Integrated Leadership: Promoting Collaboration to Transform Health Care

2015 ABMS National Policy Forum
The Future of Practice: Transformation to Patient Centered Systems.

John R. Combes, MD
Chief Medical Officer and Senior Vice President
American Hospital Association
In 5 years what will the field look like?

**Strategic Directions**

- Movement away from fee-for-service ...toward ‘integration”
- Emphasis on value vs. volume
- Emphasis on quality vs. quantity
- First curve to the second
- From illness to health
ACA or Not: Needs and Trends Continue

- Increased coverage
- Delivery system reforms
- Payment reforms
- Increased transparency
- Adoption of health IT

More INTEGRATION across the “silos”

More AT-RISK FUNDING

More PUBLIC ACCOUNTABILITY and reporting
Care System of the Future

Administrative

Clinical

Institutional management

Patient management
Vision of Transformation

• Providers taking responsibility for populations
• Better coordination across care settings and providers
• More effective management of chronic disease by both providers and patients
• Greater role for primary care
• Support from both provider and payer leadership
Implications for Physicians

RIP
Community Hospital & Medical Staff
1917 - 2012
“Separate, but equal”
“Hey, it worked almost 100 years”
Physician Leadership Opportunities

• The organized medical staff will focus on organizational tasks such as credentialing, privileging, corrective actions, and physician behavior

• Economic linkages, managerial roles, and risk sharing will characterize the key relationship with physicians

• Development of shared vision and strategy with aligned physicians will be critical

• Broader physician leadership roles in:
  - Medical Group Governance
  - Co-managed Clinical Services Lines
  - Boards of ACOs, PHOs, JVs, etc.
  - Quality Improvement and Patient Safety Programs
  - Care Redesign and Transformation

• Governance and leadership roles will be based on essential competencies
### Concepts of Leadership

The role of the leader is evolving from a top-down approach to a more collaborative approach.

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Modern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leader crafts vision</td>
<td>Group crafts vision that leader articulates</td>
</tr>
<tr>
<td>Leader demands performance</td>
<td>Leader inspires performance</td>
</tr>
<tr>
<td>Paternalistic model</td>
<td>Partnership model</td>
</tr>
<tr>
<td>Emphasis on leader's intellect</td>
<td>Emphasis on leader's emotional intelligence</td>
</tr>
<tr>
<td>Leader seeks to control others</td>
<td>Leader seeks to empower, motivate, and empathize with others</td>
</tr>
<tr>
<td>Team focuses on work arena</td>
<td>Team seeks balance between work and home</td>
</tr>
</tbody>
</table>

Source: Catherine D. Serio, PhD, Ted Epperly, MD, Physician Leadership: A New Model for a New Generation: Today's leaders need more than vision and a high IQ. *Fam Pract Manag.* 2006 Feb;13(2):51-54.
### Medicine vs. Leadership

<table>
<thead>
<tr>
<th>THE NATURE OF MEDICINE</th>
<th>THE NATURE OF LEADERSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribe and expect compliance</td>
<td>Lead, influence and collaborate</td>
</tr>
<tr>
<td>Immediate and short-term focus and results</td>
<td>Short-, medium- and long-term focus and results</td>
</tr>
<tr>
<td>Procedures/episodes</td>
<td>Complex processes over time</td>
</tr>
<tr>
<td>Relatively well-defined problems</td>
<td>Ill-defined, messy problems</td>
</tr>
<tr>
<td>Individual or small-team focus</td>
<td>Larger groups crossing many boundaries, integrated approach</td>
</tr>
<tr>
<td>Being the expert and carrying the responsibility</td>
<td>Being one of many experts and sharing the responsibility</td>
</tr>
<tr>
<td>Receiving lots of thanks</td>
<td>Encountering lots of resistance</td>
</tr>
<tr>
<td>Respect and trust of colleagues</td>
<td>Suspicion of being a “suit”</td>
</tr>
</tbody>
</table>

Original content published in the October 2012 issue of *Trustee* magazine, Vol. 65, No. 10.
## New Competencies for Clinical Leaders

### Three ways to lead

Research suggests that at least three distinct types of clinical leaders exist.

<table>
<thead>
<tr>
<th>Few</th>
<th>Institutional leader</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Identity</strong></td>
<td>Clinician executive acting as steward of whole organization</td>
</tr>
<tr>
<td></td>
<td>Little direct contact with patients</td>
</tr>
<tr>
<td><strong>Sources of power</strong></td>
<td>Highly credible to colleagues as clinician and leader; able to communicate vision</td>
</tr>
<tr>
<td><strong>Selected leadership skills and knowledge required</strong></td>
<td>Corporate-level strategic thinking, talent management, succession planning</td>
</tr>
<tr>
<td></td>
<td>Political savvy; strong skills in negotiation and influence</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Few</th>
<th>Service leader</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Passionate advocate for own service, feels responsible for clinical and financial performance</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Moderate level of direct contact with patients</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Sources of power</strong></td>
<td>Highly credible to colleagues, primarily as clinician; well connected, can tap into centers of excellence</td>
</tr>
<tr>
<td></td>
<td>Innovative, willing to take risks</td>
</tr>
<tr>
<td><strong>Selected leadership skills and knowledge required</strong></td>
<td>Fluent service-management skills - eg, strategy/people development, budgeting</td>
</tr>
<tr>
<td></td>
<td>Detailed knowledge of evidence-based medicine in own clinical area</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Many</th>
<th>Frontline leader</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Great frontline clinician who focuses on delivering and improving excellent patient care</strong></td>
<td></td>
</tr>
<tr>
<td><strong>High level of direct contact with patients</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Sources of power</strong></td>
<td>Passionate about clinical work, credible to colleagues</td>
</tr>
<tr>
<td></td>
<td>Close to patients and frontline realities; can see opportunities for improvement</td>
</tr>
<tr>
<td><strong>Selected leadership skills and knowledge required</strong></td>
<td>Understanding of systems- and quality-improvement techniques - eg, process mapping, operational improvement</td>
</tr>
<tr>
<td></td>
<td>Self-starter, able to work well in teams</td>
</tr>
</tbody>
</table>

Physician Leaders – Key Competencies

1. Technical knowledge and skills
2. Knowledge of healthcare
3. Problem-solving prowess
4. Emotional intelligence
5. Communication
6. A commitment to lifelong learning

Source: Stoller JK. Developing physician-leaders: Key competencies and available programs. J Health Admin Ed, Fall 2008
Integrated Leadership

• Collaborative discussions between AHA and AMA

• Opportunity to redefine care delivery to achieve the Triple Aim through new care and payment models

• Many organizational models that are successful, but essential to those is a structure with **collaborative and integrated leadership** between physicians and hospital
What is successful integrated leadership?

- Requires functional partnership between organized physicians and hospital

- Requires capability to accept and manage clinical and financial risk, improve quality and reduce cost

- Management decisions on quality improvement and population health agenda should be made jointly between physicians and hospital
Principles for Integrated Leadership

1. Physician and hospital leaders with:
   – shared vision and mission
   – similar values and expectations
   – aligned financial and non-financial incentives
   – goals aligned across the board with appropriate metrics
   – shared responsibility for financial, cost, and quality targets
   – service line teams with accountability
   – shared strategic planning and management
   – shared focus on engaging patients as partners in their care

2. An interdisciplinary structure that supports collaboration in decision-making, preserving clinical autonomy (defined as putting the needs of the patient first) needed for quality patient care while working with others to deliver effective, efficient and appropriate care.

3. Integrated leadership at all levels and participation in key management decisions.
   – Teams of clinicians and administrators leading together at every level
   – Teams accountable to and for each other and can commit for each other
Principles for Integrated Leadership

4. An collaborative, participatory partnership built on trust.
   – Sense of interdependence and working toward mutual achievement of the Triple Aim
   – Physicians and hospital leadership must trust in each other’s good faith and abilities

5. Open and transparent sharing of clinical and business information by all parties across the continuum of care.

6. Clinical information system infrastructure that allows capture and reporting of key clinical quality and efficiency performance data and accountability across the system to those measures.
Key Elements for Physician Organizations

- Inclusive governance process overseeing competencies in quality management, practice efficiency, clinical discipline, clinical and financial risk management
- Process for leadership selection, support, and training
- Structures outlining membership requirements, including professional conduct, clinical protocols
- Development and review of physician organization’s overall strategy and guidelines for employment or affiliation arrangements
- Adopting clinical information technology and resources necessary for effective population and patient care management
- Robust member communication strategy and plan
Leadership Skills

Both physician and hospital leaders must possess the knowledge, skills and professional attitudes to be effective leaders and managers in empowerment-oriented, and consensus-based management models.

**Physician leader skills**
- Mission and strategy development, alignment and deployment
- Understanding of patient and consumer expectations
- Quality measurement and improvement
- Team building, negotiation and management
- Effective adoption of health care clinical information technology
- Risk, finance and cost management in various types of practice organizations
- Understanding payment based on care, quality, outcomes and accountability
- Population health management

**Hospital leaders skills**
- Understand medical professionalism, care delivery processes and clinical decision making
- Knowledge of physician practice finances and workflow
- Ability to achieve consensus with physicians
- Understand need for physicians to advocate for patients
- Accept need for physician clinical decision autonomy in specific settings while expecting physician accountability for overall institutional success
- Willingness to create true integrated leadership model by sharing management responsibilities and accountabilities
Cultural Needs

• A focus on health of entire population served by integrated health system
• Common mission, vision and values
• Mutual understanding and respect despite different training and perspectives
• Sense of common “ownership” of integrated health system and its reputation
• Joint commitment to performance measurement and improvement
• Focus on individual patient’s care over time and across the continuum
• Performance data that is understandable, timely and trusted
• Fair financial and non-financial incentives aligned to improve care and manage costs across the organization
• Shared governance and involvement in decision making
• A sense of responsibility for the integrated health system
• Consensus decision making between all parties
Challenges to Success

- Commitment to business model transformation
- Differing mind sets
- Lack of clarity on values
- Lack of more “accessible” and generalizable models of physician organization
- Lack of integrated leadership and management skills
- Need for robust of primary care involvement
- Need for payer partnering and new payment models
- Legal and regulatory issues
- Contractual issues
- Ancillary services issues
- Coordination of the Organized Medical Staff
Clinical Integration Model

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Committee Structure

CIN Governing Body

CIN Management Team

CIN or Medical Group Board

- Payer Strategy & Contracting
  - Redesign Incentives
- Quality / PI
  - Redesign Care
- Professional Standards
  - Set Standards
- Primary Care Collaborative
  - Redesign Care
- Transitions of Care (TOC)
  - Redesign Transitions
Governing “Board” membership

- Initial membership: 16 voting members (range 16-20)
- Two classes of members:
  
* 8 independent, 4 employed

→ HS = 3 Health System Executives (at large)

Source: BDC Advisors. Copyright 2014 BDC Advisors, LLC. All rights reserved.
Governance of Physician Organizations

• In depth interviews of 6 Organizations
  – Advocate Health Partners
  – Billings Clinic
  – East Bay Physicians Medical Group
  – Hill Physicians Medical Group
  – HSHS Medical Group
  – MHMD, Memorial Hermann Physician Network

• Review by a Panel of governance experts and physicians

• Report issued in January 2015
Key Learnings About Governance

- Need for broader governance competencies and outsider perspectives
- Representational governance dominates with benefits and limitations
- Governance practices are evolving important to avoid application of traditional biases from governance in other organizations
- Most study boards have executive, quality, credentialing and peer review, finance and contracting and compensation committees
- Board members are highly engaged
- Orientation and continuous learning are critical for these boards and require strong commitment to education by members
- Boards are frequently compensated
- Practices for handling conflicts of interest may be less than robust
- Board member evaluation processes are still evolving
Gaps in Physician Governance

• Understanding the difference between governance and management, since physicians are involved at both levels in their organizations;
• The need to define relative roles, responsibilities and authorities among boards and management (such as who hires and fires the physician organization CEO);
• More rigorous use of skill and behavioral competencies in board member selection, reappointment and succession;
• The need for deeper infrastructure (committees, outsider board members) to power governance in younger physician organizations and a better understanding of committee effectiveness;
• More self-reflection on board capabilities to drive improved governance.
<table>
<thead>
<tr>
<th>Level</th>
<th>Focus/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Level</strong></td>
<td>Self-preservation $\xrightarrow{\text{Needs of the individual}}$ Needs of the individual $\xrightarrow{\text{Needs of the team}}$ Good of the group/org</td>
</tr>
<tr>
<td><strong>Organization Level</strong></td>
<td>Inward focus on org’s needs $\xrightarrow{\text{Outward focus on mission}}$</td>
</tr>
<tr>
<td><strong>Board Level</strong></td>
<td>“Board of the whole” $\xrightarrow{\text{Governing committees}}$ Representational $\xrightarrow{\text{Competency-based}}$ Operating oversight $\xrightarrow{\text{Engaged/Strategic/Generative}}$</td>
</tr>
<tr>
<td><strong>Culture</strong></td>
<td>Trust (low) $\xrightarrow{\text{Trust (high)}}$ Trustworthy (low) $\xrightarrow{\text{Trustworthy (high)}}$</td>
</tr>
<tr>
<td><strong>Board Practices</strong></td>
<td>Haphazard $\xrightarrow{\text{Focused &amp; Deliberate}}$ Informal $\xrightarrow{\text{Formal}}$</td>
</tr>
</tbody>
</table>
Summary of Study Findings

• Physician organization governance drives value for patients and health care organizations by championing a relentless focus on quality, safe, cost-effective care.

• A vision of providing the highest quality care and a commitment to being the best at delivering it can provide common cause and alignment for physicians and health care organizations.

• Not engaging in crucial conversations, being perceived as self-serving and failing to base decisions on data and evidence are some ways governance can impede organizational success.
## The Changing Nature of the Health System

<table>
<thead>
<tr>
<th>Focus</th>
<th>Today</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board</td>
<td>Fiduciary</td>
<td>Generative</td>
</tr>
<tr>
<td>Leadership</td>
<td>Hospital</td>
<td>Health across continuum</td>
</tr>
<tr>
<td>Operations</td>
<td>Procedure-based</td>
<td>Outcome-based</td>
</tr>
<tr>
<td>Physicians</td>
<td>Productivity</td>
<td>Quality</td>
</tr>
<tr>
<td>Risk</td>
<td>Conservative</td>
<td>Proactive</td>
</tr>
<tr>
<td>Accountability</td>
<td>Assumed</td>
<td>Transparent to public</td>
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</table>
Questions/Comments

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