Building a Successful Hospital-Business Alliance
A Case Study
By
Randy Flechsig

In this case study, we examine how the engagement process can be used to introduce new plans, pursue bold initiatives, help create understanding and bring people together. The purpose is to stimulate innovation in the pursuit of meaningful change that positively impacts all stakeholders in the community.

The vision for collaboration was set forth by a regional hospital council, (a membership association representing 21 hospitals is a 14-county area), based upon the belief that there should be common ground to address employer health benefit costs. Further, the vision included a shared agenda to foster and sustain cooperative community-wide endeavors in alignment with the interests of hospitals.

It was clear that employers in the region were getting restless, and small employers were increasingly feeling powerless over controlling the cost of healthcare benefits. They were looking for solutions. This seeking of solutions posed an opportunity for the hospital council to assume a leadership role in finding solutions. How then to engage businesses to identify options and the means to help them lower the cost of health care benefits? It would need to be employer friendly, and offer hospitals a level of influence and control in shaping how it would impact them.

Identify the Problem: The hospital council embarked upon a plan to engage hospital and business leaders in meaningful dialogue and to explore areas of mutual interest and benefit. How could we join forces to identifying innovative ways for employers to lower their healthcare costs? What would shape and elevate dialogue? How could a shared agenda be created?

It began with a Health Care Cost Survey of the region's businesses. The goal: to elicit responses on the issues that drive healthcare benefit costs. The survey was going to be a tool for the local business communities, which was accomplished by reaching out to local chambers of commerce, in the region, to endorse and distribute the survey on behalf of their membership as part of the chambers' advocacy work.

The survey reached 4,800 businesses in the region; 900 responses were received, which was an incredibly high response rate. Success of the survey exceeded expectations, and offered the first picture of the difficulties facing the region's businesses. It indeed stimulated interest and begged the question of what next? It created a shared agenda. Action needed to follow!

Frame the Issue: The survey provided results that were interesting and useful; however, the real value of the survey was to capture the attention and imagination of the business community. It was an invitation to begin working together. The survey initiated and solidified relationships with chambers of commerce in the region and taught us how to communicate with the business community. In the end, the survey uncovered a surprising willingness to work cooperatively with hospitals. The survey results were in hand. Now, how best to activate engagement?

The council was now in the position to reach back out to the chambers with next steps. The gambit was for the council to use survey results to stimulate an engagement process; to build upon the

growing interest stimulated by the survey results. The council stepped up to proactively set the agenda, select participants and establish terms of the engagement process.

We needed to create a process that spoke to the interests of business leaders though avenues they trusted and supported. The key would be establishing credibility so that engagement would not be viewed as defending or promoting the agenda of hospitals.

Identify the Stakeholders : The hospital council explored next steps with the region's chambers of commerce. A Blue Ribbon Committee on Health Care and Business would take-up where the survey left off. Thus, a group of committed providers and business leaders would collaborate at identifying specific strategies that would have clear benefit to both business and health care communities.

Participants would be selected by the council from the nominees presented by the chambers. We would involve only decision makers with the clear understanding that the work would need to be used to assist in designing and implementing specific courses of action. Business members on the Blue Ribbon Committee were selected through a formal nomination process. The region's chambers were each asked to nominate three to six persons they believed would be productive members of the Committee. The final selection criteria emphasized the following:

- Decision-makers (preferably owners, presidents, or CEOs of their companies) and leaders in their communities
- Regional diversity: a cross section of representatives from various sectors – local/county government, education, manufacturing, service and agriculture
- Smaller and medium-size employers
- Firms that have stopped providing coverage or do not offer insurance because it is too expensive

The council then selected committee members from the chambers' lists of nominations. The formality of the nomination process, supported by growing community-wide interest sparked by the survey results, made selection of nominees a high-profile endeavor. The stage was set for engagement.

Set Boundaries: We found, above all else, that business interest hinged upon the clear expectation that the process must deliver on the promise of concrete benefit for business. Engagement would need to add tangible value, where a balance would be struck between recommendations that can achieve savings in the short-term while considering more significant action in the future that would include collaborating with hospitals.

From the outset, the council offered to fund and facilitate the process. The first order of business was to set proper boundaries in order to preserve the balance, transparency and integrity of the two major interest groups: the hospitals and the businesses. The boldness of the engagement rested upon creating a means for the chambers to not advance or support narrow local agendas that could turn against hospitals. At the same time, the risk for the hospital council was to create a process that could lead to the unintended consequences of empowering business leaders to convene a like process at their local level without hospital participation. No small risk indeed!

We immediately established that because both hospitals and businesses are employers, we would focus on issues as such. Both pay health insurance premiums and both have experienced the rapid

escalation in the cost of these premiums. As employers, there is a sense of shared destiny and it became easier to identify mutually acceptable solutions. This was an essential foundational underpinning that cemented everyone's common ground: common values, common vision and common purpose as pre-requisites to common solutions.

Other ground rules then followed:

- The chambers and council boards would pass board resolutions to endorse the Committee's work.
- The Committee would operate separate and distinct from both hospital council and chambers. Its members would not be representatives of the council or chambers; the committee would be independent of organizational agendas.
- Hospital leaders would participate in the process
- The hospital council would be responsible for seating physicians on the Committee, which would be done in league with its member hospitals to assure that the physicians selected would be most productive.
- Chamber executives could attend as observers and resource persons, but would not be Committee participants.
- We established how outside observers and resource persons would participate in meetings. Speakers – content experts - would be identified in advance by the hospital council and provided with specific questions that the committee would like them to answer, keeping them within the range of issues unearthed by the survey.
    - Further, speakers would be informed of the expectations and group dynamic in advance of presenting to the Committee.
    - A speaker violating the expectations would be disqualified from any future activity with the Committee.

It is worth noting the process within the process that was required to align the council's hospital membership with the vision for engagement. Not every member hospital chose to participate, three hospitals declined, which eliminated their communities from having nominations for Committee participation.

Our boundaries having been set, major questions still remained:

- Would the council be embarking on a venture that would organize the opposition?
- How would a process, paid for by the hospital council members, maintain neutrality?

This put a premium on the next aspect of engagement: process management.

Process Management: The sheer breadth of the health care debate would quickly overwhelm the committee, and would find participants becoming immersed in disjointed discussion. This could be the greatest barrier to overcome out of the gate, and although surmountable, we did not underestimate the tenacity needed to manage the process. Extensive upfront planning was required for each scheduled meeting of the Committee, particularly since we were promising action and had to establish recommendations within the established six-month period of engagement.

The Committee needed to focus on developing recommendations from among potential options identified as a result of the survey process. It was critical not to venture outside the framework of the survey results.

It was essential that the time commitment of participants be respected, which was to be achieved with the promise that the process result in concrete outcomes, in the form of recommendations for action. This was more than just a forum for discussion, it would lead to action.

Reports were drafted after each Committee meeting, capturing the ideas and recommendations as they emerged. The Committee would accept the reports as the first item on each agenda. This iterative process helped participants maintain a clear view of process, recall discussions and ensuing outcomes, and helped eliminate backsliding to revisit topics already addressed. The Committee's final report was to be endorsed by the chambers, which was highly probable, since we selected influential local business leaders who were active members in the chambers; there would be no side stepping the recommendations set forth by the Committee.

The hospital council and chambers were asked to remain politically neutral, which required adopting resolutions by the council and chamber boards to support the process without interference. The Committee needed to take on a life of its own. This was one of the more challenging elements of the engagement process, albeit unseen. It became even more challenging as the Committee's engagement began to show signs of success since it was now a vehicle that could be used outside the purview of the council and chambers.

A failsafe was built into the Committee charter that the Committee could remove members if the consensus was the participant was no longer behaving objectively or was attempting to overly influence the process.

The Facilitator: It was essential, given the hospital's funding of the engagement along with the potential risk of it going rogue, that the council president remain closely involved to anticipate, confront, address and assuage the potential for fragmentation because of local agendas. It was equally important that the chamber executives not be alienated, because their continued support was required and their trust could not be violated. Therefore, the neutrality of the engagement process was paramount. This led to the absolute need for an independent consultant to be the facilitator.

The consultant, hired by the hospital council, would help assure that the pronouncements of collaboration not be side-tracked based upon self-interests, and that the Committee's best intentions not succumb to natural inclinations to see issues in terms of narrow self-interests. The process needed to be unbiased and objective.

The consultant facilitator needed to remain wary of organizational agendas that could be brought to the table; assist in setting meeting agendas and help choreograph proceedings; prepare reports; and, assure the hospital council president – the client – not overly guide the process. The pressure on the consultant was to objectively address issues knowing the organizational priorities of the council and chambers. As a result, the Committee was able to take on a life of its own, serving no master.

The consultant was able to be the provocateur, challenging preconceived notions and biases, and expounding upon input to flesh out the outcomes sought while steering clear of organizational politics. The consultant needed to respect the role and objectives of its client and need to uphold the

trust placed in the process by the chambers. The input gleaned needed to be balanced, yet it also needed to adhere to the goals of the council and chambers. The process could not be allowed to devolve into a slugfest where the process turned against the hospitals or the chambers. Any and all wrangling would be off-line between the council president and chamber executives.

The frankness and transparency of the consultant's work fostered credibility. The Committee became less guarded and comfortably able to focus on innovative ideas.

Measuring Success:

The participants found value in the process: The community was the common denominator. Recommendations called for implementation of strategies to be local, building upon a working relationship between hospitals, the council and local chambers, business leaders and physicians. The Committee found much opportunity for collaboration on initiatives and rallied around a closeness of cause and kindred spirit.

The community became better equipped to stay the course in supporting a vision for the future: The Committee benefited from a shared learning curve, reaching consensus on a set of realistic recommendations. It received and processed new content and teased-out innovative ideas. It embraced a long-term commitment and sought ways to sustain the process.

We saw a high level of community interest and support: The committee, a reflection of the region's communities, gained confidence through the engagement process, and it gained a willingness to look for and accept different ways of doing things. The Committee enabled a group of committed health care providers and influential business leaders to focus on practical solutions and work toward implementing specific strategies that would have clear benefits for both business and health care communities. The Committee's recommendations reflected comprehensive, community-based health initiatives making the most of the resources and the expertise of community leadership. Most importantly, we successfully moved the project from its origin as a hospital-based initiative to a business-led initiative.

Engagement became the expectation: It took a tremendous leap of faith and suspending of disbelief to permit the engagement process to evolve and reach its desired conclusion, which was to build and strengthen the relationship between hospitals and local businesses, and together identify mutually beneficial outcomes. Hospitals were no longer seen as barriers, but rather as facilitators. The engagement process ushered in a new level of trust and cooperation, bringing together people with shared interests but different perspectives. It created the trust and goodwill necessary to sustain a high level of commitment essential for longevity.

The community now reached out to the hospitals to initiate dialog around issues and questions: The Committee rose above the political fray, embraced collaboration and demonstrated it could produce concrete outcomes. It sought ways to best work together, knowing the inherent biases of those at the table, and at the same time the trust placed in its work to be objective. It proved that businesses, hospitals and physicians could work together, for mutual benefit, and it became emblematic of collaboration.

The engagement process committed to concrete outcomes: The Committee's recommendations resulted in a comprehensive regional education programs to help create a shared understanding of and a greater sense of control over health care costs. A new local healthcare foundation was created to receive contributions from community foundations, further enhancing the credibility of this community-

based initiative and solidifying the growing regional commitment. A new enterprise was founded, a regional healthcare purchasing alliance responsible for negotiating coverage and underwriting a new health benefits plan with a national insurance company, an exclusive product only available in the fourteen county region, and it gave the local chambers of commerce responsibility for its distribution, which became a new member service. This formative healthcare purchasing alliance was supported by a newly formed Preferred Provider Organization (PPO). The PPO network included the 18 hospitals and over 1,800 physicians, and it was governed by business and hospital leaders and physicians; purposefully structured to put business leaders in the majority with equal numbers of physician and hospital.

Conclusion: The resulting outcomes went on to serve the region for 25 years, and enriched the region with an unprecedented level of collaboration. This successful community engagement process galvanized and inspired people around new ways of doing things to achieve shared goals. It offered a chance to learn and helped demystify the organization and delivery of local healthcare resources; taking the fear, and distrust, of the unknown out of the equation. It brought parties together to recommend solutions that all could contribute to implementing. It pooled creativity and found productive ways to make the most of local resources and expertise.

The engagement process created a shared agenda for 18 hospitals and 12 local chambers of commerce representing more than 4,800 employers across a 14-county region. Over the years the healthcare purchasing alliance became the venue with the expertise to meaningfully explore value added purchasing, and guided an understanding of an Accountable Care Organizations (ACO) and Clinically Integrated Networks (CIN). It supported community-based consumerism through education and collaboration. The engagement process proved to be worthwhile and a huge success, in and of itself. In addition, it represents a potential model that could be adopted and replicated by other communities across the country, for a multitude of complex issues at the interface of healthcare and business.

Randy Flechsig is a healthcare consultant and speaker. His accomplishments, applying 30+ years of CEO experience, are shaped by driving organizational change through innovative thinking needed to help organizations navigate change and realize their desired futures. He is accomplished at community engagement, pursuing innovative paths, and rallying organizations and communities around change. He can be reached at rflechsig@comcast.net.

Randy is available for keynote presentations and breakout sessions through Innovative Healthcare Speakers innovativehealthcarespeakers.com. His programs include: *Aligning Expectations - Community Engagement; The New Healthcare Consumerism – Beyond Patient Engagement; Behavioral Health - Reinventing the Acute Care System; Building a New Care System for Substance Abuse Disorder - Niche opportunities for Community Hospitals; Opioid Crisis: Unintended Consequences of Solving the Epidemic; Governing in a Twitter World – Social Media Transparency;* and *The Sword in the Stone – Moving the Immovable Object.*