



# From Gridlock to Governance

Three insights on building and enforcing system-wide decision structures

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Advisory Board interviews and analysis.

# Multiple paths to building a greater whole

Health care organisations are increasingly partnering with one another to connect services and achieve economies of scale. These networks are often created as independent entities, and they are usually assembled in one of three ways: top down, bottom up, or both at the same time.



## Top-down restructuring

- + Organisation-focused
- + Creates clear and firm reporting lines
- + Sizeable effort devoted to politics, less on delivery considerations



## Both simultaneously

- + Simultaneous focus on optimising savings and physical footprint results in broad interpretation
- + Unclear controls means system management difficult to achieve



## Bottom-up restructuring

- + Volume-based targets encourage looser affiliations between partners
- + Assembly ambiguous or self-reliant

Each of these models has benefits and drawbacks. But in most cases, no matter what form a network chooses, the path to integration is usually not direct and lacks a clear vision for the final goal.

**The concept of ‘systemness’ provides that clear path and vision.**

## VISION

We define systemness as:

The extent to which a cooperative of owned or independent health care organisations is capable of unlocking the **benefits from their collective action.**

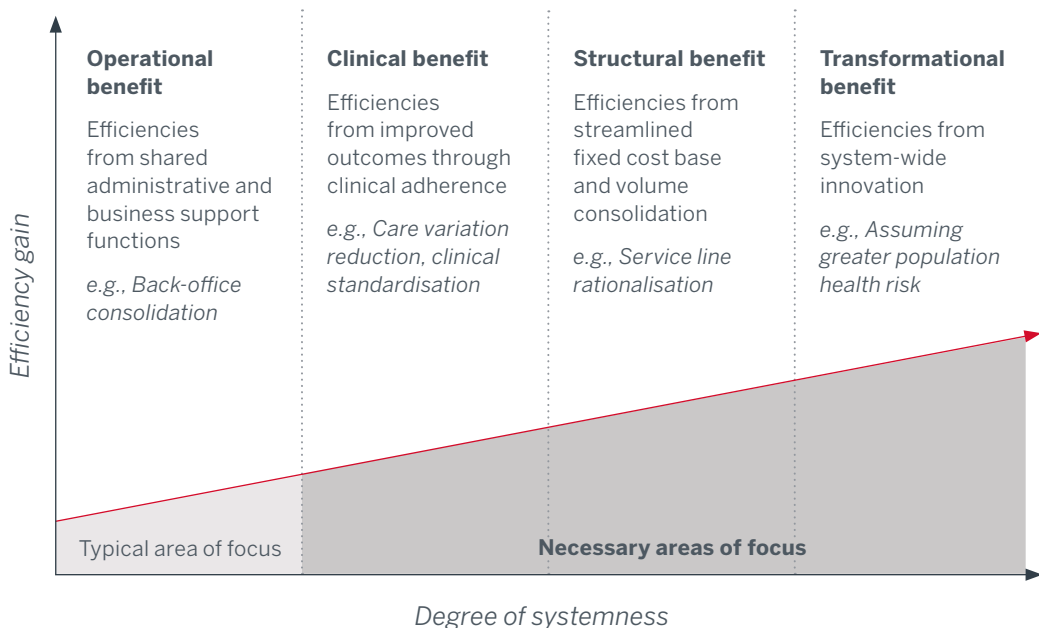
# The blueprint for **systemness**

While systemness is an outcome, it is also a journey.

Time and again, we've heard about organisations trying to achieve systemness but stalling. Without a blueprint on how to get there, organisations are likely to simply replicate the same silos and divisions as before, omitting critical steps in their approach. Others will jump too far, too fast.

In our review of systems around the world, we found a road map for system development. Best-in-class systems unlock considerable benefits by staging out system development and cooperation over time—building on work streams in a particular sequence. From their experience and lessons learned, we engineered a map for system development.

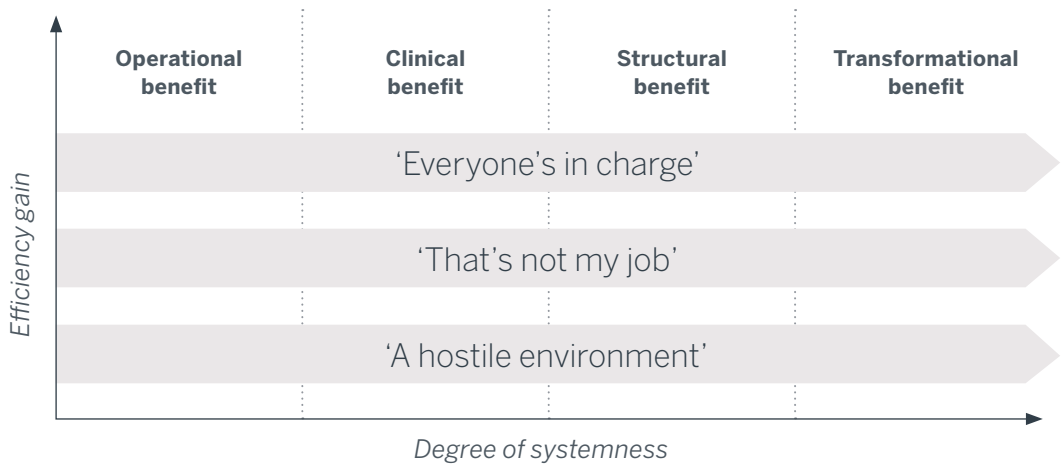
## Steps and benefits gained through systemness



This blueprint, extending from the baseline operational focus to an ambitious transformational identity, outlines the journey most systems should follow to be greater than the sum of their parts. This framework is helpful for setting the ambition. To move from idea to action, we need to address the common barriers to unlocking each of these benefits listed above.

# Common barriers in the pursuit of systemness

One of the major insights that came out of our research was that the successful systems we studied all had to overcome the same three major barriers on their path to systemness, shown in the gray areas below:



- 1 When we build alliances of partners and equals, it's not always clear who's in charge.** And it can become contentious when decisions need to be made.
- 2 Stakeholders tend to identify most closely with their role in the system.** As a result, they often see any change as disruptive to their core responsibilities.
- 3 Incentives and resources that dictate our operating environment are sometimes antagonistic toward system development.** Partners are often paid, sourced, and rewarded individually—making collective action all the more difficult.

While the third barrier lends itself to policy solutions, solutions for the first two are in direct control of the entities working together on this pursuit. These are where we focused.

In this briefing, we will take a deeper look at this first barrier—unclear decision-making authority—and offer our key insights on developing an effective governance structure that enables system progress.



For more of our research on the second barrier—diffused system affiliation—read our other systemness briefing, *Creating System Citizens*.

# There's no single governance model for achieving systemness

In our interviews, chief executives routinely pointed to the fact that **pursuing systemness is inherently political**. But while most executives intuitively understand that, they focus efforts on form instead of function—running first to constructing an organisational chart.

A common misconception is that governance must be grounded in organisational hierarchy. However, this concept ignores what governance is designed to do—**enable the ability to make decisions**.

What our research showed was that before you talk about reporting structures, the following three key insights should be considered:

- 1 The currency of governance is decision-making, not hierarchy.
- 2 Authority to make decisions should be delegated to people best suited to make them.
- 3 Enforcement mechanisms range in intensity; avoid jumping straight to penalties.

INSIGHT 1

# The currency of governance is **decision-making**, not hierarchy.

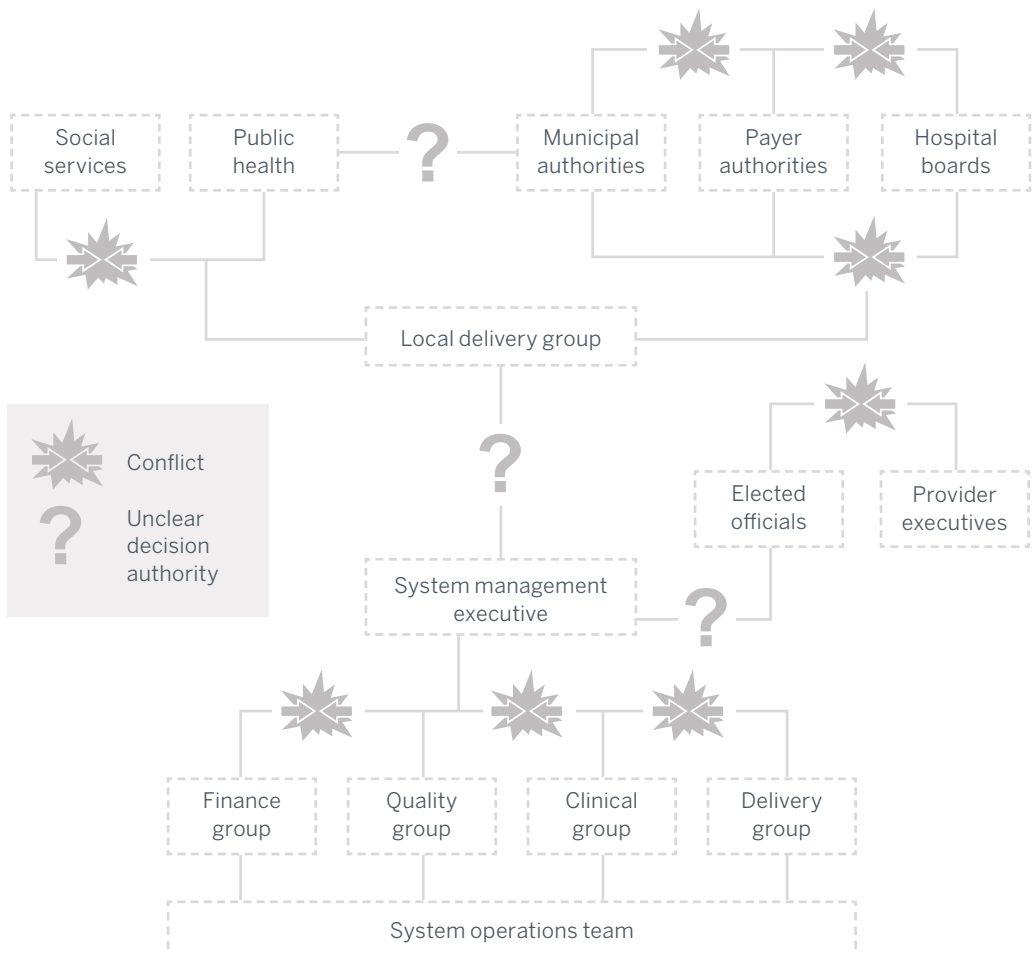
When deciding on the best governance structure, it's helpful to start with an example of one to avoid. Below is the pseudonymed governance structure of an alliance in England that is attempting to create a geographic cluster of providers. Their goal is to collectively harmonise services and invest in services that their communities need.

Look at the organisational chart below. I challenge you to identify who is in charge in what instances.

Who is in charge at all?

## Governance structure at Blue Jay System (pseudonym)

*Solid lines indicate reporting relationships*





When creating organisational structures like this, serious questions become clear: It's great to establish a reporting structure, but what happens when you need to take action? What about contentious actions?

And herein lies the problem. Governance is not about communication or even reporting lines. **What we need from our governance structure is the ability to make decisions.**

This is our most critical insight when it comes to governance.

Focus less on reporting lines and hierarchy when designing system governance structures, and instead base the structure on the critical decisions that need to be made and who has authority to make them.

# Authority to make decisions should be delegated to people **best suited** to make them.

If decisions are our governance currency, then an organisational chart will not help solve governance problems until two things are clarified:

- 1 What are the mission-critical decisions that we're going to have to make as a system?
- 2 Of that inventory of decisions, who among our team is best situated to make them?

The general rule of thumb we've gleaned throughout our research is that the partner(s) closest to the patient should be authorised to make decisions related to patient care and navigation. And the partner(s) with the widest view to system direction and performance should be empowered to make decisions affecting those spheres.

Put another way, consider splitting up the authority to make decisions into two buckets that will help evaluate roles and decisions in a more constructive way: **planning power** and **operational power**.

## Planning vs. operational power

### *Planning power*

- Related to overall system direction
- Focused on what system should do and why

### *Operational power*

- Related to the execution against overall direction
- Focused on how, when, and where system should deliver on strategy

## Delegating authority based on proximity to patient



It's easy to assign decision-making authority to the issues on the top and bottom of the graphic above; they fall clearly in the system or local level. But the issues in the middle are harder to categorise. Who should have authority over these areas that are partially planning but also partially operational?

Clalit Health System in Israel has solved this problem particularly well. We detail their story on the next two pages.

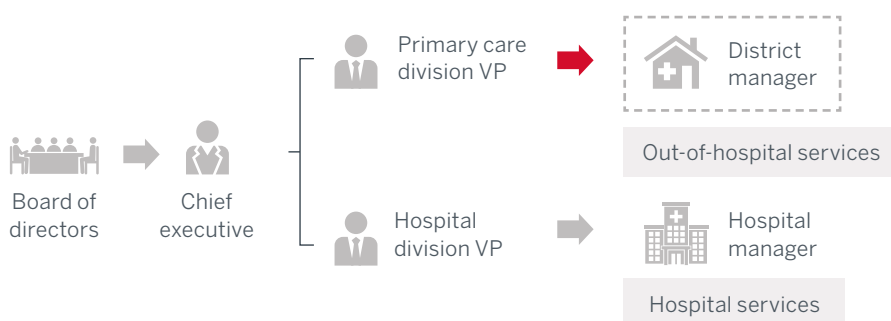
## Case Study: Clalit Health System

Clalit is Israel's most successful health maintenance organisation (HMO)—a vertically integrated, not-for-profit entity that is responsible for both insuring and delivering care for its members. Clalit, which owns 14 hospitals and covers 3.8 million lives (about 60% market share), exists in a market where financial success happens when the collective can deliver quality outcomes below budget. As such, it's in the organisation's best interest to ensure that their decisions are allocated to the part of the system best able to make them—especially as they get closer to the patient and the care delivered.

At first glance, Clalit's reporting structure looks like any other multi-geographic, multi-divisional institution: a board at the top guiding strategy, a chief executive who interprets and marshals teams toward collective goals, and two co-equal branches of delivery—primary care and hospital care—that manage the cost and delivery of services for Clalit's insured population.

What makes Clalit stand out is how they allocate authority for issues that fall between planning and operational—the centre section of on the graphic on the previous page. Clalit has found their regional and district managers are best suited to make decisions on these 'middle' issues, such as adjusting system strategy to the local context, deciding on referral patterns, and adjusting their regional portfolio of services.

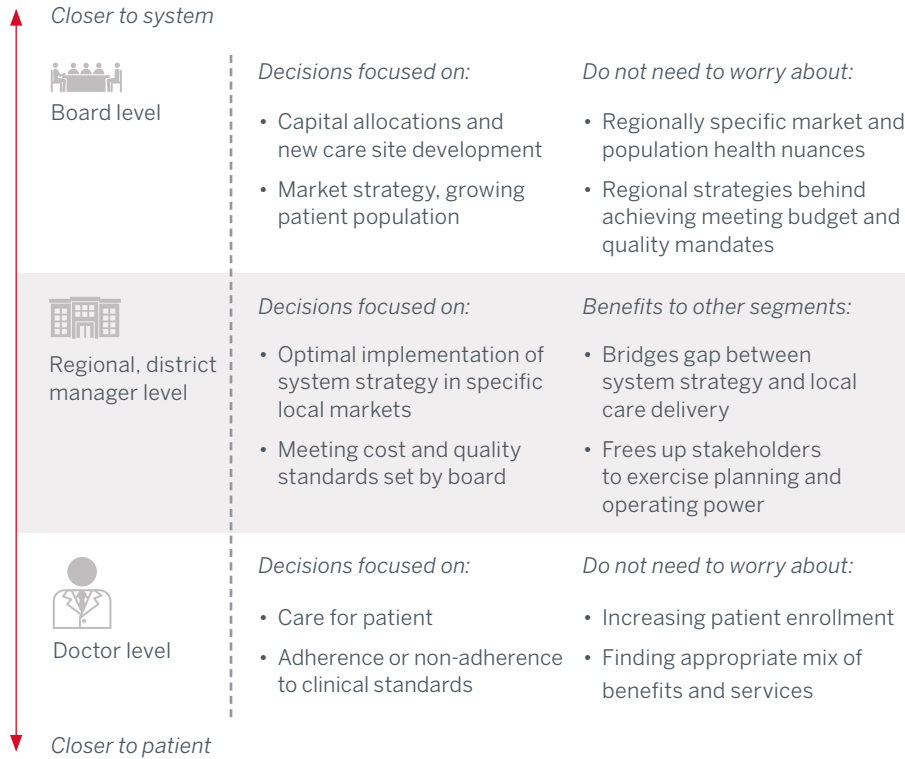
### Clalit's organisational structure



This middle-system power allocation has two key benefits:

- 1 Regional managers can both interpret top-down strategy as well as pull information from frontline staff more effectively than other leaders in the system.
- 2 With regional managers assuming responsibility for middle-system decisions, executive and frontline leaders are able to devote their time and effort to the decisions they are best situated to make.

## Clalit's decision focus area



The three middle-system decisions from page 9 now fit within Clalit's regional managers' remit:

### **Service planning**

What is our product and asset portfolio for the market we manage?

### **Referral strategy**

Where do we refer for specialist care across our local network?

### **Doctor relations**

What support should we give clinicians?

### INSIGHT 3

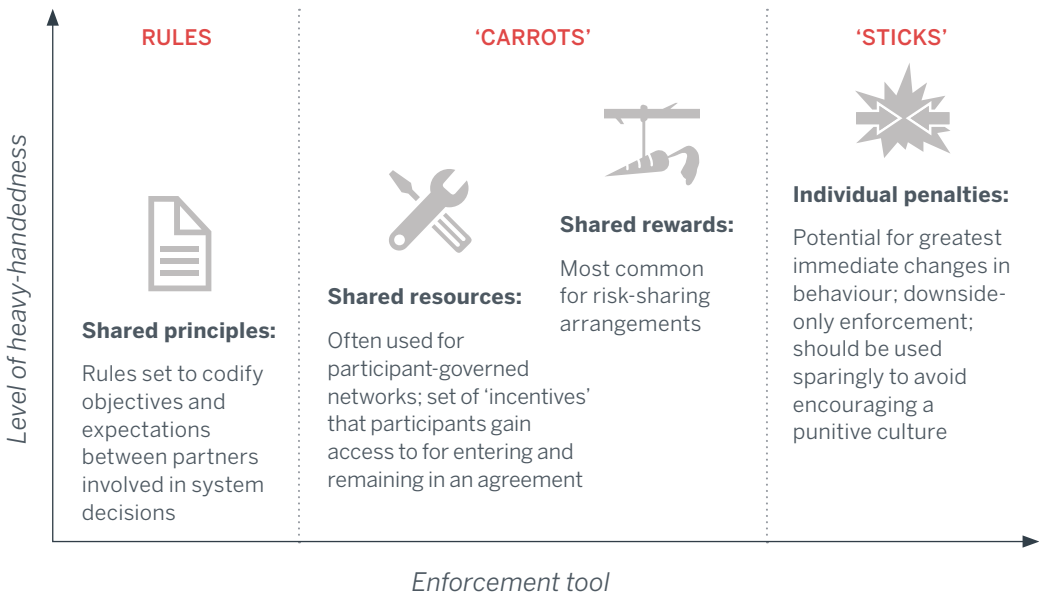
# Enforcement mechanisms **range in intensity**; avoid jumping straight to penalties.

**Not all decisions are the same.** While some decisions will be easily accepted by everyone, others will be deeply contentious even when they're the right course of action. When stakeholders push back against decisions, a variety of enforcement tools must be used to get those who are resistant on board with the changes.

In our research, we saw that best-in-class systems used a spectrum of enforcement mechanisms to deliver on their proposed changes. These ranged in heavy-handedness based on the level of oversight and formality each system had with its stakeholders.

## Multiple enforcement tools at your disposal

*Common means of enforcement*



Because the first two insights in this briefing are more theoretical and this one is more actionable, we are spending a majority of our time here to give guidance on how to best enforce your decisions.

In the following pages, we'll take a look at case studies on each of the four enforcement options, ranging from the tamest, shared principles, to the most punitive, individual penalties.

## SHARED PRINCIPLES



*When crafted correctly, shared rules—particularly when established at the outset—can take you farther than you think. In many cases, simply outlining a rubric of common principles gets most detractors on board with system change.*

### **Case Study:** *Yale New Haven Health System*

Yale New Haven Health System's flagship hospital, Yale New Haven Hospital (YNHH), is one of the largest academic medical centres in the US. Several years ago, despite having grown to three sites, YNHH was stretched thin and needed additional capacity.

One option was to build a new inpatient tower—a US \$700 million project. But a less-expensive option was to purchase the nearby Hospital of Saint Raphael, which was operating under capacity. The system chose to purchase Saint Raphael, but was worried that the acquisition would lead to potentially redundant or even self-competitive services, disrupted practice patterns, and a slew of other challenges. Leaders soon realised that they didn't need an additional hospital, they just needed additional space. So they bought Saint Raphael, but rather than keeping it as a separate hospital, they completely integrated it into YNHH.

As the system looked to rationalise services between the sites, they evaluated each service based on a set of five strategic considerations, ranging from capacity to religion. This created a rubric to help the system make the difficult decisions of what services would go where and how the system would anchor those decisions to its larger tenets.

#### **Strategic considerations for rationalisation of services**



Matching access and capacity to historical volumes



Opportunity for growth in a new and existing service lines



Regulatory issues with state and federal agencies



Culture of clinical and non-clinical staff constituencies



Religious directives for Saint Raphael campus

#### **Rationalisation action based on strategy**



Analysed operating room procedural volumes to determine appropriate locations



Invested in services with high forecasted demand to create care destinations



Required zero duplication of new services or technologies at two sites



Created single medical staff and evaluated clinical need at sites



Respected ethical and religious directives for Catholic health care at Saint Raphael

These considerations were wrapped up into one, nonnegotiable principle that Yale lived by during the change:

## | No unnecessary duplication.

Leading with tenets and objectives allows you to start discussions with benefits instead of costs. And starting conversations by listing the positives can help get everyone to work together.

When Yale's leaders met with Saint Raphael doctors, they pitched service rationalisation as a benefit. The focus was on the efficiencies gained rather than the services moved. The system also invested in renovations and equipment for the Saint Raphael campus. And Yale extended its name-recognition to all Saint Raphael staff to help secure their buy-in on the integration plan.

### Tactics for achieving doctor buy-in during integration



#### Evidence

Facilitated focus groups to discuss data-driven decisions on service rationalisation



#### Prestige

Established Musculoskeletal and Restorative Care Centers; planning centres of excellence for bariatric and neurovascular services



#### Investment

Renovated facilities and invested in equipment at Saint Raphael campus to improve care quality



#### Branding

Offered Yale New Haven Medical Staff membership to all doctors at Saint Raphael campus

# \$80M\*

Savings after one year as a result of consolidation

# \$300M\*

Projected five-year reduction in clinical, operational costs



Learn more about creating shared principles in our report *A Principled Approach to Service Line Rationalisation*, available at [advisory.com/sla/rationalisation](https://advisory.com/sla/rationalisation).

\* In US dollars.



## SHARED RESOURCES



*Enforcement isn't always punitive. We find that 'sweeteners,' such as shared resources, do a good job of encouraging participation across disparate organisations.*



### Case Study: Circle MSK

In 2014, Bedfordshire Clinical Commissioning Group—the local health payer, in Bedfordshire, England—put a bid out for another entity to assume responsibility for their elective musculoskeletal (MSK) procedures. Circle Health won the contract and took on a five-year fixed capitated budget to manage this population, which meant they had to manage all referral growth over those five years without any year-on-year increase in budget.

However, Circle faced a problem. Under the contract they were allowed to pay specialists and acute, tertiary, and post-acute providers, but not general practitioners (GPs). GPs in the UK serve a gatekeeping role, which means they are crucial players in referral pathways, in terms of both volume and referral type. As such, Circle needed a way to engage non-affiliated GPs to refer MSK patients to Circle only when they absolutely needed to receive specialist care.

To ensure that GPs made appropriate referrals, Circle offered them shared resources, such as fully funded senior physiotherapists (PTs) that Circle placed in the primary care clinics.

#### Circle MSK's physiotherapist-GP support protocol

	Visit frequency and result	Circle benefit	GP benefit
 GP GP GP	<b>60%</b> Of patients are discharged after PT provides education session	No unnecessary low-acuity referrals into MSK service	PT addition to GP practice promotes top-of-licence care delivery
 Physiotherapist	<b>40%</b> Of patients are referred to MSK pathway by PT or GP	High-quality referrals and downstream utilisation tracking	GPs and PTs get access to standardised referral form for MSK patients

Circle Health provides additional support to GPs who may be unfamiliar with musculoskeletal issues or who serve as a care substitute. Roughly 60% of the patients who are initially referred to Circle's MSK programme return back to their GPs after an education session with the PT. The remaining 40% are appropriate referrals and get treated in Circle's MSK programme.

This programme has many benefits. On average, up to 30% of GP visits are MSK-related, and having a physiotherapist co-located in the primary care setting has improved the quality of Circle Health's MSK referrals. In addition, physiotherapists are able to free up GP capacity, ensure certain standards for referrals, and provide education sessions for patients. The GPs appreciate this resource provided by Circle and the extra capacity it provides—which means they can grow their business.

### Results of physiotherapist placement in GP clinics

30%

Of primary care visits are related to MSK issues

0

Unnecessary referrals to Circle's MSK pathway

0.5 days

Time saved per week per GP supported by a Circle PT

<5%

Of Circle patients veer from original treatment plan over 1–2 years

Over the last three years, Circle has experienced 15–20% referral growth year over year. But they have still managed to keep costs under budget through standardising and streamlining referrals, as well as moving a significant volume of care out of the hospital and into the community. And they cite the senior physiotherapists as an integral part of setting this system up for success.

Adding staff to a doctor's team is one example of a non-monetary incentive. We have seen other institutions offer free facility space or lab/waste/pathology services. There are a host of other shared resources you can consider providing to your doctors to engage them in maximising the benefits of systemness.

### Example non-monetary incentives



Free rent in your owned space



Grant-writing assistance



Pathology or lab services



Back-end office support



Waste management services



Laundry, grocery, or transportation services



Learn more about incentives you can provide in our report *The Primary Partnership* (pages 20–23), available at [advisory.com/gfhi/theprimarypartnership](https://advisory.com/gfhi/theprimarypartnership).

## SHARED REWARDS

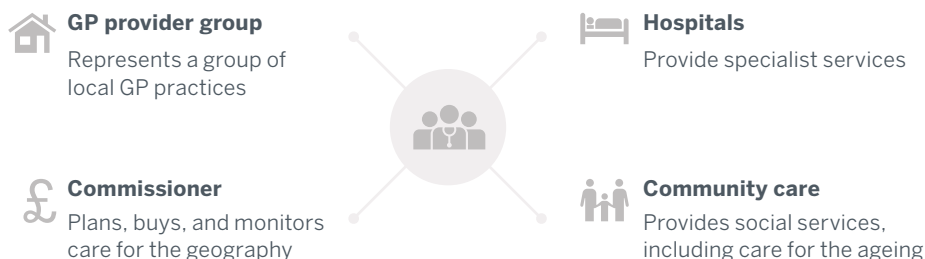


The most prominent 'carrot' to use when enforcing decisions amongst stakeholders is creating a way to share the benefits of system integration with all participants. One such example is the shared savings model, also referred to as 'gainsharing'. This is an incentive model whereby an alliance of partners commits to saving money through collective action and clear divisions of labour. If they are able to bend costs below a set threshold, they often split the benefits (either savings or a bonus) among the group. To be clear, these models are difficult to navigate, but they can be highly effective.

### Case Study: LLR Alliance

LLR Alliance is a collective of clinical commissioning groups (the main payers in England), hospitals, and community partners in Leicester, England. The LLR Alliance is trying to drive demand for ambulatory-sensitive services from the emergency department into outpatient facilities and thus achieve a collective savings. In 2014, LLR assumed responsibility for outpatient, diagnostic, and day cases for eight hospitals in the region under a seven-year, £22 million contract. The contract is designed to compensate providers for reduced volumes that result from increased prevention, better care management, and alternative care site use.

#### System responsibilities under LLR Alliance gainsharing contract



#### Alliance contract includes:

- Principles for guiding member behaviour
- Integrated governance
- Performance framework linked to shared outcomes
- Commercial framework for both 'gainshare' and 'painshare' (splitting bonuses and penalties)

Within the first year, by pushing services out of the inpatient setting, LLR Alliance was able to achieve savings. In 2015 alone, the contract yielded a £500K savings for the group, which they've since re-invested into the collective to cover additional services. As the contract has progressed, LLR has expanded their goals to include the shifting of care for endoscopy, gastroenterology, rheumatology, pain management, and MSK to non-acute centres.

These types of agreements have taken off in the US under the Affordable Care Act, and are continuing to grow in the UK and Europe as certain markets pursue integrated care models involving risk-based contracts.

### Five key pillars to shared savings

- 1 Mutually agreed upon opportunities for improvement
- 2 Clear division of benefits and work
- 3 Impartial arbiter to divvy out savings
- 4 Up-front method for dispute resolution
- 5 Transparent and outcomes-based quality metrics



Learn more about leveraging shared rewards in our report *Shared Risk, Shared Rewards*, available at [advisory.com/gfhi/sharedrisk](https://www.advisory.com/gfhi/sharedrisk).

## INDIVIDUAL PENALTIES



*For truly contentious decisions, there is no incentive that will be enough of a sweetener to get partners fully on board. In those situations, heavy-handed approaches are necessary to ensure action.*

### **Case Study: Geisinger Health System**

One organisation that chose to go with penalties rather than incentives is Geisinger Health System, a 12-hospital system in Pennsylvania, US. They were one of the first providers to implement a readmission penalty, a practice that has spread to organisations in several other countries.

Traditional fee-for-service reimbursement incentivised more care rather than better care. In response, Geisinger implemented its 'ProvenCare' policy, in which they guarantee high-quality care by forgoing reimbursement if there are complications. Geisinger started with coronary artery bypass graft (CABG) surgery. If a CABG patient is readmitted to the hospital or experiences complications within 90 days of surgery, the system will not charge insurers for the associated costs of the complications.

It's a strong guarantee: if Geisinger doesn't perform to their high standards, they're on the hook for every dollar spent on each readmission or complication. The policy has been successful—and popular with insurers. Geisinger has now established the same guarantee for hip replacement surgery, perinatal care, angioplasty, and cataract surgery.

Geisinger's readmission penalty has now become a mandatory part of the accountable care organisation payment models in the US and is being considered with private insurance providers in Australia.

#### **The ProvenCare guarantee**

- + Geisinger worked with payers and their own health plan to implement a self-imposed penalty system for subpar or mismanaged care
- + Provides 90-day care warranty for elective CABG surgery:
  - No reimbursement for readmissions or complications
  - Policy has been expanded to multiple additional procedures

**100%**

Lower in-hospital mortality

**45%**

Decrease in 30-day readmissions

**21%**

Decrease in number of patients experiencing complications

**10%**

Increase in patients discharged to their homes

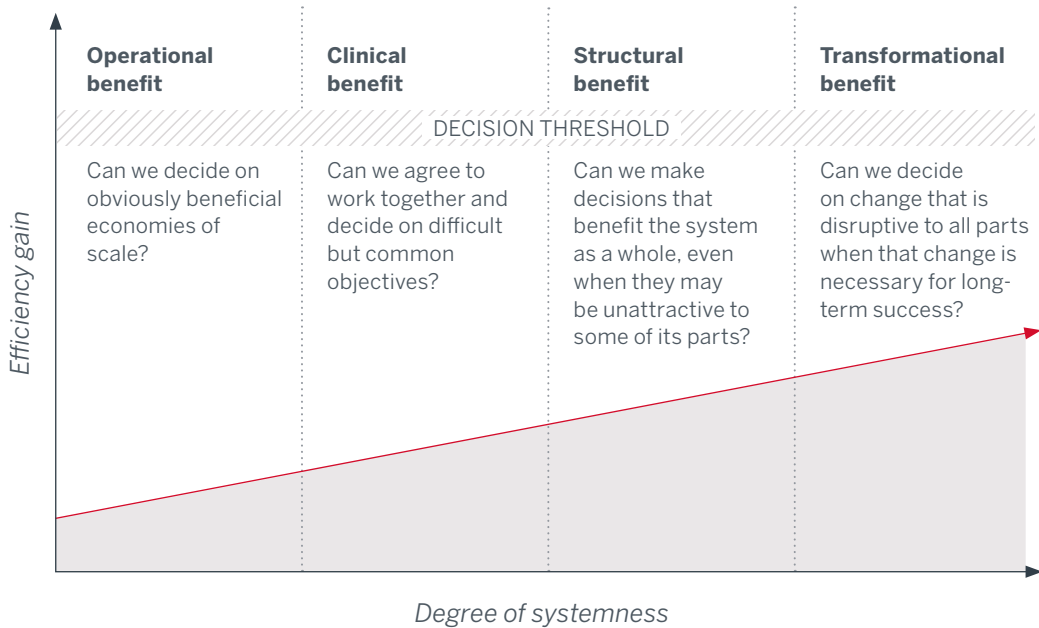
# Closing thoughts: **Transformational capability** is a function of decision-making prowess

In any sort of governance agreement, the ability to make and enforce collective decisions is what influences how far you will go as a system—and how fast you'll get there. When we spoke to chief executives, they showed us that the systemness blueprint can also frame the kinds of decisions you will have to make to achieve the benefits of systemness.

We overlaid these decisions onto our systemness roadmap from page 3. As you can imagine, the harder the decision for a collective to agree upon and enforce, the more they stand to benefit. While attaining a 'transformational' status is both ambitious and difficult, there are distinct questions to decide on—together, as a collective whole—before getting there.

Consider the framing graphic on the facing page both as a tool for focusing your efforts, given the kinds of decisions your collective is willing to make at this time, and a gauge for what it's going to take to unlock other stages along the systemness journey.

## Steps and benefits gained through systemness



Governance models need to be flexible and adaptable. Likewise, good governance is rarely all-or-nothing. Sometimes certain partners will have clear authority when making decisions, and other times it will be a decision amongst equals.

The insights presented in this briefing, as well as the framework displayed here, will prepare you to more readily adapt for changes and lack of clarity around decision-making as it comes.

We captured a few examples of our systemness insights within this brief. For additional support, please access our additional 'systemness' resources on the next page, or contact [gphi@advisory.com](mailto:gphi@advisory.com) with questions.

# Selected systemness resources

from the Global Forum for Health Care Innovators



## Research reports: Blueprints for best practice replication

### Creating System Citizens

No matter where an organisation is along their path to system development and integration, there are several key areas on which to focus. This briefing focuses on one of these no-regret areas of health system development: creating system citizens. In it, we map out the ways organisations can build greater stakeholder affinity for their system through four targeted and sequential engagement strategies.

### Expert Perspectives on Systemness

Many health systems are only scratching the surface of the potential their scale offers. But today's market leaders are leveraging purposeful integration and cohesive effort—what we call 'systemness'—to streamline operations, deliver more reliable and coordinated care, rationalise fixed costs, and even transform entire delivery models. This publication offers expert insights and strategies from our researchers and consultants on how to achieve true systemness.

### The New Partnership Advantage

As providers struggle to cope with the unprecedented challenges of today's health care landscape, hospitals and health systems are increasingly recognising the need to turn to partnerships for survival. This briefing discusses the two main obstacles that hinder successful partnerships in health care—and how your organisation can refine its partnership strategy.

### The System Blueprint for Clinical Standardisation

Providers have responded to financial pressures and policy changes by turning to consolidation. Often, though, the result is a lack of 'systemness'—too many organisations get larger but less effective, diminishing quality and consistency of care in the process. This executive briefing offers a blueprint for achieving a properly organised, successful system that delivers predictable, consistent care.



## The System Approach to Service Line Management

While there is no one-size-fits-all organisational model for service line management, our research shows that some kind of system-level oversight is required to achieve true 'systemness'. This executive briefing includes an overview of more effective and cohesive service line approaches, analysis of eight organising principles common among top-performing institutions, interviews with service line experts, and detailed case studies.



## Implementation resources: Plug-and-play tools to embed change at your organisation

### Care Transformation Readiness Assessment

This tool helps shape and refine strategy by identifying organisational strengths and weaknesses as well as commissioner readiness.

### Partnerships and Affiliations Diagnostic

Use our diagnostic to identify proven means for working through gaps between strategic imperatives and organisational capabilities.



## Retreats: Facilitated day sessions to turn strategy into action

### Care Transformation Strategy Retreat

This executive retreat provides a platform for learning how best to prepare for the uncertainty, disruption, and upheaval within health care today in order to imagine, design, and offer next-generation health care services.

### M.A.P. Partnership Retreat

This strategy retreat is a five-hour workshop designed to reframe your approach to partnerships, create a short list of innovative partnership opportunities, and inform execution with strategic partnership tools.



Learn more about these and other resources on [advisory.com/gfhi](https://advisory.com/gfhi)

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practices are  
the ones that  
work for **you.**<sup>SM</sup>

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