Moving up the Integration Pyramid

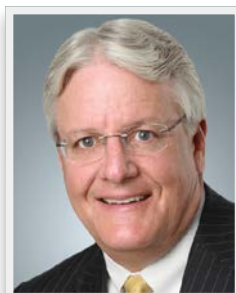*BY MARC D. HALLEY, M.B.A., THE HALLEY CONSULTING GROUP, INC.*

Our Move toward Integration

In response to healthcare trends our industry is consolidating. Health systems continue to merge or acquire hospitals and smaller systems. Hospitals continue to acquire medical practices and to employ physicians. Large medical group practices continue to grow larger by acquisition of smaller practices. Such consolidation in other mature industries is not uncommon, as competition increases and profitability declines.

Physicians, hospitals, and other providers of healthcare services are also attempting to integrate through a variety of methods, including consolidation. Factors driving integration include the need to collaborate across organizational silos in order to optimize clinical quality and service quality, while improving utilization and reducing costs in order to manage population risk.

Effectively managing an entire episode of care or improving the health of those with chronic ailments requires far more than a shared organizational structure. Board members and executive/physician leaders of integrated delivery systems—even those using merger, acquisition, or employment—are often frustrated that their organizations don't *act* like integrated systems. A key indicator of that dysfunction is referral leakage to competing organizations. Another common sign of dysfunction is the inability to hold individuals and organizations accountable for clinical quality, service quality, productivity, or financial viability.

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The Integration Pyramid

While we admire highly integrated healthcare delivery systems like Mayo Clinic, Geisinger Health System, Cleveland Clinic, and others, most community healthcare delivery systems are not and will never be structured like a Mayo or a Geisinger. Despite fact-finding trips or consulting contracts, our integrated cultures will not mirror those found in Rochester, MN, or Danville, PA. Most community healthcare delivery systems will continue to require collaboration among organizational silos including employed physicians, independent physicians, hospital departments, acute care settings, post-acute settings, and more. A key question for healthcare leaders today is how to achieve some level of collaboration when those silos have their own objectives and incentives to meet their own payrolls or budgets.

Again, many *structurally* integrated organizations don't *function* like integrated systems.[1] Despite great effort and identified best practices in the areas of clinical integration, organizations still find it difficult to inculcate evidence-based medicine across the various physicians, practices, departments, and facilities involved in an episode of care or serving the chronically ill. Differences in training and experience and incentives and culture often seem to stand in the way of agreeing on and consistently implementing the best way. Financial incentives (e.g., risk) will certainly help, but if past history is any indicator, financial incentives are not always adequate to change behavior. Consider how few traditional physician–hospital organizations (PHOs) or independent practice associations (IPAs) survived the managed care pressures of the late 1980s and 1990s.
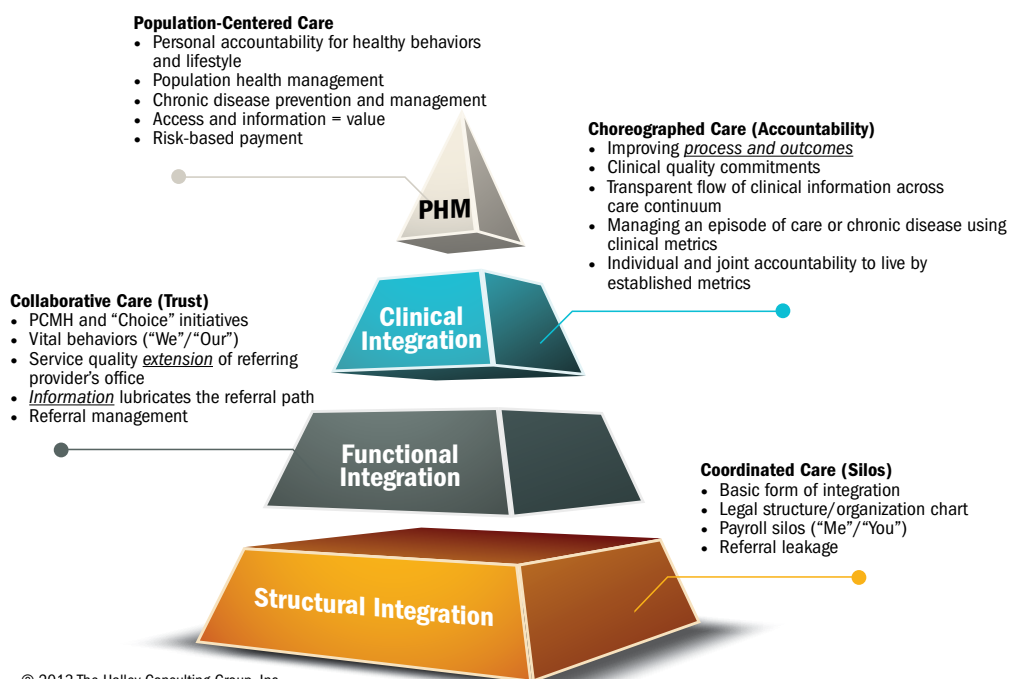
Based on our experience and observation, we believe organizations need to go through a process to move from structural to functional to clinical integration in preparation for population risk management, and, ultimately, to support population health. The "Integration Pyramid" in **Exhibit 1** defines and illustrates the steps involved in moving from structural to functional and on to clinical integration.

As illustrated, structural integration (e.g., a medical staff is a loosely integrated structure) facilitates *coordinated* care from one silo to another. However, the silos remain independent and focused on their own payrolls and department budgets. The transitions from one silo to another look like traditional customer/vendor relationships

Exhibit 1: The Integration Pyramid

Population-Centered Care
- Personal accountability for healthy behaviors and lifestyle
- Population health management
- Chronic disease prevention and management
- Access and information = value
- Risk-based payment

Choreographed Care (Accountability)
- Improving *process and outcomes*
- Clinical quality commitments
- Transparent flow of clinical information across care continuum
- Managing an episode of care or chronic disease using clinical metrics
- Individual and joint accountability to live by established metrics

Collaborative Care (Trust)
- PCMH and "Choice" initiatives
- Vital behaviors ("We"/"Our")
- Service quality *extension* of referring provider's office
- *Information* lubricates the referral path
- Referral management

Coordinated Care (Silos)
- Basic form of integration
- Legal structure/organization chart
- Payroll silos ("Me"/"You")
- Referral leakage

PHM

Clinical Integration

Functional Integration

Structural Integration

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[1] Marc D. Halley, "Integration: From Structural to Functional," *Healthcare Financial Management,* June 2012, pp. 74–77.

with the patient as both prize and pawn in the process. Each silo provides services to patients according to its own processes and preferences, and creates its own revenues. Patient referrals are based on relationships, ease of access, effective communication, and prior patient experience. Frequent referral leakage to other providers and systems is a classic indication of structural integration.

Functional integration is collaborative care. The term "collaborative" connotes silos working together to ensure a seamless experience for the benefit of "our" patient. Functional integration is driven by excellent service quality to our patient and to each referring provider along the referral path comprising a particular episode of care. Demographic, clinical, and financial information is the lubricant required to smooth the transitions from one silo to another, with each subsequent provider looking like an extension of the previous provider's office (just down a different hallway). "We are expecting you!" is the message to the patient from the subspecialty office, the ancillary services department, or hospital registration desk. Functional integration encourages collaboration to develop service commitments and joint accountability for achieving them. It is often focused on a service line or chronic disease where there is common interest among the various service providers. Developing, measuring, and achieving those service commitments creates trust among the providers as they collaborate to improve service quality to each other for the benefit of their patients.

As collaboration and trust build, the functionally integrated partners are ready to face a more significant challenge—examining how they provide their clinical care. Talk of "cookbook medicine" can quickly kill clinical integration initiatives if the players lack the trust necessary for introspection, innovation, transparency, and joint accountability. Improving processes and outcomes brings the partners face-to-face with the challenges of organizational change. Seeing ourselves clearly is the beginning of wisdom, but only the beginning. Physicians and other knowledge workers cannot be *bossed*—even if they

are on the payroll.[2] Instead, they must be *engaged* in developing the "recipes" that will define how they will work together and with others to ensure consistent clinical quality and appropriate utilization. Choreographing an episode of care while allowing for the variability inherent in individual patients, many with comorbidities, is a challenge requiring our best "integrated" selves.

Effective governance is the key to successfully navigating the process of moving up the Integration Pyramid. We discuss two types of governance. Vertical governance occurs within distinct organizational silos (e.g., a hospital, department, practice, etc.). Horizontal governance connects multiple silos—some of which may reside in the same legal entity and others not.

Vertical Governance

Vertical governance occurs within silos and is responsible for the success of the individual silo. Effective vertical governance is critical to functional integration, since an integrated delivery system is only as strong as its weakest link (silo). In its simplest form, vertical governance derives its authority from the owners. For example, a private small group medical practice is likely "governed" by its members who sit in council with one another in order to make decisions. The owners assume the risk of their decisions and provide (or borrow) any required capital to support their decisions. They then support their manager to implement their decisions and hold that person accountable to do so effectively. In properly functioning silos, the owners also hold each other accountable to support their decisions publicly.

In more complex organizations vertical governance starts with a formal board, an elected or selected body, which represents the "owners" (e.g., tax payers, shareholders, etc.) and protects their interests. "Fiduciary" governance is *strategic oversight.* For our purposes, we define fiduciary governance as the process of developing and approving strategy, sponsoring policy to support that strategy, providing or

approving resources, overseeing regulatory compliance, and establishing accountability for performance. In larger organizations, the fiduciary board hires the chief executive officer and holds him or her accountable as the chief implementer for the organization.

Horizontal Governance

Horizontal governance is essential to the integration process and fundamental to moving up the Integration Pyramid. Some organizations have tried, unsuccessfully, to ignore organizational silos in an effort to promote an "enterprise" or integration philosophy. Failing to acknowledge silos, however, does not negate their existence and their influence (positive or negative) on the integration process. Instead, integrators should acknowledge the reality of silos and spend their energy effectively connecting them.

Horizontal governance connects multiple silos in the pursuit of a common objective (e.g., across an episode of care). Some of those silos may be independent medical practices, while others may be hospital-employed physicians. Ancillary departments may be involved, as well as acute and post-acute facilities. These silos often have different ownership structures or distinct fiduciary boards. Consequently, horizontal governing bodies derive their authority through common consent. In essence, each silo agrees to meet certain requirements as a condition of participation or

2   Peter F. Drucker, *Peter Drucker on the Profession of Management* (Boston: Harvard Business Review), 1998, pp. 122–125.

membership. Members are "governed" by those commitments as long as they choose to participate (a vertical choice). Failure to do so results in expulsion from the integrated body.

Successful horizontal governance requires the following:

1. **A common interest:** A service line or a chronic disease provides a great forum for gathering members that have a common interest and incentive to participate in improving clinical quality and service quality while reducing cost and utilization.

2. **A clear and compelling vision:** Engaging members in developing a clear vision for their common interest provides the glue to engage the silos in a common cause. That vision must be compelling enough to keep the members together during the inevitable disagreements over tactics.

3. **Shared tenets:** Tenets are the ground rules that govern how the members agree to filter and make decisions. The following filters are commonly employed by decision makers who ask: Does the proposed policy or decision:
   - Maintain or enhance clinical quality as defined by our physicians and evidence-based medicine, where available?
   - Maintain or enhance service quality as defined by our referring providers and their patients?
   - Reduce inappropriate utilization?
   - Reduce overall cost?
   - Maintain or enhance care coordination?
   - Maintain or enhance the productivity of our member physicians and other providers of care?
   - Maintain or enhance efficient operational processes?
   - Maintain or enhance financial viability of all members?

   Decisions that cannot pass the selected filters are tabled until they are modified, or do not receive further consideration. Because horizontal governance authority is derived from the membership, decision filters become very important when there is disagreement among members over specific tactical

decisions. Otherwise, the hospital plays the capital card, the physicians play the referral card, and everyone—especially the patient—loses.

4. **Working together:** Clarity around how the silos will work together involves addressing the following:
   - Individual silo roles and responsibilities (vertical governance)
   - Shared commitments (horizontal governance)
   - Performance targets (horizontal governance)
   - Performance management (vertical governance)
   - Individual accountability and performance reporting (vertical governance)
   - Joint accountability, meaning rigorous and transparent performance reporting (horizontal governance)
   - Appropriate incentives and rewards (horizontal governance)

5. **A culture of accountability:** Critical to the success of horizontal governance and the integration effort is the development of a culture of accountability. Members cannot be allowed to violate terms to which they have committed, and still remain in the integrated service line, nor can sole community providers be allowed to hold other members hostage without the risk of being replaced. The authors of *The Oz Principle: Getting Results through Individual*

and Organizational Accountability make the following statement:

> "It's worth repeating: An attitude of accountability lies at the core of any effort to improve quality, satisfy customers, empower people, build teams, create new products, maximize effectiveness, and get results. Simple? Yes and no. It's a simple message, but it takes a tremendous investment of time and courage to make accountability an integral part of an organization."[3]

The message is simple. *Paying* for performance (a common tactic in our industry) will only get an organization part way up the Integration Pyramid. Only individual and joint accountability will take us to the pinnacle.

Moving up the Integration Pyramid

Managing population health is certainly a worthy objective. Achieving that significant objective will require that we include a healthy—and potentially disinterested—population in preventive efforts to maintain their health. (It is difficult enough to engage even the chronically ill in managing their health.) While preparing for that challenge, healthcare providers must "get our own act together" by effectively connecting our silos as we move up the Integration Pyramid. Successful *integration*, by its nature, requires that clinical experts and business experts work together *in partnership* to balance clinical quality, service quality, productivity, and financial sustainability. Neither will physician-led nor will executive-led integration move organizations up the pyramid. Only a partnership based on a compelling vision, shared tenets, and a culture of accountability will be equal to the task. ◉

3   Roger Connors, Tom Smith, Craig Hickman, *The Oz Principle: Getting Results through Individual and Organizational Accountability* (New York: Penguin Group), 2010, p. 16.