



## **Integrated Leadership for Hospitals and Health Systems: Principles for Success**

In the current healthcare environment, there are many forces, both internal and external, that require some physicians and hospitals to rethink their traditional relationships. These physicians and hospitals are being both pulled and pushed together in new ways by these changes, including increased direct employment of physicians by hospitals, the development of Accountable Care Organizations (intended to manage the quality and cost of care of defined populations of patients), new payment methodologies and financial incentives from public and private payers, and the need to deliver greater value in an increasingly competitive marketplace. Among the suggested solutions is a call for integrated physician-hospital leadership.

The ultimate marker of success of all new models of care will be if patients have a better experience, improved health and a lower per capita cost compared to current models. It is possible that integrated leadership would benefit patients by focusing on developing new channels for patient engagement, and delivering care in a manner that eliminates overuse, underuse and misuse of resources while increasing physician professional satisfaction, building trust relationships and financial stability for both physicians and hospitals.

There are and have been for decades institutions in the U.S. that satisfy the criteria for integrated leadership and practice. Some, such as the Mayo Clinic, have created integrated practices through a single physician-led multidisciplinary governing body that employs and oversees both hospital administrators and practicing physicians alike, sets and maintains the integrated health system's mission and culture, and has established integrated leadership at most management levels throughout the entity. Others, such as Kaiser Permanente, are structured as a contract-based ongoing business relationship between a self-governing medical group or groups (i.e. Permanente Medical Groups) and a hospital or health system (i.e. Kaiser Foundation Health Plan and Hospitals). Many within these and other entities, such as Independent Practice Associations, have found them to work well.

Not all physicians or hospitals are seeking integration. For physicians who choose to work in an integrated health system, there are multiple integrated leadership models with many diverse physician and hospital organizational arrangements from which to choose. As physicians consider whether to engage in such a relationship with a hospital or health system and which model to choose, it will be important for physicians to choose if such a relationship and model best suits their ability to serve their patients while maintaining professional satisfaction and practice viability.

Many hospital leaders recognize that for new models of care delivery to succeed, they may need new models of engagement with physicians. Some hospital leaders are unsure how to best achieve engagement and alignment with their employed and affiliated independent physicians on their medical staffs. For those physicians and hospital leaders who choose to create an integrated

hospital or health system, we identified six principles central to the success of the structure and maintenance of these new relationships.

## **PRINCIPLES OF INTEGRATED LEADERSHIP FOR HOSPITALS AND HEALTH SYSTEMS**

At its core, successful integrated healthcare leadership between physicians and hospitals involves a functional trust-based partnership between those organized physicians<sup>1</sup> and a hospital or health system, with the capability to accept and manage health risk, improve quality and reduce cost. To accomplish this goal, it is paramount that all important management decisions related to the new structure's quality improvement and population health agenda are made jointly between the physicians and the hospital/health system managers.

In compliance with the applicable law, it is paramount that the arrangement and characteristics of any integrated leadership structure include the following to best achieve success:

1. Physician and hospital leaders with:
  - a. similar values and expectations
  - b. aligned financial and non-financial incentives
  - c. goals aligned across the board with appropriate metrics
  - d. shared responsibility for financial, cost, and quality targets
  - e. service line teams with accountability
  - f. shared strategic planning and management
  - g. shared focus on engaging patients as partners in their care.
2. An interdisciplinary structure that supports collaboration in decision-making between physicians and hospital executives. It is important that physicians preserve the 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 clinical physician and hospital leadership, including nursing and other clinicians, present at all levels of the integrated health system and participation in all key management decisions.
  - Teams of clinicians and hospital or practice management administrators (leading together at every level of the integrated health system).
  - Teams accountable to and for each other and who can speak and commit for each other.

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<sup>1</sup> The term *organized physicians* in this document refers to a group of practicing physicians capable of leadership selection, broad management capabilities, mutual accountability and collective performance measurement and improvement.

4. A collaborative, participatory partnership built on trust. This sense of interdependence and working towards mutual achievement of the Triple Aim, better care and improved health at a lower per capita cost, is crucial to alignment and engagement. It is important for physicians and hospital leadership to trust in each other's good faith and abilities.
5. Open and transparent sharing of clinical and business information across the continuum by all parties to improve care.
6. A clinical information system infrastructure that allows capture and reporting of key clinical quality and efficiency performance data for all participants and accountability across the system to those measures.

## **KEY ELEMENTS**

### **PHYSICIAN ORGANIZATION**

The need for physicians to organize under a formal self-governance and management structure, whether employed by a hospital, in a large group, small group or solo practice (these structures and functions will differ based on the arrangement) cannot be overstated. These structures are the starting point for developing policies, practices, and an infrastructure to support a partnership-like relationship with the hospital or health system with multiple options for physician organizations, and to share accountability for the quality and cost effectiveness of healthcare provided by the organization. It is imperative that physician organizations are capable of creating such a foundation.

These capabilities include:

1. Developing an inclusive governance process that includes establishing and overseeing the necessary competencies in quality management, practice efficiency, clinical discipline, clinical and financial risk management and the culture needed to accomplish the goals of the integrated structure;
2. Developing a process for leadership selection, support, and training;
3. Setting structures specific to membership requirements, including professional conduct, clinical protocols and developing structure-specific physician membership policies and guidelines, including changes to membership requirements;
4. Development and annual review of the physician organization's overall strategy and guidelines for employment or affiliation arrangements;
5. Leading the adoption of clinical information technology and other resources, including personnel, necessary for effective population and patient care management and measurement; and

6. Overseeing the development and implementation of the physician organization's member communication strategy and plan.

## **LEADERSHIP DEVELOPMENT**

While there are many examples of great leaders, both on the physician side and the hospital side, in the current healthcare environment, there still remains an inadequate supply of physicians and hospital executives with the training or experience in leadership and management skills required for successful leadership of integrated health systems. Promoting and developing new skills for both groups, as outlined below, is an important characteristic for a successful integrated health system not to be ignored.

### **Development of new skills for physician leaders**

It is important for a successful integrated health system to have physician leaders with training or demonstrated competency in leadership and management skills and an environment that supports their success. This requires that:

1. The physician organization be capable of selecting and supporting trusted and capable physician leaders and then following the recommendations and commitments made by these leaders. The support and respect of one's peers is also critical in these leadership and management activities.
2. Physician leaders be selected, educated and trained in the knowledge, skills and professional attitudes needed to be effective leaders and managers, as well as strategic partners. These skills include, among others:
  - a. Mission and strategy development, alignment and deployment
  - b. Understanding of patient and consumer healthcare expectations and requirements
  - c. Quality measurement and improvement
  - d. Team building and management
  - e. Effective adoption of healthcare clinical information technology to understand population health management including variation in access
  - f. Information, communication and risk management
  - g. Personal leadership skills that include effective negotiation with fellow physicians, hospital or health system administration and others
  - h. Understanding finance and cost management based on care, quality, outcomes and accountability in various types of practice organizations
  - i. Balancing the ethics of care to the individual with care to the community

### **Development of new skills for hospital and health system leaders**

1. It is also important for hospital and health system executives and leaders to acquire new training, skills and attitudes in order to engage successfully with physician leaders and

physician entities. Some areas where training is needed are in participatory, empowerment-oriented, and consensus-based management models. The skills include:

- a. Understanding the core elements of medical professionalism
- b. Understanding the fundamentals of the care delivery process including how physicians make clinical decisions
- c. Knowledge of physician practice finances
- d. Knowledge of physician practice workflows in various settings
- e. The ability to achieve consensus with physicians
- f. Understanding and accepting the need for physicians to advocate for the needs of their patients
- g. Accepting the need for physician clinical decision autonomy, while expecting physician accountability for overall institutional success
- h. Create a true integrated leadership model by sharing management responsibilities and accountabilities in specific areas of clinical and business administrative decision making with physicians, e.g., including:
  - Quality improvement
  - Strategic planning, alignment, deployment, and rapid cycle improvement
  - Care model redesign
  - Financial planning, budget creation, capital and operations
  - Public affairs and reputation management
  - Cost management
  - Human capital management
  - Performance reporting and management
  - Information technology management

## **CULTURAL ADAPTATIONS**

Culture is the way an organization, institution or integrated health system does business, in a way that is predictable, known to all and consonant with the mission and values of the organization, institution or integrated health system. The creation of a common shared culture that includes an integrated set of values is important to serve as a guide to the entity and will serve as a touch point to help resolve the inevitable conflicts that will arise.

Characteristics of such a culture include:

- A focus on the health of the entire population served by the entity
- An awareness of, and agreement to, a common mission, vision and values
- Mutual understanding of and respect for each other, despite different training and perspectives
- A sense of common ownership of the entity and its reputation
- A joint commitment to performance measurement and improvement
- A focus on the 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 entity
- Shared governance and involvement in decision making
- A sense of responsibility for the entity
- Consensus decision making between all parties

## **IDENTIFICATION OF CHALLENGES TO SUCCESS**

There are many challenges and barriers to creating and instituting integrated healthcare leadership between physicians and hospitals. In order for integrated healthcare leadership to succeed, it is important to identify these barriers and work to resolve them so the implementation does not stop before it can take hold. Currently, many hospitals and physicians are simply not capable of instituting such integrated healthcare leadership because they are not organized to do so. In addition to issues with structure, there are several other barriers dealing with cultural gaps, and legal and regulatory issues.

### **1. Commitment to business model transformation**

It is important that the business model of hospitals and health systems focus on population health improvement and acknowledge the key role that physicians play in the integration of the various settings of care: inpatient, outpatient, post-acute, home, and palliative and hospice. This new focus may be challenging for some that have business models focusing more on the treatment of disease and minimal physician engagement.

### **2. Differing mind sets**

Physicians and hospital administrators assess issues differently due to different training and perspectives. These divergent viewpoints can lead to strained relations. Having a mutual understanding of and respect for each other's points of view and accepting shared leadership and accountability is important to implementing a successful model.

### **3. Lack of clarity on values**

A lack of understanding and integration of organizational values by both physician and hospital leaders leaves both groups uncertain of what to expect of each other.

### **4. Lack of more accessible and generalizable models of physician organization**

There is a need for much more rapid development of models for physician organization, characterized by capable self-governance and collective management of care and accountability for quality and cost performance in order to be able to assume the responsibilities inherent in the principles and key elements described above. There is a need for more expertise and resources dedicated to addressing this need.

### **5. Lack of integrated leadership and management skills**

There is an inadequate supply of physicians and hospital executives with the training and experience in leadership and management skills required for successful leadership of integrated health systems. It will be important to integrate training throughout the continuum

of physicians' careers, e.g. medical schools, residency training programs, hospital executive degree programs (e.g. MHA, MBA), and by organized delivery systems and professional associations (AHA, AMA). Interdisciplinary team training involving different clinical disciplines and administrators should be integrated earlier in the educational curriculum.

#### **6. Need for robust primary care involvement**

A robust aligned primary care network is critical for chronic disease management and population health strategies to be successful. Providing primary care the appropriate representation and voice needed to lead population health improvement initiatives may be a challenge in the existing leadership structure of the current hospital/health system environment, but it is clearly a need to be addressed in the near term.

#### **7. Need for payer partnering and new payment models**

The evolution of payment for professional and institutional services away from payment for volume toward payment for value can catalyze the development of more effective physician-hospital leadership integration. Payers need to expand their willingness to engage and partner with physicians and hospitals in these payment models. Hospitals and physicians may find it difficult to operate in a partnering model with payers after years of challenging negotiations over contract rates and provisions, but this, too, is clearly a need to be addressed in the near term.

#### **8. Legal and regulatory issues**

Physician organizational development and leadership integration with hospitals will present legal and regulatory issues. If issues are due to state and federal laws, it is important for physicians and hospitals to develop appropriate policies to the greatest extent possible and work with federal and state policymakers/regulators to amend or repeal laws so that collaboration towards achieving the Triple Aim is possible.

#### **9. Contractual issues**

There are physicians that currently have employment contracts either directly through hospitals, through outside staffing firms, or through other arrangements that are not necessarily consonant with the principles and key elements necessary for effective integration strategies. Such contractual issues and any relevant legal issues will need to be resolved through mutual agreement.

#### **10. Ancillary services issues**

It is important for hospitals and private practice physicians to begin thoughtful discussions on how ambulatory services with varying reimbursements based on site of service can be addressed in an overall system strategy for improving access and lowering the cost of care. Leaders will need to consider these opportunities recognizing that the transition from fee-for-service (FFS) to fee-for-value (FFV) (global population risk) may occur over a range of timelines depending on the market and payers.

## **11. Coordination of the Organized Medical Staff**

The Hospital Governing Board-Organized Medical Staff (HGB-OMS) model codified in law in most states, as well as The Joint Commission standards, provides value and may need to evolve. The OMS may provide the mechanism for physicians from various practice modes (independent, hospital employed) and settings (outpatient, inpatient) to be the source of the physician leaders needed to integrate with hospital executives. It will be important to assure coordination and prevent unnecessary duplication of effort or the development of conflict between physicians in different practice modes and settings with the hospital leadership.

Following the principles and key elements on integrated healthcare leadership will be of help.

## **CONCLUSION**

The healthcare delivery system is going through a period of unprecedented change. In order to achieve the Triple Aim of better health and healthcare at an affordable cost, some new delivery models will require new levels of collaboration and partnership between physician and hospital or health system executives who organize care, and physicians who are at the front lines of care delivery. In those integrated models, healthcare leadership between clinicians and managers must be advanced to establish new ways to deliver efficient and coordinated care. While challenges exist, they are not insurmountable when professionalism, respect and cooperation are at the core of this partnership and when the vision is clear how best to meet the needs of their patients and communities that they are privileged to serve.

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