INSIGHT SERVICE EXPERTISE

Integrated Healthcare Strategies
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The Transformative New Executive Roles,

The Talent Needed, and How to Pay Them

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Summary

Population health management and accountable care are changing the structure of integrated health care systems, and health systems are inventing the leadership team of the future as they create new leadership roles, select the first generation of transformative leaders, and design new reward systems. Success in the new roles will require leaders who are innovative, tech savvy and data-driven, who excel at collaboration, leading through influence, and winning cooperation. Because these roles vary from one organization to another, and because there are so few leaders experienced in these roles, the right pay for the new job may depend more on the person chosen to do the job than on what other organizations pay for a similar role.

Introduction

As health systems begin their forays into accountable care and population health management, they are transforming the organization by creating new business ventures, adding new executive roles, finding leaders with the entrepreneurial drive to invent a new model for healthcare delivery, and bringing onto the leadership team physicians and executives recruited from managed care, hospitality, and retail organizations. The new ventures are charged with creating something from scratch, with little information about the best way to do it. The positions leading the new ventures are tasked with figuring out how to do something new—inventing their own roles as they develop the plans, structures, systems and processes for developing the new modes of delivering healthcare. The talent chosen to lead these ventures often has no prior experience doing the job. Most of the executives recruited from outside the industry have little or no experience with the culture of a health care delivery system, yet their expectations—for rapid change and for competitive compensation—often disrupt established internal patterns, just as the new ventures themselves do.

At the same time, hospitals and health systems are responding to competitive threats that also force them doctors on call isn't an effective way of competing with retailers, are developing their own retail clinics. Others are re-organizing their clinic networks to make it easier to access care 7 days a week and 12 or 15 hours a day. As new firms offer interactive, video-based medical services on-line, some health systems are developing their own capabilities for meeting consumers' expectations for on-demand service.

What's behind the changes?

Hospitals and health systems are embarking on the most fundamental change they have seen in years. While they have had to adapt to changes in reimbursement patterns, learn how to do better with less, learn how to improve clinical quality and customer service, they have not had to fundamentally change the way they are organized to get their work done. Most hospitals are still organized the same way they were organized thirty and forty years ago. While multi-hospital systems have centralized most staff functions (finance, human resources, legal, information technology), they have generally done little to change the way operations are organized. While most health systems have acquired medical practices, they have generally left the medical practices organized as separate business units rather than organize clinical

services in a way that truly integrates medical practices with hospital operations.

Hospitals and health systems have traditionally been organized in silos. The standard structure for operational and financial management of hospitals has been using divisions (e.g., nursing, finance) and departments (e.g., critical care nursing, lab, housekeeping) organized around a single skill set or discipline or activity, with a focus on doing each separate activity as well as possible. The standard structure for operational and financial management of multi-unit health systems has been treating each facility (hospital or clinic) and other business (e.g., home health, transportation) as a profit center, or grouping them together in regions, each managed as a separate business unit, with a focus on optimizing the performance of each unit. As medical practices have been incorporated in systems, they have typically been organized as a network of medical practices, with individual practices left intact as they were before acquisition, or organized within regions of geographically dispersed systems, with a focus on financial management (minimizing losses).

Accountable Care calls for providers to focus on the total cost of care for a specific population (much of which occurs outside a facility), and systems have not been structured to focus on specific populations or on total cost of care. Population health management calls for providers to focus on managing care for a specific population across the entire continuum of care, and systems have not been structured to manage care across the continuum. Clinical integration, which is widely assumed to be the best way to manage care and cost of care for a population with a chronic disease or some common health problem, calls for horizontal management of clinical service lines across facilities and across the boundaries between ambulatory, acute, and post-acute care, and most systems are not organized in a way that facilitates horizontal management across all units in a system, let alone across the entire continuum of care.

As systems embrace accountable care and venture into population health management, though, they are re-organizing operational and financial management in three ways: organizing around system-wide service lines; organizing around populations with medical homes responsible for total care and total cost of care for a panel of patients; and organizing to distinguish between risk-based contracting and volume-based operations. Systems are centralizing leadership of clinical departments and service lines and moving away from the traditional focus on managing each facility as a separate business unit. They are re-organizing their physician networks around medical specialties, chronic diseases, and panels. They are integrating management of clinical services across medical specialties and hospital-based service line operations. And they are creating new divisions to venture into population health management and accountable care, offering health insurance plans and managing care under risk-based contracts. They are changing so rapidly that they have introduced an entirely new discipline of project management and a project management staff to help people manage all the change.

The old business paradigm—provide all the services the community needs, obtain as much volume as possible, and manage operations to keep costs below net revenue—doesn't work under value-based reimbursement. Hospitals and health systems are reorganizing to manage care as well as possible around groups of people (panels, diseases, age, gender) and along service lines. Managing cancer care as well as possible makes more sense than managing operations at each hospital as well as possible. Managing care for senior citizens as well as possible makes more sense than managing their care only when they have an appointment, show up in the emergency room, or get admitted to the hospital. Managing care for people with diabetes or cardiovascular disease as well as possible means helping them maintain their health so they need less acute care, which makes far more sense than managing their care only when they have crises.

What are the New Structures?

The new structures fall into three categories—those that are focused on the business of managing population health and accountable care; those that are focused on the business of offering services in new venues or new ways; and those that are focused on re-organizing operations to manage them in a way that supports population health management and accountable care.

Structures focused on the business of managing population health and accountable care

- Health plan or managed care divisions
- Population health management divisions
- Clinically integrated networks

Structures focused on delivering services in new ways or new venues

- Retail clinic organizations
- Work-site clinic organizations
- 24-7 telemedicine services

Structures re-organizing operations to support population health management and accountable care

- Service line organizations, especially ones that integrate physician specialties with hospital services
- Medical homes
- Clinically integrated physician networks for accepting and managing risk-based contracts
- Continuity of care/post-acute care divisions

Another new type of structure is the regional collaborative. A collaborative is often just a virtual organization formed to allow multiple health systems to work together in certain areas, such as developing capabilities for population health management, or forming a regional network of providers to contract directly with state-wide or region-wide employers. It sometimes evolves, though, into a separately incorporated organization to allow it to conduct business on behalf of its members. A collaborative is often limited to specific joint projects, but it is sometimes viewed as a trial marriage, a first step toward a potential merger.

Yet another is a local collaborative between a health system, other independent providers such as nursing homes, home health agencies, and federally qualified health centers, and various agencies in the community focused on the social determinants of health, such as housing, education, and food. These local collaboratives focus on improving the health of the community, managing the risks that lead to over-utilization, and engaging the population in maintaining their own health. [1]

[1] [1] As these new structures require governing across organizations that health systems do not own or control, developing agreements on health needs

What are the new executive positions?

The new positions are those leading these new initiatives or ventures. But the jobs vary from one organization to another, depending on the goals and design of the initiative. The jobs are new enough that there are no standard benchmarks for job content. The jobs are being invented or customized as the first incumbents decide what needs to be done to be successful and how to do it.

The positions are the leaders of these initiatives and ventures:

head of population health management
head of health plan division
head of clinically integrated network
head of patient experience
head of clinical transformation
head of clinical integration
head of innovation
head of collaborative
head of continuity of care
head of transformation
head of project management
head of retail operations
head of cancer center
head of heart institute
head of post-acute care
head of senior services
head of outpatient services

Most organizations are introducing only a few of these new roles, but that still expands the executive team and increases executive payroll. Larger systems are introducing quite a few of these roles.

There is clearly no one best way of organizing for accountable care or population health management. Organizations are taking different approaches, experimenting with structure and new roles to figure out what works best for them and what works best for the leader chosen to lead the venture.

What issues do the new ventures and executive positions raise?

Organizations introducing these new ventures and new executive positions encounter a number of challenges related to their being new. There are few precedents, success stories, benchmarks or best practices to show exactly what needs to be done and how. There are no standard job descriptions, so they need to be invented (with careful attention to how the jobs fit into the organization and overlap with other positions). There is no ready-made labor market of executives with experience and success at leading these initiatives. There is no reliable survey data on what the jobs should be paid. And the jobs, by their very nature, are disruptive: as they decide what to do and begin to implement their plans, they create new challenges, and they need to do so, in order to succeed.

Any organization planning to put one or more of these new initiatives into place should be prepared to handle these challenges:

- The new job is taking over certain responsibilities other executives have now, and the new incumbent, to succeed in the new role, will need to step on the toes of whomever has the related responsibilities now.
- These jobs are organizational disrupters ("creative disruption") that challenge the organization to do things differently.
- Since the jobs are being invented, developed, and refined on the fly, the accountabilities are often diffuse.
- There is no existing labor market representing talent experienced in doing most of these jobs, although some people with the appropriate experience can be found in health insurance and in general industry.

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and resource allocation calls for new governance structures and strategies referred to as "Collaborative Governance." See James A. Rice's white paper on this issue, http://www.integratedhealthcarestrategies.com/knowledgecenter_article.aspx?article_id=16679

- Since the jobs are standardized or well represented in compensation surveys, it is hard to know what the jobs are worth. The right pay for the role may depend more by the personal market value of the person chosen for the role than on what other organizations pay for a similar role.
- There are so few people experienced in leading clinical integration, clinical transformation, and population health management that it can be very expensive to recruit and retain someone who is experienced.
- Talent recruited from health insurance or from consulting firms is often far more expensive than talent recruited from health care providers. Recruiting executives from insurance or general industry can disrupt internal equity and even require the introduction of new programs (like long-term incentives).
- The talent needed to develop a new venture often commands more pay than traditional executive positions with much larger budgets and much larger staff.
- Recruiting talent from health insurers or from general industry introduces a risk of cultural conflict, getting someone who doesn't fit into the traditional style of a not-for-profit provider organization.
- Developing a new "destination cancer center" or "destination heart center" often requires recruiting a star from academic medical center, and these clinical leaders know how much they can demand to take on a risky leadership position in a new venture. They typically want exceptionally high base pay instead of the typical mix of base pay, incentives, and supplemental benefits, so recruiting them may require development of a different pay program for these physician executives.
- Adding these new positions increases executive payroll, and the additional costs will need to be offset by reductions elsewhere or paid for through incremental revenue.
- Most of these positions are charged with influencing others to produce outcomes, rather than directing and controlling operations to achieve outcomes. They work in a matrix structure in which success depends on teamwork.
- The jobs require leaders who excel at collaboration and winning cooperation (getting to yes), who are innovative, tech savvy, and data-driven.
- The jobs focused on population health management need to engage diverse stakeholders outside the organization and build teams spanning the entire community and multiple community organizations.

Potential solutions

After having watched any number of organizations struggle with these issues, after having had to help clients decide how to deal with them, we have formulated this advice on dealing effectively with the new initiatives and the new leadership positions:

- Define accountabilities and expectations as clearly as possible. Create the job you want, rather than just copying a description from another organization.
- Figure out how the new job overlaps with and needs to interact with other executives with related roles, and clarify the relationships between the new job and the old ones.
- Recognize that there isn't a ready-made labor market of people with experience, so consider choosing an insider who can develop into the role.
- Recognize that the person you choose for the role will define and shape the role, so choosing the right person for the role is just as important as defining the job.
- Make sure that the person you choose has the right competencies to lead through influence,

promote teamwork and collaboration, and win cooperation from those who control resources and operations.

- Recognize that there isn't a right rate of pay for the job, just a right rate of pay for the person you choose.
- Be careful not to overpay for experience, because you will have to live with the internal equity problem a long time.

Leading change is hard enough, if you know what needs to be done. Being on the leading edge of industry-wide change is far harder, because you need to invent what needs to be done.

There is an alternative, of course, which is waiting—waiting until other organizations have charted the way, learned what works and what doesn't, and established benchmarks and best practices. It may be a way to avoid mistakes and to minimize risk, but it also means taking a chance on being left behind.

Understanding these issues and planning how to deal with them should go a long way to making them easy to deal with. It should make it easier for the new initiatives to succeed, too, and easier for the new leaders to be successful. It would be wise, however, to expect some bumps along the way.

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David A. Bjork, Ph.D., joined Integrated Healthcare Strategies, a division of Gallagher Benefit Services, Inc., as a partner in 1994 to start a division focused on executive compensation and incentive plans. Over the next decade, as practice leader, he helped develop the largest and best respected executive compensation consulting practice serving the health care industry. He developed the standards the firm now uses in evaluating the reasonableness of executive compensation; advising boards on CEO performance appraisal; advising boards on governance of executive compensation; and conducting surveys of executive compensation.

Drawing on his knowledge of executive compensation in the healthcare industry, he has helped dozens of clients minimize the risk of intermediate sanctions by redesigning their compensation arrangements or providing evidence that the compensation arrangements are indeed reasonable. He has helped dozens of boards recruit and retain CEOs by showing them how to configure compensation arrangements and employment agreements to meet their needs. He has helped others strengthen their governance processes.

Dr. Bjork earned an A.B. at Harvard, an M.B.A. in finance at the University of Chicago, and a Ph.D. from the University of California at Berkeley.