effective utilization of data to support quality and cost improvement efforts.

Integrated organizations may want to consider specialized organizational tools or structures to enhance the engagement of physicians in achieving the goals of the integrated entity. "There is a significant opportunity for physicians to play a more substantial leadership role in many of our hospitals and health systems. However, few physicians are trained to lead business, strategy, and marketing functions," says Craig Holm, senior vice president of Health Strategies and Solutions, Inc., Philadelphia. "Many physicians are working to add or bolster these skills." The formation of physician leadership councils—which allow medical staff to provide critical input into formal executive team leadership functions—enable hospitals to gain physician input while providing opportunities for physicians to hone their business planning, strategy, and marketing skills. Alternatively, organizations can solicit physician input on a more informal basis by inviting physicians to participate during important committee and task force meetings that address these topics.

The development of this art of collaboration with key stakeholders has taken considerable time in many of the systems studied by HFMA for this report. However, given the urgency to improve quality of care and reduce healthcare costs, it is clear that healthcare systems will need to achieve alignment and engagement very rapidly to succeed in a reform environment. Developing clinical leaders should be an explicit part of an organization's planning process as integrated systems form and evolve toward tighter organizational structures.

Many large, corporate entities have dedicated business development departments that are responsible for finding and executing new business opportunities. These departments focus on new ways to use current assets and capabilities, review candidates for mergers and acquisitions, and develop strategic partnership opportunities. Given the pace of change in the healthcare industry, one could easily hypothesize that a constant focus on the current "portfolio" of assets and capabilities and a continual scan of the external market would be helpful to the success of an integrated system. Yet during the course of interviews for this report, HFMA did not find any evidence that integrated health systems have developed this specialized function. CFOs interviewed by HFMA for this report generally indicated that the responsibility for business development functions resided with the senior leadership team. Although the fact that senior leaders oversee business development functions is a sign that organizations understand the importance of these functions, it is likely that execution of business development is inconsistent in these organizations, given the other duties that require the attention of senior leaders.

The development of an effective, dedicated business development team could result in many benefits for an integrated system, no matter what stage of development the organization is in. As an integrated system is forming, the process of developing components of the new system would consume a large amount of senior leaders' time and energy. The formation of a business development team, with experts who can efficiently and consistently lead

these efforts, would be enormously beneficial for the emerging system. In more established systems, a dedicated business development team could continually review a system's existing portfolio of services and assets to ensure that the portfolio matches organizational goals and market realities, and could be involved in the process of assimilating acquired organizations. This would help to ensure that the culture and values of the integrated system are communicated clearly as new clinicians and other staff are brought into the system.

Changes in the healthcare industry will create both the need and opportunity for new partnerships and nontraditional uses for system capacity. An investment in leaders that have the skills to execute business development functions consistently should produce a strong return for healthcare systems and enable them to rapidly evolve to meet the challenges of the industry.

Related to and augmenting this business development structure, integrated systems—and, in fact, all provider organizations—should develop formalized capabilities, tools, and systems for continually checking the pulse of the markets and customers they serve. It is easy to foresee future developments in the healthcare industry that will produce profound impacts on patient volumes, payments, and cost, with only a small fraction of these changes spelled out in the *Federal Register.* Changes in insurers, patients, physicians, hospitals, and nearly every other provider segment will disrupt traditional relationships. To produce solutions to these challenges, we must first see them. As General Jimmy Doolittle once remarked about fighter pilots, "To become an ace, a fighter must have extraordinary eyesight, strength, and agility, a huntsman's eye, coolness in a pinch, calculated recklessness, a full measure of courage—and occasional luck!" Investing the time and energy of the leadership team in an annual assessment of the market and detailed planning of organizational responses should be the norm. The days are gone when an organization can succeed with a static strategic plan that is produced every three to five years and sits unopened on the shelf. Invest the resources to produce the plan, make sure the entire organization knows the key actions contained in the plan—then execute those plans.

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