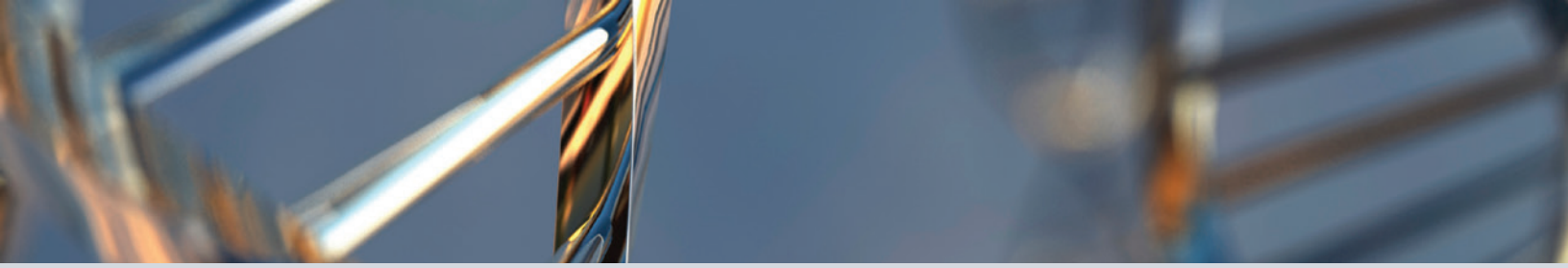
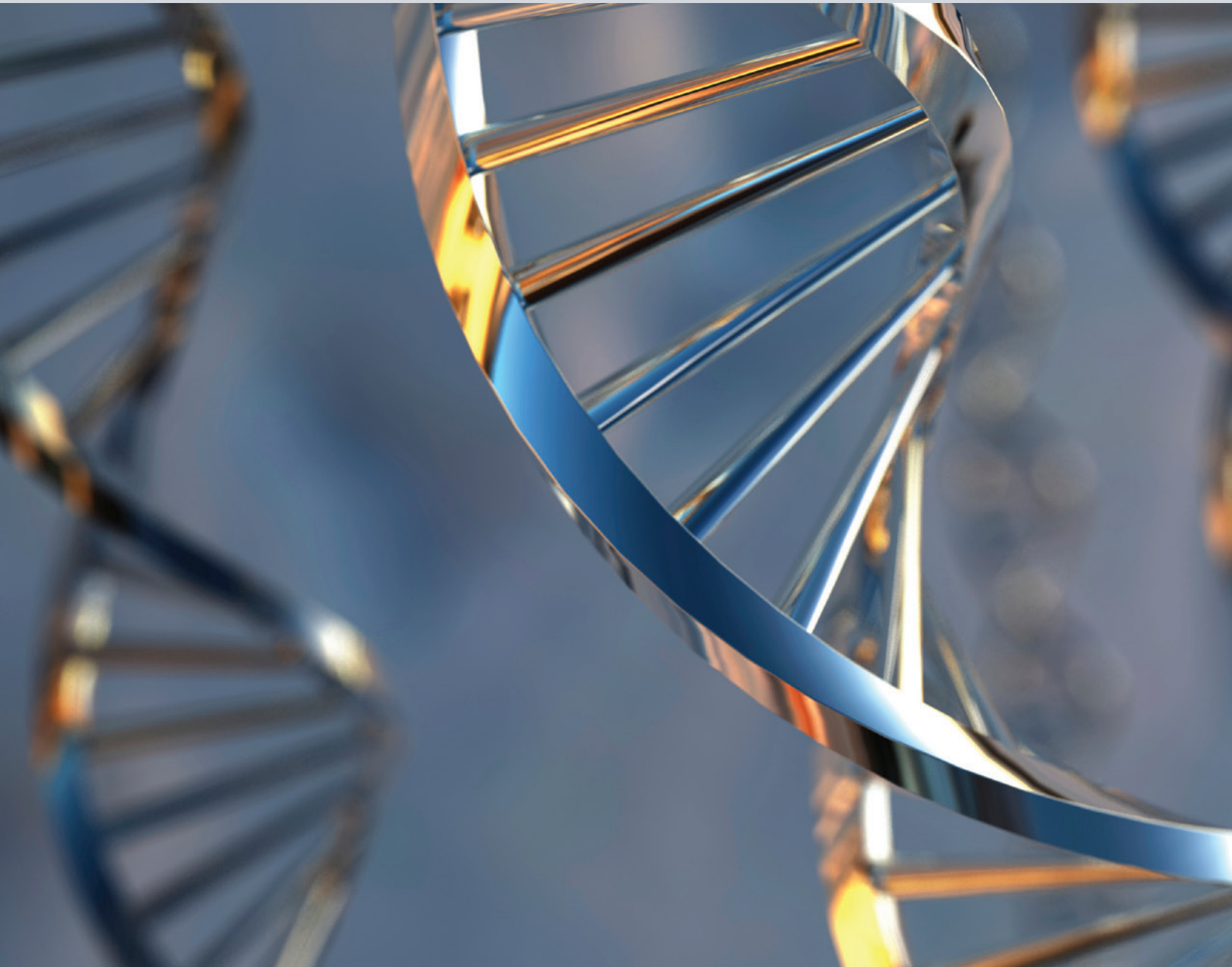


Wharton
University of Pennsylvania

THE WHARTON HEALTHCARE QUARTERLY

FALL 2012
VOLUME 1, NUMBER 4



THE FUNDAMENTAL 'GIVES' AND 'GETS' - THE BASICS FOR EFFECTIVE COLLABORATION IN HEALTHCARE

This is the second in a series of four articles exploring opportunities to improve collaboration in healthcare, in this case, between institutions. We will describe practical tools that can be applied to improve overall institutional performance through better collaboration - against the primary goal of providing better patient care.

A major academic medical center and a small but respected post-acute care system formed a joint venture in 2007 to create a comprehensive continuum of care that expanded the reach and academic scope of the post-acute care system and filled a strategic gap for the academic medical center. Three years later, the new entity's reputation for poor quality threatened its very survival. Its partners had intended to create an organization that could fulfill both sides' interests, but when the new entity launched operations, the focus on collaboration waned. It turned out they had neglected to visit some fundamental ground rules about what each entity expected to gain - and give in return - in service of the overall objectives of the alliance. This is the story of how a 'back to basics' assessment saved an organizational collaboration from becoming just another statistic.

A wave of integration - and evidence of the challenge

New collaborative partnerships are sprouting up everywhere, such as a private equity firm's deal with the largest Catholic health system in Boston; an acquisition by a dialysis company of a firm that owns medical groups; physician networks, and the venture described above. This trend is due in part to the recent passage of the Patient Protection and Affordable Care Act and the Supreme Court's affirmation of its constitutionality. The volume of hospital merger and acquisition transactions increased by 45% between 2008-09 and 2010-11, with associated investment increasing by 435%[i]. M&A activity is expected to grow.[ii] At the same time, research shows 30-70% of alliances fail, and 50% of alliances actually terminate.[iii]

From alignment to shared accountability

With healthcare reform shepherding in an era of reduced capital and mounting shared risk, stakes for effective collaboration are higher than ever. (The number of approved Accountable Care Organizations more than doubled in July of 2012 alone.) The national trend is unmistakably moving beyond clinical integration to shared accountability. However, implementing a complex set of shared objectives does not happen by itself. The challenge is to align goals, incentives, and expectations across the individuals and entities involved in delivering care to benefit each party **and** to deliver value to patients and their families.

The "gives" and "gets" of collaboration

Organizational collaboration depends on agreements whereby each participating entity expects that together they can do something greater than either partner could do alone. Each has something to "give" to the partnership, and each has something to "get" out of it (i.e., compromise). In any collaboration, there are some fundamental principles that can set the stage for lasting success:

- **Identify your "gives" and "gets"** when asking whether the whole will be greater than the sum of its parts.

  1. What do we need from a partnership?
  2. What can we offer in return?

  This fundamental step is often overlooked in the heat of early discussions about alliances - as it was with the joint venture. One way to do this is to invite clinical and administrative staff to understand "the current state of the business."

- **Understand the current state.** This assessment is a critical opportunity to test assumptions about what's driving the business against data that reveals what's actually happening. The process reveals areas of agreement and conflict between the partners.

  In our case, the joint venture partners had not clearly established (or kept current) their targeted "gives" and "gets," nor had they developed a process to examine assumptions about how to

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reach those expectations. When CFAR helped them conduct a current state assessment, we found that misperceptions of each other's culture and practices were getting in the way of operational improvements. For example:

- The post-acute system had not bargained on having such a high level of acuity among referred patients, and thus had not thought to negotiate consults that would help prevent patients from returning to the hospital with complications.
- The academic medical center, which had never operated this kind of post-acute facility, was unaware of the many regulations that governed its operations and had assumed the new unit would be able to handle their referral volume and care for patients without sending them back. When these issues occurred, the joint venture acquired a reputation among the academic medical center's referring physicians for poor quality and sending too many patients back to the hospital.

- **Keep issues on the table.** To keep a clear picture of the current "gives" and "gets" on the table, and the interplay between assumptions and realities on the ground, an alliance needs to co-opt time in regular venues.

  The joint venture Board carved out part of their mandatory quarterly meetings to review the current state and reformulate their objectives, coming to an agreement on "gives" and "gets" that allowed the partnership to survive. By using that time, they also established a precedent and a process for considering issues moving forward - supported by skills and a new level of trust that enabled open negotiation of interests.

- **Start with small wins.** Starting small with low-risk projects that appeal to current supporters is a time-honored campaign strategy in many arenas including politics, marketing, and fundraising. They build momentum and trust that forms a strong foundation for larger undertakings.

  The joint venture Board chose to address research and education first, although some other areas seemed more pressing - because they knew they could gain from a small win. Both partners wanted to pursue the academic mission. By creating a concise set of agreements about who would participate in research and how education would play a role - and when they could afford to build academic programs - the partners developed something they could communicate to their own institutions. This process, with its small but impactful agreement for the identity of the partnership, built momentum on the ground and the trust and confidence to commit to developing a shared vision.

Effective collaboration is an ongoing, systematic, strategic process. The next segment will examine collaboration in different groups and roles, between physicians and administrators.

For more information on this topic or related materials, contact CFAR at info@cfar.com or 215.320.3200, or visit our website at http://www.cfar.com.

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