Aligning Practice Goals with Health System Goals: 
*Developing a tiered accountability model and revised organizational structure*

Case Study Submission

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Introduction

The medical ambulatory and hospital-based practices of a pediatric medical center have grown to twenty-four (24) primary care sites, twenty-two (22) subspecialty divisions, and eighty (80) locations serving more than 700,000 patient encounters annually. These practices are part of the pediatric hospital system (Hospital), which includes two (2) acute care hospitals, neonatal intensive care and inpatient pediatric units in five (5) adult community hospitals, an employed primary care network, surgical services, and regional medical and surgical subspecialties spanning eleven (11) counties. These practices are owned and operated by the Hospital and structured with an employment model for the medical staff.

This case study focuses on the Department of Pediatrics (DOP) and its infrastructure for primary care, medical subspecialty, and hospital-based practices. The surgical practices fall under a separate reporting structure. The DOP is composed of the divisions of Primary Care, Urgent Care, Adolescent Medicine, Sports Medicine, Child Protection, Palliative Medicine, Global Pediatrics, Allergy and Immunology, Endocrinology, Gastroenterology, Genetics, Hematology-Oncology, Infectious Disease, Nephrology and Dialysis, Pulmonology, Rheumatology, Psychiatry, Psychology and Behavioral Health, Critical Care Medicine, Emergency Medicine, Neonatology, Hospitalist Medicine and employs more than 1,200 providers and staff. Key challenge was how to align the vision, goals, and priorities of each Division and Practice Site to those of the DOP and the Hospital.

The burning platform resulted from:

- **Evolving health care environment**
  Drivers toward clinical integration and coordination of care among primary care, specialties, inpatient, ancillary, and support services have set the stage for developing strategies for health, wellness, medical home model, and chronic disease management across and among divisions. Changes in reimbursement models and stakeholder expectations have spurred intense focus on quality, patient experience, and financial performance.

- **Significant growth**
  The ambulatory and hospital-based practices span more than eighty (80) practice entry points for patients and families. With rapid regional expansion, the infrastructure to support current state and future growth was viewed as a challenge. This sparked the need to create an organizational model that would provide an effective operational framework to promote positive patient experience, inter-site communications, and service delivery in the market.

- **Competing priorities within the Hospital**
  Divisions have historically focused on providing high quality care, promoting medical education, and supporting research initiatives with little collaboration across and among divisions. Resources have traditionally been allocated within a division’s specialty and not shared among multiple divisions and priority setting was not clear, which added to the competition for resources. Challenge was how to drive growth, innovation, and performance improvement, while balancing and allocating resources effectively.

The Chairman and the Vice President of the DOP partnered with their leadership team to evaluate and develop a strategy for evolving the DOP’s organizational structure to support alignment of
goals throughout the system. Key outcomes were to enhance communications and collaboration among divisions and practice sites and support priorities as set by the Hospital. The Center for Operational Excellence (COE), an in-house team of lean six sigma experts led by a Master Black Belt, was engaged to spearhead the evaluation of current state and develop a future model. Without a move to a new model, the DOP would remain reactionary, responsive only to high profile and problem areas, inconsistent in juggling priorities, and struggle with managing variation and independence of twenty-two (22) divisions. It was an unwieldy model that was not working effectively to align priorities and resources across all divisions and within the hospital system.

Alternatives Considered

One alternative was to continue “as is” with the current organizational structure and the goal setting process. Advantages were the ease of individual divisions maintaining the status quo, not dealing with resistance, and keeping control without facing the growing pains of change. Disadvantages were the continued variability of quality and performance improvement goals and lack of synergy with divisions’ alignment of direction, resources, and operations. Leadership would remain reactive not proactive and the broad number of direct reports to the Chair and Vice President would maintain the unwieldy model.

The second alternative was to revise the DOP organizational chart to align synergistic divisions into clusters while maintaining the same accountability model. Advantages would be taking a step forward to foster collaboration among divisions within each cluster, creating a leadership partnership with a physician and administrative leader for each cluster, and reducing direct reports to the both the Chair and the Vice President. Disadvantages would be the negative perception of inserting a level of leadership that divisions may resist. Also, revising the organizational chart only would not provide the framework for enhancing management and accountability throughout the practice sites.

The third alternative was to revise the organizational chart and structure a tiered accountability model. The revised DOP organizational chart would reflect clusters of divisions with a management reporting and tiered accountability process (e.g. goals, metrics, and communications at each tier level). Advantages would be the spark of a new day with a look to the future, fostering synergies among division leaders, engaging and empowering physicians and staff to serve our families and meet quality and patient experience expectations, promoting a culture of continuous performance improvement, and strengthening alignment with hospital goals. Disadvantages include the challenge of getting staff buy-in and developing trust in a new model, dedicating sufficient time, energy, and expert resources to effectively implement as changes take time to evolve, and skepticism about exploring an unknown and unproven pathway – will it really work?

Chosen Solution

The DOP leadership team, in collaboration with their Division Directors, Operations Directors, and practice leaders, pursued alternative 3: revise DOP organizational chart and structure a tiered accountability model. This model would revise the reporting relationships as they exist and would drive a new way of communicating and working together. The key outcome would be enhanced communications and alignment of goals among practice sites, divisions, and clusters throughout the DOP. There was general apprehension by stakeholders at large as to what this
would mean for their areas. While there was an expression of positive support, it was recognized that true buy-in and engagement would be essential and a strategy necessary to pave the way.

Factors considered included the burning platform of the external and environments, vision of the department, synergy of division realignment, the leadership and support in place, and readiness of leaders to make change. The process follows for evaluating the organizational options and reaching best decision that fosters the department’s alignment with health system goals.

**Process**

The Vice President and Chair partnered with their leadership team and the COE to spearhead the evaluation of current state and develop a future model. This included planning and conducting two separate weeks of kaizen sessions to evaluate current state and recommend a future state. Each kaizen session included key stakeholders from the DOP, Physician and Administrative leaders, Hospital leadership, hospital support departments (Human Resources, Financial Improvement, Nursing, Managed Care) and practice physicians and staff at large.

Time out of the practice setting was allocated for key stakeholders to participate in the kaizen. There were multiple four hour blocks of time structured over a two (2) week period when the most participants could be made available with sufficient lead time. The sessions were held off-campus in a conference room with lots of windows, food, and room to move around. The first kaizen week was focused on setting clear goals for the kaizen as to scope and desired outcome. With facilitation by the Black Belt, the initial sessions identified the burning platform and created a vision for the DOP. Detailed work ensued at each session supplemented by subgroup meetings to identify gaps with the current organizational chart and management and operations model and recommend options for improvement.

Outcomes from the kaizen included the design and reorganization of the DOP leadership and organizational chart, development of a tiered accountability model, and creating a framework for implementing a daily management system throughout all levels of the DOP. The model was presented to the DOP leadership (physician, administrative, and management leaders), evaluated several times in multiple forums, and modified along the way. The result was a reframing of the divisions in the DOP to a leadership and management structure that:

- reorganized the twenty-two (22) primary care and subspecialty divisions into four (4) clusters (Primary Care & Community Health, Medical Subspecialties, Behavioral Health, and Hospital-Based) reporting to the Chair and VP leadership to foster synergies and collaboration regarding patient care quality and care transformation, patient experience, market position and strategy, operational efficiency, financial performance, medical education, and research

- redefined the reporting levels of the DOP into four tiers (Tier 1: Local Practice/ Site level, Tier 2: Division level, Tier 3: Cluster level, Tier 4: Department level, Tier 5: Hospital Executive/ C-suite level), which set the stage for defining accountabilities for physician, administrative, and management leaders and staff at each tier level; focused goals at each Tier on “what matters” so to align with DOP and Hospital goals; empowered providers and staff to problem solve and enhance service to our families at every level
promoted ongoing partnership with physician, administrative, and management leaders, emulating from the top with the Chair and Vice President; escalated leadership development for physician and administrative partners and provided for training of local leaders and staff; prioritized a goal of provider and staff satisfaction by creating a great place to work

**Implementation**

Phase I and phase II are complete, while Phase III continues to be refined. These phases evolved over 2-3 years as new ways of working and communicating unfolded.

- **Phase I – Implement revised organizational chart and tiered accountability model**

  The future state model was developed with input from key stakeholders. In the first year, the DOP organizational chart was revised with physician and administrative leadership restructured into four clusters (Primary Care & Community Health, Medical Subspecialties, Behavioral Health, and Hospital-based). The physician cluster leadership and administrative director positions were defined and individuals identified to lead those roles. The Chair and VP worked individually with division leaders (clinical, administrative, and non-clinical) on their transition into this model. A new meeting format was created whereby the divisions, clusters, and DOP created forums for discussion of regional growth, quality, safety, patient experience, and education and discovery. This was accomplished in the initial year.

  In preparation for Phase II, a plan was established to educate the leadership teams on tiered accountability (Tier 1: Practice/ Site level, Tier 2: Division level, Tier 3: Cluster level, and Tier 4: Department level, Tier V: Hospital executive team) and the daily management system and reporting at each level. A timeline for implementation was established with the DOP leadership team and the COE and this was accomplished in Phase II in the second year.

- **Phase II – Pilot and expansion of Daily Management System**

  The daily management system was initially piloted in 3 divisions (Endocrinology, Behavioral Health, and one location of Pediatric Primary Care). Physician leaders and staff completed Blue Belt training to learn and implement the daily management system of daily huddles, visual metrics, lean analytical tools, and reporting up thru the tiers. This was expanded to all divisions and sites and over time all were trained and engaged at each tier in the system-wide daily huddle system. Structured cluster meetings were established monthly and bimonthly and the new reporting structure evolved. Focused time was spent on refining the responsibilities and accountabilities of cluster leaders, their onboarding, and ongoing support. This was accomplished in years two (2) and three (3) and continues into Phase III.

- **Phase III: Refine and modify model to accommodate practice growth**

  This phase is ongoing to develop leaders at each tier level and continue to educate and evolve the tiered accountability model and daily management system. As the network expands, leadership roles continue to be evaluated for morphing the management model to enhance operations, partner administrative & management leaders with their physician leaders at all levels, and flexing for the future as more regional sites and new services are created. Efforts continue with developing standard work for leadership, directors, managers to keep the...
momentum of accountability thriving. Specific leadership accountabilities are being fine-tuned for the leadership team and for the goals and deliverables of the divisions and sites.

Lessons Learned

- This exercise was trailblazing for the department as it created a new way of thinking and working together. Communication at all levels can not be overstated. It is the number one improvement area highlighted in provider and employee satisfaction surveys and becomes especially important when moving in a new direction. Even though most of the leadership teams vocalized understanding and acceptance, it did not naturally flow to all staff. More communications – including communications of not knowing all answers - would have been a plus to the engagement.

- There is a learning curve – very steep in the early days - for adapting to new expectations. Shifting from a historical, decentralized focus on clinical care, medical education, and research to one that includes focus on service optimization, operational efficiency, and financial performance takes time to evolve. Also, the creation of new roles, onboarding physician cluster leaders, and developing new relationships among physician and administrative leaders takes time. Reflecting on the execution, incorporating a change engagement and change management process would have been a plus to leverage the resistance encountered by those not directly involved in the planning process.

- Adapting to new models will most likely be successful if the culture of the organization and focus on patient experience are kept at the forefront. When individuals look inward to what’s in it for me, the best leverage is what’s best for our patients and families. Meeting each and every individual’s expectation is not feasible, but getting team buy-in is the key on the path to change. Overall effectiveness will excel by engaging “teams” at all levels and involving individuals right from the start.

- Providers and staff at large are the source for innovative ideas – they want to make a difference every day. Giving them opportunity to express and share those ideas goes a long way to creating a model that sustains for the future. Ask for input along the way and create several avenues for new ideas to come forward.

Recommendations

It is valuable to have an external, objective facilitator with expertise to keep the project focused on outcomes, on track with time and resources, and guiding a new pathway of thinking. Right from the start, make change engagement and change management a priority in the process. Dedicate time to talk through ideas, communicate continuously, and solicit buy-in from stakeholders at all levels from the very beginning. Success is dependent on how effectively physicians and providers, administrative and management leaders, and staff are engaged with a shared vision, so it is important to make that vision clear.

Endnote:

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Manuscript Tags

**Key paragraph:**
This case study focuses on the development of a new organizational structure for the largest department of the hospital, the Department of Pediatrics. The overall goal was to foster alignment with the health system’s goals. Objectives of the case study are to outline the process for assessing the current state and recommending and implementing the future state using a lean approach. Outcomes include the development of a new organizational chart with structure of four service clusters, realignment of operational divisions within each cluster, and creation of a tiered accountability model incorporating a daily management system. Included in the model are the structure of daily huddles and communications throughout Tier 1 - Local Practice level, Tier 2 - Division level, Tier 3 - Cluster level, Tier 4 - Department level, and Tier 5 - Hospital Executive C-suite level. Insights are shared regarding critical success factors, challenges with implementation, and change engagement with leaders, providers, and staff.

**Key words:**
Practice Goals, Health System Goals, Goals Alignment, Tiered Accountability, Daily Management System, Huddles, Organizational Structure, Change Engagement, Kaizen, Operational Excellence, Lean, Black Belt, Blue Belt, Leadership