EIGHT LESSONS ON COLLABORATION

The Daughters of Charity National Health System Experience

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Dramatic changes have occurred in the way healthcare services are delivered and financed in the United States. Inpatient services are increasingly focused on the most seriously ill patients, with a corollary expansion in ambulatory care. Many hospitals have evolved toward more comprehensive health systems by offering increased services along the continuum of care and by linking more closely with physicians and other providers of healthcare. Many providers are taking risk previously associated with insurers.

All these changes have occurred as part of the same phenomenon: the need to utilize improvements in science and technology, health education, and clinical and management practices to improve efficiency and outcomes for public and private payers and consumers who feel overburdened by higher costs.

One potential area of promise for responding to these environmental pressures is collaboration, which may also help fulfill mission imperatives.




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Finding partners to help fill out the continuum of care may provide financial benefit to hospitals, which can expect to manage significantly fewer inpatient dollars in the future, and at the same time provide "one-stop shopping" for patients. Bundling services for more fixed payment (by unit of service, procedure or episode, or covered life) requires greater structural and operational unity, which consolidation provides. Consolidation can also help providers share the task of eliminating excess capacity, which would help them meet their cost containment obligations without eliminating needed services.

For these and other reasons, hospital consolidation activity has hit record-setting levels of late. But our evolution toward integration is more complex than we thought. Physician-hospital organizations and management services organizations have often not immediately produced membership, savings, or leverage. Hospital-based health maintenance organizations have proved to be more difficult to maintain on a profitable course than originally predicted. Some providers are selling their HMOs. There is now discussion of "focused factories" and the dismantling of integrated delivery systems.

It is still too early to tell whether these recent events represent merely the usual ups and downs of transition or a trend that would bring into question the long-term benefits of integrated delivery. We continue to believe in the value of integration and collaboration; however, our nation's experience with these strategies is relatively short. By sharing lessons from experience with collaboration, we hope to enhance our nation's collective ability to improve the delivery of care into the next century.

The Lessons Learned Project

The Daughters of Charity National Health System (DCNHS) has been working to create "a

future worthy of our past." In 1997, the system developed its "VISION *transformation* Strategic Plan," a road map for the challenging future. Building effective integrated delivery networks is integral to the achievement of DCNHS's overarching goals (see **Figure**).

To accomplish its local integrated delivery network strategy, its goals, and ultimately its mission, DCNHS believes it must honestly and thoroughly examine its collaborative experiences. Toward that end, DCNHS commissioned its "Lessons Learned from Collaboration" project, convened a multidisciplinary internal steering committee, and invited The Lewin Group to synthesize the learnings from 15 local-level collaborations and four system-level experiences. The selected experiences offered a range of partners, geographic locations, legal structures, and successes and disappointments. DCNHS's goals were to use the lessons to improve the system's ability to plan, negotiate, implement, and operate networks and other collaborative arrangements.

Each collaboration was assessed in eight areas: basic rationale; vision, values and expectations; organizational culture and trust; deal breakers and key understandings; organizational structure; leadership; benefits and costs; and impact on the Catholic health ministry and DCNHS. The Lewin Group reviewed written reports submitted by system executives, interviewed key system leaders for additional information, and summarized the findings.

Following is a summary of the findings, which were presented in a more comprehensive report to DCNHS leaders at a leadership conference in March 1998.

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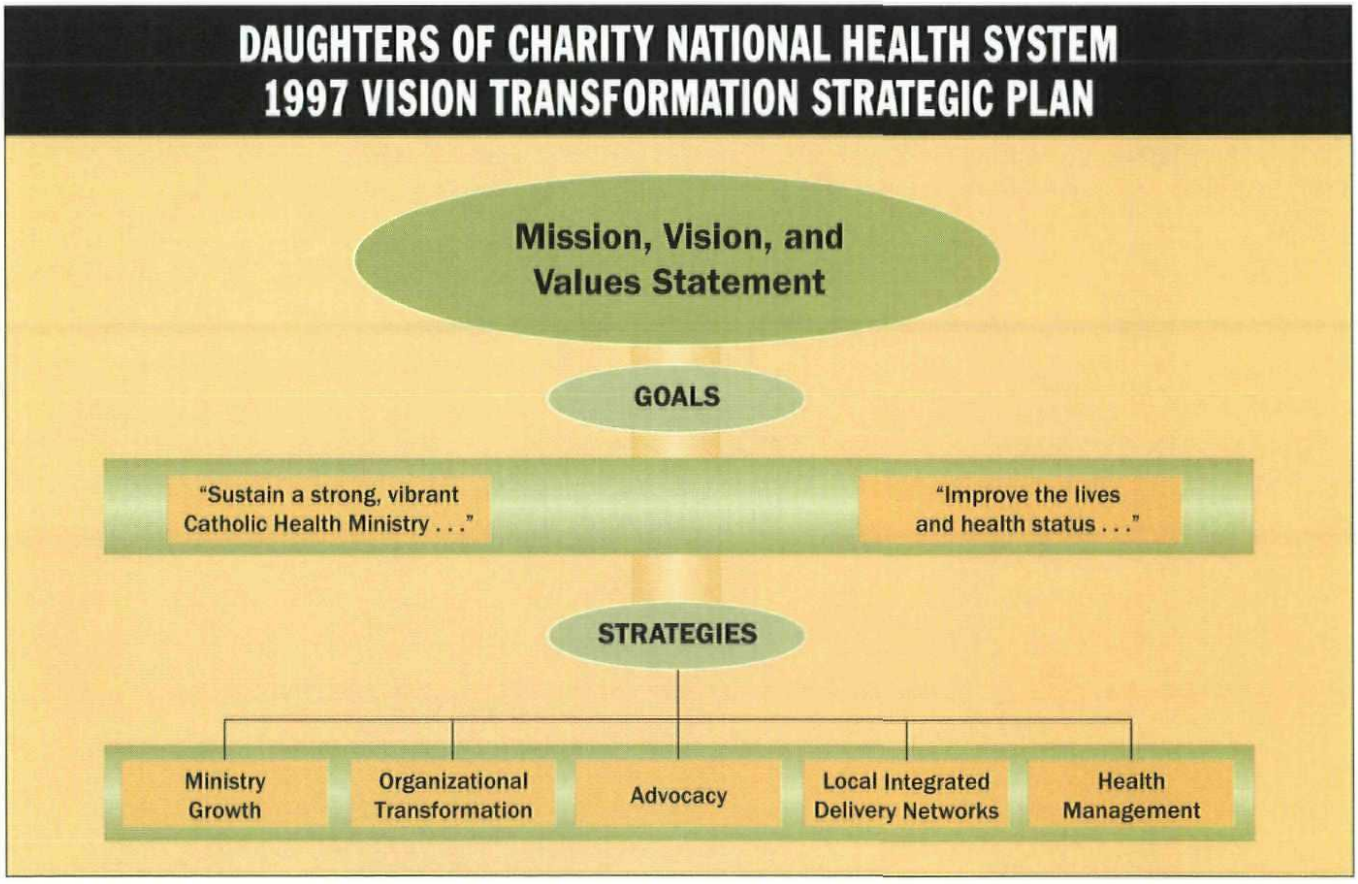
Eight Lessons on Collaboration

Lesson 1. The rationale for individual collaborations must be clear, compelling, and sufficiently detailed to be meaningful to the partners.

Basic Rationale DCNHS's overall policy of supporting collaboration was a propelling force for the collaborations studied. The rationale for collaboration fell into two general categories: strengthening Catholic healthcare in the face of market threats and anticipating competitive pressures.

When the rationale for the collaboration was a market threat, the parties showed a greater desire



and willingness to collaborate and compromise than when the collaboration focused on future advantage. In the latter case, the parties had a more difficult time following through and making the collaboration work.

Mission Benefits and Strategic Advantages DCNHS found a variety of mission benefits (i.e., factors that strengthened the Catholic health ministry) and strategic advantages (i.e., benefits that made the partners stronger in the marketplace together than separately) from its collaborations. Mission benefits included increased strength, visibility and presence; the opportunity to better integrate care for the communities served, with special emphasis on the poor; improved working relationships with the public sector; the avoidance of sale to a for-profit system; and an increase in charity care and community benefit. Strategic advantages included growth in market share and influence; the removal of duplication and greater efficiency; improved service and quality; more clout in contracting; the facilitation of stronger physician organizations and integration of the medical staffs; and financial advantages through the addition of a new member to DCNHS's expanded obligated group.

Costs of Collaboration DCNHS bore the costs of planning, negotiating, implementing, and operating partnership arrangements, as well as the costs incurred by failure. These costs included the time and energy needed for planning, negotiation, and implementation; high internal stress which resulted in loss of momentum and constraints on the organization's ability to respond to the environment in a timely fashion; staff turnover and its negative impact on morale; and community unrest over service reconfiguration plans. Such costs are significant considerations, given that they compete with other demands for financial capital and the time, attention, and expertise of senior managers and trustees.

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Articulate a Shared Local Vision DCNHS found that a powerful local rationale for the partnership is required. In some cases in which the collaboration was not successful, DCNHS and its partner did not share a common vision to the degree required to drive the consolidation process. DCNHS found several important elements of the vision that should be clearly articulated (see **Box**). Clarity of vision is important because DCNHS's experience suggests that following through on collaboration is difficult when the perceived need for change is not compelling.

Lesson 2. Congruence of mission and values is an essential requirement for successful collaboration. Careful, formal analysis of mission and values compatibility improves the likelihood of a successful long-term partnership, but other factors must be considered and understood as well.

Test for Compatibility In every case reviewed, DCNHS compared mission and values early in the process and found compatibility. Measures of comparison included:

- A formal assessment tool
- The study of philosophy, mission, values, and beliefs
- A transition period with defined expectations
- Acquired knowledge of the partner over many years
- Meetings/discussions between executives, department directors and mission services to perform due diligence on mission compatibility
- Open communications

However, some partnerships have been disappointing for DCNHS and its partners, despite an apparent congruence of mission and values. Such congruence is an essential ingredient for successful partnerships, but it alone is insufficient. Cultural harmony and excellent leaders are also essential.

A VISION FOR PARTNERSHIP

Daughters of Charity National Health System found that important elements of the collaborative vision must be clearly articulated, including:

- How the institutions envision themselves succeeding in the marketplace of the future (before and after partnership)
- Why the collaboration is compelling from mission and strategic perspectives, given that vision
- How much consolidation is expected to take place and where (e.g., administrative services consolidation, clinical services consolidation, integration of the medical staffs)
- Whether the partnership will be equal, with separate and distinct identities, or whether a single identity with more complete integration will be created
- Who will lead the collaborative effort; whether key management personnel will be retained or replaced; whether internal candidates will be eligible for the new CEO position
- What governance authority will be granted to each board; who will serve on the governing bodies
- In concrete terms, what it means to be a Catholic organization
- Whether the collaborative relationship is fundamentally with DCNHS or the local health ministry

Recognize Insurmountable Barriers Stepping away as early as possible from a potential partnership that has a marginal chance of success may be difficult, but if there are fundamental issues that prove to be barriers to coming together, they will not go away.

Lesson 3. Choosing the right leadership for collaborations is vitally important. Organizational trust and cultural harmony depends on visible, superior leadership.

The Importance of Leadership A compelling rationale; common mission, values, and vision; and cultural compatibility are still not enough to ensure partnership success. Leadership at the CEO and governance levels is an absolute requirement for bridging two disparate cultures and achieving strategic and mission success.

A clear theme from the study is that the character and integrity of individuals in leadership and governance roles is the main driving force for success after mission and values compatibility. Leadership can overcome a variety of difficulties or collaborative shortcomings (e.g., cultural differences and morale problems) and still achieve strategic goals and fulfill the mission. DCNHS has found several important characteristics of leaders:

- The ability to develop and maintain trust during negotiations, and effectively communicate with and find substantive roles for physicians, employees and the community
- An understanding of employee concerns
- The ability to communicate fully and truthfully regardless of message
- The ability to nurture and sustain positive working relationships
- The ability to recruit in ways that are not perceived to disproportionately represent one partner

The CEO DCNHS has learned that in each and every situation, careful thought must be given to deciding whether external candidates will be considered for the CEO position, or whether an internal candidate will be chosen. To select the CEO:

- Develop a clear leadership succession plan
- Use a formal search process; engage the search team in preparatory work
- Resolve the CEO question early in the process and be clear about whether the CEO will serve a time-limited role
- Decide whether only outside candidates will be considered
- Create a single authority rather than a joint CEO position
- Require the CEO to commit to a fixed tenure
- Seek leaders with system experience in addition to institutional experience

The Governing Board DCNHS has developed a bias for one board with clear roles and responsibilities at the local and system levels. Members of the network board must act as integrated network fiduciaries rather than as representatives of their supporting local organizations or sponsors. If the collaboration's directors remain aligned to one former sponsor or another, the partnership will suffer.

Lesson 4. Assessing the partner's cultural attributes is vital to the process of collaborations.

A theme that emerged was that dissimilar operational cultures can be particularly problematic, despite a foundation of common values, mission and vision. As a result, DCNHS has focused much attention on cultural issues in recent years, but methods to build relationships at all levels within and outside the institutions, especially with physicians, and methods to improve understanding of the respective cultures of the partnering organizations need further work. Areas to explore include:

- Relationships with the community
- Inclusiveness and balance in staffing and decision making
- Degree of physician influence in governance and management
- Business-driven vs. soft touch management styles
- Degree of autonomy/entrepreneurship and hierarchy/process
- Communication

An early, in-depth cultural assessment process led by an outside facilitator is an important step in any collaborative arrangement.

DCNHS's experience has also shown that bridging cultural differences takes time. Work on culture will not be completed before the strategic work begins. But to be compatible, two organizations do not have to be clones. If the vision of success is compelling and time is taken to create balance, diversity can be the strength of the collaborative arrangement.

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Lesson 5. A pluralistic approach to organizational structures for collaboration provides important advantages, especially flexibility, in tailoring arrangements to each market and potential partner.

DCNHS has structured collaborations in a variety of ways. In the experiences studied, one agreement was dissolved, one was transformed to a less integrated arrangement, and two are experiencing serious postconsolidation difficul-

ties. Like other systems around the country, DCNHS has found that collaboration, whatever structural form it takes, is a complicated endeavor. An equal venture may exacerbate the difficulties, especially in situations where the parties have not come together for compelling reasons or where the vision of the relationship is unclear. Notwithstanding these issues, DCNHS has not ruled out any particular model at this time. The advantages of a pluralistic approach to meet unique needs of specific markets outweigh the advantages of hard-and-fast rules on structure.

Lesson 6. The process of collaboration is important and deserves attention in its own right. Development of communication resources and tools to facilitate dialogue with key constituencies is important.

The Process The process of moving toward collaboration can be as important as the details of structuring the relationship. DCNHS has learned to:

- Include the local ordinary early and often in the process
- Identify and address deal-breakers openly, honestly and early
- Address the CEO and board leadership positions clearly and definitively
- Create and utilize a detailed communication plan that strikes an appropriate balance between disclosure and confidentiality
- Gather input from all levels of the organization
- Ensure the support and active participation of senior executive management

DCNHS has also learned that early discussion of deal-breaking issues is important. Such issues may include:

- Application of the *Ethical and Religious Directives for Catholic Health Care Services*
- Application of system policies and use of services
- Representation of physicians in governance
- Selection of board chairperson and maintenance of community trustees
- Displacement of staff
- Joining the system's obligated group
- Purchase price and money transfer issues
- Financial penalties for voiding the arrangement

Communication One theme discussed in nearly every DCNHS collaborative experience was the importance of ongoing communication during each step of the planning and negotiation process, as well as during the life of the collaboration. Carefully constructed messages and well-executed communications plans are imperative for success. In addition, open communication is key to avoiding misunderstandings that can doom a relationship before it can take root. Stating realistic expectations for the collaboration is critical.

The development of personal relationships through communication is also critical. When key leaders had long-established friendships, as well as business relationships, trust and mutual respect were brought into the analysis and final decision to enter the collaborative arrangement. In some cases, personal relationships have proven to be pivotal.

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Lesson 7. The physician component of collaboration can be the most complex and difficult. Greater physician involvement in collaboration, particularly when facilitated by physician leaders, showed promise in increasing the likelihood of partnership success.

Physician linkages will be central to success in any future environment. The case studies emphasize the importance of physician support and the difficulty of achieving the involvement necessary to produce that support. Nonetheless, physicians must understand the collaboration before they can support the necessary changes that will be required for success.

DCNHS has found superior physician leadership to be an important factor in success. Adding physicians to the board of directors and involving physicians in planning were both help-

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ful in integrating medical staffs and in moving the system away from exclusively "hospital" thinking.

Physician relationships play a key role in service reconfiguration, and physicians, as a constituency, cannot be represented by just a few physicians. Any consolidation must provide a clear channel of communication and multiple opportunities for input and comment by the medical staff.

Lesson 8. Collaborations are works in progress. Additional research and development will help DCNHS plan, negotiate, implement, and operate networks and other collaborative arrangements effectively. Potential areas for best practices development include improved market and cultural assessment, leadership selection, support and education, central versus local governance, physician integration and communication.

A willingness to make difficult choices for optimal long-range outcomes is a necessary precursor to succeeding at collaboration. Collaborations develop over time; they all face adjustment periods. Some of the terms of collaborations have changed significantly. Not all collaborations have yet achieved major intended benefits, while others endure postconsolidation consternation or unintended costs in the form of community apprehension or backlash.

It is not realistic to anticipate every eventuality and expect to craft organizational documents that address every situation. DCNHS has learned it must be prepared to tend to these arrangements after the planning, negotiation, and initial implementation stages. The postcollaboration environment always requires attention. DCNHS believes it is better positioned for the future having confronted its multiple markets with a clear sense of purpose and a willingness to act. □

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