Integration; Patient Perspective Key to Healthcare Transformation

The healthcare industry is undergoing a tectonic shift. Its traditional landscape, one dominated by hospitals, is transforming into one marked by greater integration with physicians and others — and greater uncertainty. What trends and issues should take priority for healthcare leaders today and in the future? Who are those leaders, and what are their greatest challenges?

Jim Gauss, President and CEO of Witt/Kieffer, sat down recently with noted healthcare leaders — Jim Hinton, President and CEO of Presbyterian Healthcare Services in Albuquerque, NM, and Chris Van Gorder, CEO of Scripps Health in San Diego, CA — to address these and other compelling questions about the transformation of health care.

Q. (Jim Gauss):

What are the most critical challenges your organizations will face over the next several years?

A. (Chris Van Gorder):

The most obvious issue is healthcare reform. We will have to become much more integrated and eliminate system fragmentation among doctors, medical groups, outpatient centers and hospitals. And if what we are reading is true, reimbursement will be significantly reduced over the next decade to pay for health reform, so we will need to take cost out of the system.

Given that future, we need to enhance our integrated relationships. In my community, independent practitioners are going out of business; physicians are not coming into independent practices any longer. They want to be part of the integrated model and that's quite a transition for hospitals that have historically been dominated by independent physicians. In our case, 2,000 of our 2,600 physicians are still independent.

There are going to be cost management issues; pay-for-performance requires standardization. We must standardize for quality, safety and cost management; evidence-based best practices that require much more management engineering and processing reengineering.

It will require more employee relations skills. Today we are union-free. But with the pressure from Washington and California to make it easier to organize, we need to enhance employee relations. We are a *Fortune* 100 Best Place to Work, and we have to really work to maintain it.

There will be less local control, and our executives will need more system understanding along with culture or accountability development. In my experience, many in healthcare management have long believed, because they are unable to control what happens outside the institution, that they should not be held accountable. Our system has turned itself around over the last decade; we consistently hit our targets, and that has everything to do with accountability.

A. (Jim Hinton):

We have to stop thinking about reform as a singular event because it's too hard to predict. We need to think more about the underlying issues and trends that affect health care. Chris touched them all. We

anticipate caring for many more people in our systems with essentially the same level of net revenue we have today. That's put a premium on consistency, reliability and eliminating rework.

Our vision is that the only way to succeed in this new world is through a much more tightly integrated model with more coordination of everything that goes on in the system. We are all about integration. We are transforming systems of care through innovation, work redesign and automation. That is what really is driving us today.

Q. (Jim G.):

What worries you about healthcare reform?

A. (Jim H.):

We are one of the states that is significantly discriminated against in terms of Medicare reimbursement, and we have projected that if 30 percent of our commercial lives go into a public option, we would have to take about $110 million out of our system by the end of next year. That would be tough to do. I believe the public option would destabilize health care in America, at least in the low-reimbursed states.

Some of the positives in the reform package include the comparative effectiveness investment to find out what types of intervention help people and what types don't. Building a body of evidence around what kind of care we want to provide in this country — that would be very welcome.

A. (Chris):

Bundling payments to physicians and hospitals, or episodes of care payments are the types of strategies that will force hospitals and physicians to integrate more closely. Our organization and Jim's are both moving in the right direction by becoming more integrated. Most hospitals are not at all.

Overall, I am actually excited about healthcare reform. I believe we need to move to more universal coverage, but I personally would prefer and often recommend that we move much more incrementally instead of trying to do the big bang approach and then fixing it for 20 years.

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Q. (Jim G.):

What are the factors that most affect integration in your system?

A. (Jim H.):

Health system success will be defined as much by experiences with ambulatory centers, or physician or business relationships outside the walls of the hospital and health plan. Yet there is almost a gravitational pull to the hospital. We serve 720,000 New Mexicans every year and only about 47,000 will be hospital inpatients. So a very small fraction of the people we serve as the state's largest healthcare system, actually spend the night in one of our hospitals. The hospital is still the place where all the drama is, the trauma, neonates, and heart surgeries, etc., but it really is a small fraction of what the community experiences. We are 100 years old and for 80 of those years we were only in the hospital business. So, the last 20 years have been barely enough time to break some of the ties to that mindset.

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A. (Chris):

I’ve been one of those “doubting Thomases” over the years. Every time someone said we have to start focusing on the ambulatory side, I would say it’s never going to happen. During most of my career, the outpatient or ambulatory component was owned by the independent physicians. We might have an imaging center, but it really was controlled by independent physicians. In many cases the physicians had relationships with lots of different healthcare systems.

On the integrated side, if you happen to be in a state with an employment model, it’s now very different. When you develop the ambulatory component out in the community, it really is part of the integrated system. It’s owned and controlled by the healthcare system. The patients are directed to those hospitals — kind of a hub and spoke model — and now we are starting to see that really develop in California.

Q. (Jim G.):

What then will be required of leaders to succeed in an industry with new demands and a new architecture?

A. (Jim H.):

While these are generalizations, health plan people think in terms of finite resources; the premium mindset is “that’s all the money there is to do the work we have to do.” We need to integrate that mindset with more of the delivery system view, where patients’ needs are infinite so we have to keep doing everything we can for them. It’s really a tectonic shift: what resources are available and what are the most effective ways to use that money for the maximum benefit of the patient or member.

A. (Chris):

I often tell my own hospital chief executives and other employees I would be an absolute disaster now as a hospital chief executive. Because I was so control-oriented, hard-charging, and independent decision-oriented. We want leaders who are decisive and think independently, but also put their independence aside for the betterment of the healthcare system. We can’t have different policies and procedures at different campuses. Our quality initiatives need to be much more standardized and much more evidence-based; we’ll do best practices as a system not as an independent campus. It’s a different skill set now for our executives.

Q. (Jim G.):

Tell me more about the leadership qualities you need in this new world.

A. (Chris):

We need people who remember what business we’re in. The farther we go into the system side, generally speaking, the farther we get from the patient. When I do candidate interviews, I sometimes get a sense that people forget what we do. A finance candidate may think we are in the business of running a bank, or a potential CIO may think we are in the business of running an information department. They don’t focus on what actually benefits the patient.

I find the best candidates are often those who have healthcare experience on the ambulatory or the hospital side. These people recognize that the work that they do, be it in treasury, information services or human resources, is all focused on one thing: caring for each patient one at a time and providing the right services, people, supplies and technology for that patient.

Q. (Jim G.):

What about looking for leaders outside of health care? What kinds of experience do you look for? What skill sets do you need?

A. (Jim H.):

I struggle thinking of how somebody with no healthcare experiences could step right into a broad system leadership role in an integrated healthcare delivery system. We've had the most success with non-healthcare industry candidates in staff type roles, the HR, finance, IT and planning areas where I think there's more of an obvious transferability of skills. People who have managed a small business could pick up the nuances of health care in a pure ambulatory setting relatively easily. The hospital politics, medical staff and boards, however, are unique to our industry.

A. (Chris):

I totally agree, at least at the senior level. I know of a couple exceptions, a couple of steps below the senior level, we brought in attorneys with federal trade commission experience, for example, to deal with antitrust issues. You can see that potential in human resources. We bring in some with non-healthcare experience so we can learn from them. But at the top we really must have healthcare experience: that understanding of medical staff politics, the very unique relationships we have with physicians and the difference between the integrated physicians and independent physicians and all the laws and regulations that are unique and specific to health care. It's pretty hard for someone to jump in at the top level and understand that. I replaced a physician who understood health care but didn't understand healthcare administration and even then it's sometimes a difficult transition.

Q. (Jim G.):

How will you develop new leaders — and help experienced executives make the transition?

> "Leadership expectations are focused on coordination, enterprise-wide data to make decisions and a customer view of everything we do." — Jim Hinton

A. (Jim H.):

We have been much more intentional in the last several years about grooming leaders within our system. We have made a commitment to an internal leadership development program that we run 18 to 24 months. We hand-pick certain executives that we are positioning for system leadership roles. They're in this program to break the ties of the hospital mindset; this is a deprogramming step to test their ability to succeed at a system level. What I look for first is a deep and genuine customer focus. That sounds obvious but we would define that as understanding the customer desire for their own health as opposed to what we currently provide. When we have people who can consistently take that outside-in view of health care in their leadership role, we find they can be successful in a broader system role. The expectations are focused more on coordination, using enterprise-wide data to make decisions and taking a customer view of everything we do.

A. (Chris):

Too many physicians who want to get into administration see the CEO as the job they want. Sometimes they fail to recognize that we went through a number of steps along the way to build the skill sets we have. You can't get an executive M.B.A. and walk into the C-suite. We created a physician leadership academy to show them the overall challenges at a system level. They might have experience at a medical executive committee or campus level, but we try to give them a real snapshot of

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— Chris Van Gorder

what we deal with at the system level, what's going on with healthcare reform or what the challenges are in the state. This gives them a better view of what they are walking into. We found that in almost every case they want to help us with the utilization management area or work within the medical group as a physician leader. That becomes the training ground for our future leaders.

The challenge will be integration, as I mentioned earlier. I keep calling it the waterfall. More and more independent physicians want to move into the integrative model but not all will be successful. In fact, a number of them want to go into that model so they can semi-retire. They are hard-charging as independents but when someone else is taking care of the responsibilities for them, their production drops. So not everybody is perfect for the integrated model.

Q. (Jim G.):

Any closing thoughts on the make-up of your key staff in the future?

A. (Jim H.):

We need the quality and safety roles, the clinical informatics people who can help mine data systems to identify patterns of clinical care where we can intervene and improve. We have been looking at a program at the University of Utah turning out clinical informaticists, the kind of people who are key to our future.

A. (Chris):

We still need strong people in finance, planning and human resources. We need strong chief medical officers to help move other physicians and make sure we have a clinical perspective in the system C-suite. The new roles — quality and safety — are moving up very, very high; we are about to promote our first Vice President for Quality and Safety at the system level. We have always had them in a management role at the campus level but never in an executive role. We've had an internal project management consulting arm that turned out to be extraordinarily successful. Medical group management and integrated management turn out to be the most important roles looking into the future. We still need succession planning; we have to develop new executives who are going to work at the campus level with a system mindset.

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Witt/Kieffer is grateful to Jim Hinton and Chris Van Gorder for their participation in this provocative discussion about the future of health care and its leadership.

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