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ACHIEVING OPTIMAL ALIGNMENT IN ACADEMIC HEALTH CENTERS



THE CHARTIS GROUP
Management Consultants

Achieving Optimal Alignment in Academic Health Centers

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Most Academic Health Centers (AHCs) have performed well over the past decade despite a range of economic challenges including constrained NIH funding, insufficient GME funding, and expanding populations of underinsured patients. As they look to the challenges ahead, many AHCs will find that the conditions that traditionally supported their success will change, requiring them to consider new and more effective ways of operating. These changes could occur rapidly, making it essential for AHCs to have the foresight and agility to redirect their strategy and operations to successfully adjust to the new environment.

Agility in organizational change can pose a considerable challenge for AHCs. The inherent complexity of most AHCs makes it difficult to achieve rapid changes in strategic direction. Decision making in academic settings is often decentralized; aligning activities across the clinical, research and education missions is complex and involves a large number of faculty and staff. However, to remain recognized leaders in improving health care, AHC strategies must differentiate themselves from their competition by more closely aligning across the three missions. Therefore, any initiative to redirect strategy and operations must involve an essential element of building understanding and support among the diverse audience of faculty and staff. This initial step is crucial but can affect the organization's ability to move quickly.

While the structure of AHCs has been a strong focus in the healthcare literature, important insights into other means of achieving organizational alignment have been lacking. To address this need, The Chartis Group conducted a survey of leaders from a broad spectrum of AHCs. The findings provide important new insights regarding the nature of alignment in AHCs and strategies to develop the type of alignment that will be essential for these organizations to identify and execute change quickly in the years ahead. The findings led to the development of a new framework that AHCs can use to assess current alignment levels and mechanisms and to forge more effective alignment in their organizations.

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Why is Alignment Important?

US healthcare is likely to experience a period of turmoil caused by the pressure to both improve access and reduce costs. While it appears almost certain that health-care reform will expand access to care, existing cost problems could be exacerbated without substantial changes. A variety of approaches will be considered to drive accountability and to achieve cost control, which will, in turn, create new risks and opportunities for AHCs. Agility will be essential to redirect AHCs to remain successful in a fluid environment. Some likely changes include:

- **Loss or reduction of supplemental payments.** The likely loss or reduction of DSH payments and insufficient GME funding will have a significant impact on AHC revenues. While improved insurance coverage for the underinsured population may partially offset these reductions, most AHCs believe the effect will be a significant net reduction in revenue.
- **Increased provider accountability for cost and outcomes.** Medicare is experimenting with different approaches to incorporate financial accountability for outcomes into payment policy including bundled payments for procedures and episodes of care, non-payment for readmissions and use of quality measures to determine supplemental payments and annual rate increases. These types of payment mechanisms will become more prevalent and will require faculty and associated university hospitals to collaborate to achieve and demonstrate superior outcomes.
- **Redistribution of professional fees from specialty to primary care.** Most AHCs derive the vast majority of their professional fee revenue from specialty care. As a result, AHCs risk being disproportionately hurt by redistribution of professional fees from specialty to primary care.

While these changes take place, there will be multiple opportunities for AHCs to build competitive strength within the landscape of healthcare reform:

- **Accountable Care Organizations** – Some AHCs are positioned to manage the health of large populations, in part, because of their relatively large scale; however they will face challenges in building out the remaining components of the delivery system to improve access and achieve an effective cost per episode of care or per covered life.
- **Bundled payments** – Ninety percent of medical schools have an organized practice plan that is typically linked with a single university hospital. This model, which reflects a greater level of organization as compared to most community providers, should represent an advantage in accepting and managing a single bundled payment.
- **Physician network development** – AHCs train the medical workforce, giving them ready access to graduates to help develop distributed primary and specialty care networks.
- **Electronic connectivity** – AHCs can deploy a unified electronic health record across faculty and hospital networks. The availability of stimulus dollars to support EHR purchase and implementation will support this effort. Some AHCs already use EHRs as a mechanism to solidify relationships with independent physicians in their communities.

- **Evidence-based care** – Protocol driven medicine will continue to expand. Most AHCs have the scale and the ability to conduct effectiveness research to provide patient care based on research findings and to standardize care management approaches across care settings more rapidly than community providers.

Positioning the AHC to respond to these challenges and to take advantage of their inherent competitive advantages requires strong, unified leadership able to organize the entire AHC to act in concert. There is universal consensus that alignment will be an essential component of success in the years ahead. According to one C-level AHC leader:

“[Alignment] is becoming more important as we don’t have the time and flexibility to be wrong – no luxury of a do-over. Markets are competitive, capital is constrained, recruiting is hard; resources are scarcer and margins of error are smaller. It’s too expensive to be out of step.”

While all AHC leaders agree that alignment is critical, many report that they do not have the mechanisms in place to rapidly align their organizations. Half of all respondents in our survey indicated that leadership within their organizations agree broadly on strategic direction, but less than 25% report agreement about how to implement that strategy and operate in a fully aligned manner. At the same time, all of the respondents indicated that alignment will be more important to their continued success. This survey offers important new insights regarding the mechanisms AHCs can use to mobilize their organizations for success in this changing environment.

What Do We Mean by Alignment?

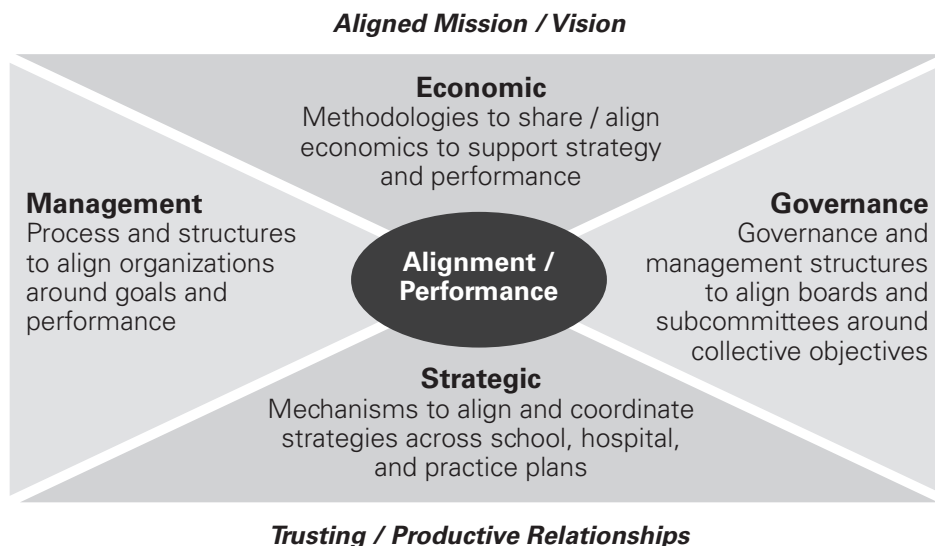
In an aligned AHC, medical school, practice plan, and university hospital leaders act in concert to achieve common vision and goals. Some AHC leaders believe that alignment requires an integrated structure that incorporates the entire AHC under a single governance and management mechanism or through a clinical enterprise model closely affiliated with the medical school and university. A unified structure makes it easier to achieve alignment but it does not guarantee success. Some AHCs with unified governance and management have not achieved alignment. At the same time, there are examples of AHCs with separate governance and management structures that have been able to forge effective alignment. For AHCs that are unable to change their legal structures (i.e., the ownership of one or more key components of the AHC), alternative mechanisms must be created to achieve alignment.

Other AHC leaders believe they can achieve alignment by creating financial incentives to encourage desired behaviors. While financial incentives can contribute to overall alignment, they are typically insufficient on their own. Furthermore, the current regulatory environment constrains the ability of all AHCs to fully align incentives between physicians and hospitals. In addition, differences between physician and hospital reimbursement mechanisms can blunt the effect of efforts to align financial incentives. While AHCs have more freedom to structure economic arrangements between hospitals and physicians, as compared to community providers, The Chartis Group’s experience indicates that achieving success in alignment requires more than financial incentives.

A unified structure makes it easier to achieve alignment but it does not guarantee success.

According to our findings, overall alignment is realized by optimizing governance, strategy, management and economics to maximum achievable levels; these four dimensions are described more fully below. Fully integrated AHCs appear to have the highest degree of alignment because they are better able to optimize on all four of these dimensions. Some AHCs achieve significant alignment by optimizing on two or three of these dimensions, even when key components of an AHC are under separate governance and management. However, based on our research, optimizing on only one dimension appears insufficient to achieve alignment.

Fig. 1 | **The Chartis Group Organizational Alignment Framework**



AHC alignment is achieved by coalescing the organization (to the greatest extent possible) in four KEY areas (*Fig. 1*):

- **Strategic Alignment.** Strategic alignment reflects agreement on a vision, measurable goals, specific strategies, and the commitment of resources required for implementation. The vision and strategy should reflect the unique value proposition that leverages capabilities and resources from across all missions to differentiate the AHC from non-academic competitors.
- **Governance Alignment.** Governance alignment reflects governance approaches that bring together senior leadership across the AHC, whether school, practice plan or hospital-based, and provide effective mechanisms for oversight and coordination among units. The availability and use of timely performance information and the willingness of the leaders to bring difficult issues to the governance group are key factors in success.
- **Economic Alignment.** Economic alignment reflects the organization of funds flows to enable and create incentives for individuals and units to support and meet personal and organizational goals. Small changes to funds flow methodologies can have a large impact on behavior and performance. Experience also shows that

the development of appropriate mechanisms to share financial information across units and missions can be a critical success factor.

- **Management Alignment.** Management alignment reflects the organization of senior team roles, responsibilities, processes and information required to effectively coordinate programs across multiple units and missions. The involvement of faculty leaders in management of programs across and between units, supported by strong managers who are able to work collaboratively, helps to build support for AHC-wide goals. Other critical success factors include unified or interoperable management systems, timely sharing and transparency of information, and individual performance incentives that align planning and behaviors around pre-determined objectives and missions.

Mission Congruity and Trust Among the Leadership Team Is a Key Alignment Prerequisite

Efforts to implement alignment mechanisms across these four dimensions cannot proceed without mission congruity and trust among the key AHC leaders. More specifically, leadership must have a shared understanding of the importance and interrelatedness of their respective missions. In addition, leaders must be willing to compromise and make decisions to optimize overall AHC performance (rather than optimize the performance of their individual organizational unit) to create trust and produce the best overall performance. The survey of AHC leaders tested the extent to which these prerequisites were in place.

Trust Among Leadership

Survey participants were asked to assess the degree to which the AHC leaders subscribe to the following five attributes that typically characterize trust:

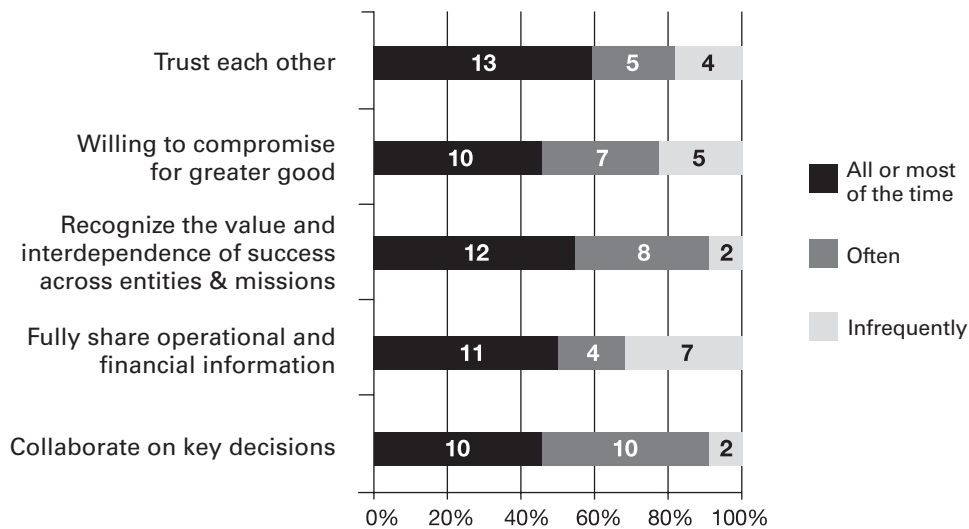
1. collaborate on key decisions;
2. fully share financial and operational information;
3. recognize the value and interdependence of success across entities and missions;
4. are willing to compromise for the greater good; and,
5. trust each other.

Most of the respondents believe that the leaders in their AHC recognize the value and interdependence of success across entities and missions. In addition, the level of trust among the leaders and willingness to collaborate on key decisions were high. However, the perceived willingness of the AHC leaders to act in a manner consistent with a trusting relationship was problematic. For example, the perceived willingness to compromise for the greater good and to share operational and financial information was viewed less positively. As expected, these challenges to building and maintaining trust were most problematic in the AHCs with the most significant separation of the AHC components. Nonetheless, building trust among the leadership team requires that these issues be addressed if overall alignment is to be achieved (*Fig. 2*).

“If the leaders do not trust, respect, and enjoy working together, then no mechanism or formula will drive alignment and subsequent performance.”

– AHC Executive

Fig. 2 | **Degree to Which Components of AHC Demonstrate Trust**



Mission Congruity

The survey respondents were asked to rate the degree to which specific elements of their AHC’s mission were shared across the AHC component organizations. Nearly all respondents indicated that patient care, graduate medical education, and community service were fully shared missions. In addition, the fully integrated AHCs indicated that all parts of their organization shared all elements of the mission. However, there were significant differences in the degree to which undergraduate medical education, clinical research and basic science research were shared. Undergraduate medical education and basic science research were generally not viewed as shared missions in the AHCs with the hospital or practice plan separated from the medical school. While this finding is not completely surprising, it is potentially problematic if these organizations are to achieve alignment. The most surprising finding is the extent to which clinical research is not viewed as a shared mission among many of the respondents. This issue is most pronounced among the AHC respondents where the hospital is separate from the medical school and practice plan and may reflect the inability or unwillingness of these hospitals to have financial responsibility for clinical research. Nevertheless, this sentiment may prevent some AHCs from leveraging clinical research to succeed in their missions and local markets.

Methodology

In this effort, The Chartis Group surveyed current or former clients on key issues related to AHC alignment. Telephone and in-person surveys were completed in mid-2009 with leaders from 22 AHCs who provided perspectives on alignment within their organizations with a focus on alignment within the four key areas of strategy, governance, economic/funds flow and management. The structured interviews were conducted by consultants from The Chartis Group

who were familiar with the specific AHC's organization, strategies, operational goals and challenges. All respondents had C-level responsibility for a medical school, teaching hospital, faculty practice plan, or the entire AHC.

Survey Participants

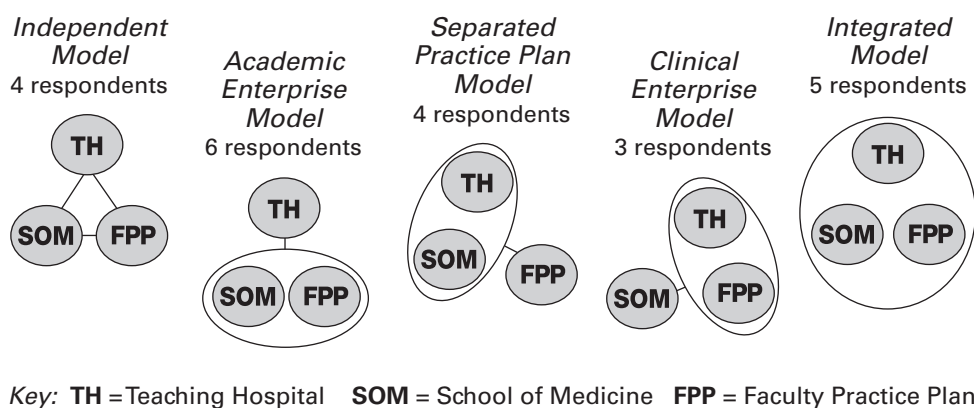
The AHCs included in the survey represented at least three from each of the five AHC organizational typologies described below. In a few cases, leaders from two different parts of an AHC were surveyed together. Respondents covered a broad spectrum including seven leaders of health sciences centers, four medical school deans, eight CEOs or COOs of university hospitals or university-based health systems, two CEOs of integrated clinical enterprises and one university provost. The survey findings provide a helpful starting point in understanding the perceived future importance of alignment and the approaches used to achieve alignment.

The sample included at least three AHCs in each of the five major AHC organizational structures*:

- **The Independent Model:** four respondents were from AHCs where the primary teaching hospital, school of medicine and faculty practice plan are not formally related by shared or overlapping governance.
- **The Academic Enterprise Model:** six respondents were from AHCs where the school of medicine and the faculty practice plan are under common ownership, but the teaching hospital is legally separate from the school/practice plan.
- **The Separated Practice Plan Model:** four respondents were from AHCs where the school of medicine and the university hospital are under common ownership, but the faculty practice plan is legally separate from the school/university hospital.
- **The Clinical Enterprise Model:** three respondents were from AHCs where the faculty practice plan and the teaching hospital are under common ownership, but the school of medicine is legally separate from the clinical enterprise.

*The organizational structures and diagram were originally described by Jay K. Levine in *Considering Alternative Organizational Structures for Academic Medical Centers*, AAMC Academic Clinical Practice, a Publication of the Group on Faculty Practice, Summer 2002 (14:2)

Fig. 3 | AHC Organizational Structures

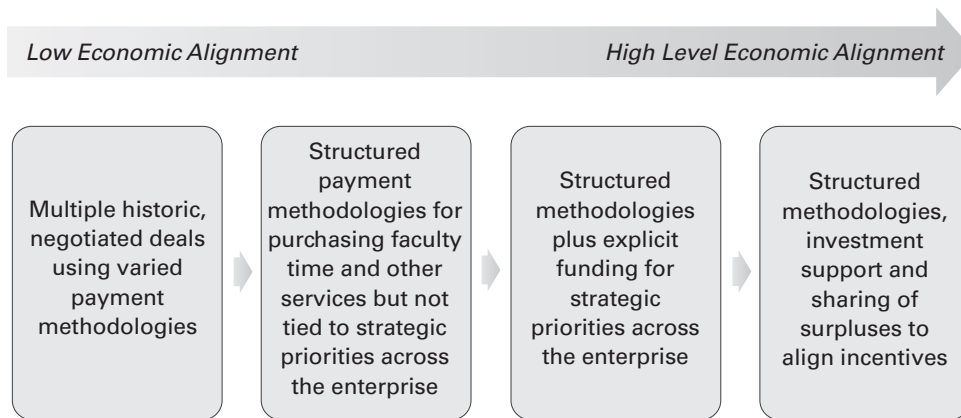


- **The Integrated Model:** five respondents were from AHCs where all three entities are formally related through a unified or overlapping governance structure.

The majority of AHCs are in one of the four models to the left of the fully Integrated Model (Fig. 3), with at least one key component of the organization legally separated from the other components. While full integration is more common among the top 25 AHCs (as ranked by NIH awards or *US News & World Report*), it is much less common among the remaining AHCs. In addition, the 1980's and 1990's trend of separating university hospitals from the university provided many of these hospitals with greater operational and financial flexibility leading to greater success. However, this separation has made it more challenging to achieve the alignment required for continued success.

The survey was designed to assess whether overall alignment is achieved by optimizing strategic alignment, governance alignment, economic alignment and/or management processes. Respondents were asked to describe the overall level of alignment in their AHC as well as their alignment strategies in each of these four dimensions on a low to high scale. The example in Fig. 4 shows the range of options respondents could use in characterizing an AHC's approach to funds flow within the economic alignment dimension:

Fig. 4 | **Sample Criteria for Assessing Economic Alignment Dimension**



Responses to survey questions were assigned a value from 1 to 5, with 1 representing the option that described the lowest level of alignment and 5 representing the most complete alignment option along the continuum. The survey responses of the 22 participants were then compiled and the results analyzed to determine what conclusions could be drawn regarding the nature of alignment in AHCs. The results provided many new insights that can be used to strengthen and maximize the benefits of alignment strategies at AHCs. These findings also provide new insights that The Chartis Group will use in developing alignment strategies for AHCs in the years ahead.

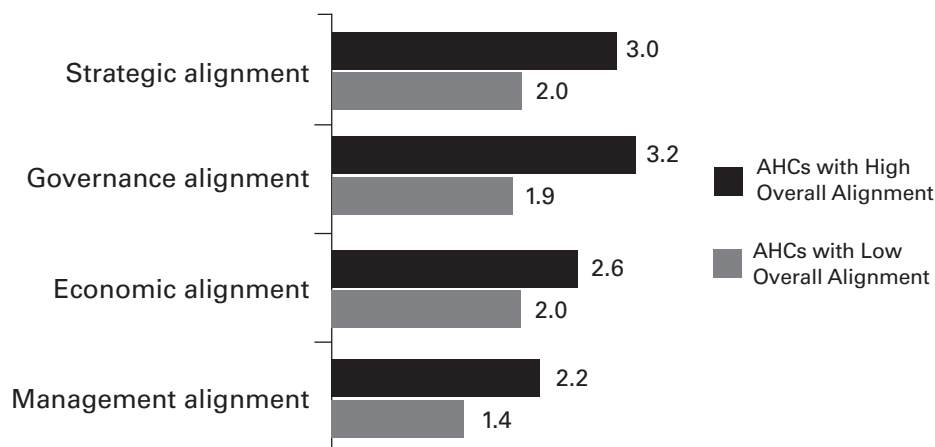
New Perspectives on Alignment Strategies

Observation #1: Overall alignment is of increasing importance

All respondents believe that overall AHC alignment will be increasingly important for AHCs in the future for several reasons:

1. Clinical margins are critical to the viability of the entire academic and clinical enterprise. Health care reform will likely put downward pressure on hospital and provider reimbursement, thereby stressing margins and requiring greater agility in managing operations.
2. Increased use of bundled payments will require greater alignment between hospital and physicians.
3. Increased focus on outcomes and pay for performance will drive demand for transparency, focus, availability of data and more effective operations.
4. There will be pressure to add residents and fellows, with Medicare resident caps requiring hospitals and AHCs to access funds elsewhere.
5. There will be a continuing need to fund research deficits due to start up costs and other structural deficits of the research mission.
6. New IOM recommendations regarding resident work hours, if adopted, will put more pressure on AHCs to cover gaps in service with the addition of non-resident staff.

Fig. 5 | **Alignment by Dimension for AHCs with High & Low Overall Alignment**
Scale: 1-5 5 = max. alignment



Observation #2: Overall AHC alignment corresponds with higher levels of alignment in all of the four key dimensions.

Fifty percent of survey respondents reported a strong sense of overall alignment across the AHC and indicated that overall alignment correlated with relatively strong alignment in strategy, governance, economics/funds flow and management at their institutions (Fig. 5). Leaders from the clinical enterprise and integrated AHC

models reported stronger overall alignment as well as stronger alignment along each of the four key dimensions. Leaders from the independent, academic and separate practice plan models almost unanimously reported far lower overall alignment and less-well developed alignment in strategy, governance, economics, and management. This finding confirms the enhanced ability of more integrated AHCs to achieve alignment on the key dimensions required for overall alignment.

Observations #3: Strategic alignment at the leadership level does not necessarily translate into operational alignment and the ability to implement a strategy successfully.

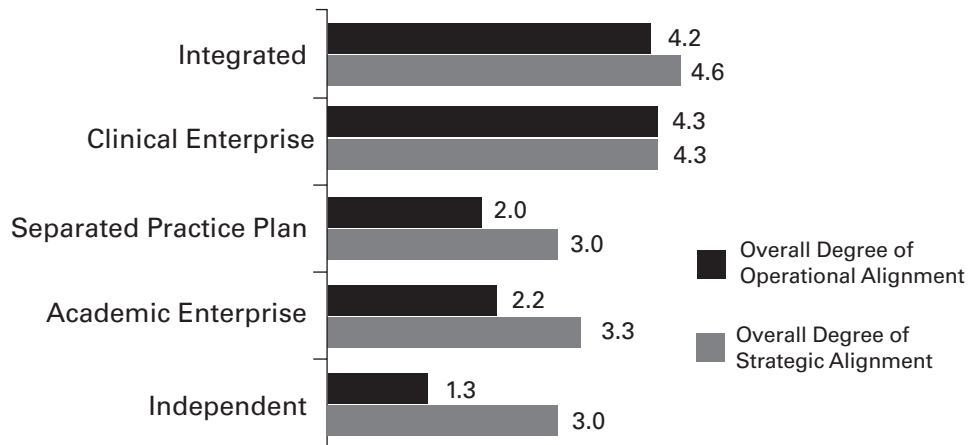
Many respondents indicated a significant level of strategic alignment among AHC leadership but cited difficulty in translating that strategy into operational alignment. Challenges may be caused by the inability to translate key strategic objectives into actionable tactics, a lack of resources to support strategy implementation and a lack of clear metrics and accountability mechanisms. A number of respondents also cited difficulty creating a partnership or an “aligned culture” within their organizations, which prevents them from achieving operational alignment. This may reflect management challenges in balancing the need for operational control with a need to collaborate with the faculty.

AHCs with integrated and clinical enterprise configurations report higher overall strategic and operational alignment as compared to an independent, academic enterprise or separated practice plan models (Fig. 6).

“Nothing is more important than alignment. Culture is what it is all about and you’re not going to get culture straightened out until you get alignment.”

– Clinical Enterprise CEO

Fig. 6 | **Perception of Strategic and Operational Alignment**
Scale: 1-5 5 = max. alignment



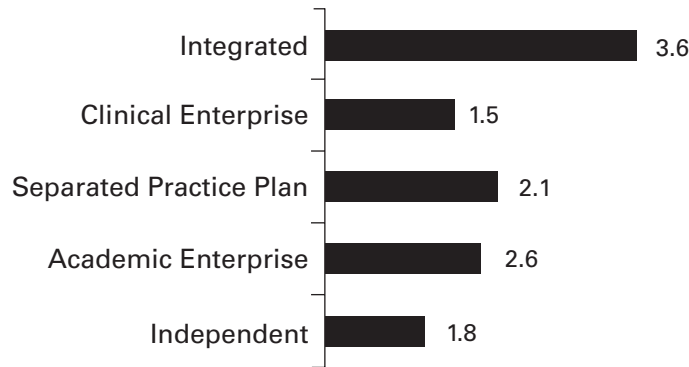
Observation #4: Economic factors are critical and a lack of economic alignment was universally seen as a major impediment to overall alignment and to successful alignment in other key dimensions.

In general, alignment in two key components of the economic dimension – funds flow alignment and aligned budgeting and reporting – were reported to be extremely low. As illustrated in Fig. 7, only fully integrated AHCs received a score of 3.6 out of 4 on

funds flow alignment; the remaining AHCs received scores ranging from 1.5 to 2.6 on this measure. Most respondents reported structured methodologies to pay for faculty time in support of hospital service, but there was limited use of incentives to drive behavior across the organization. In addition, structured payment methodologies are not well understood and lack appropriate documentation. Furthermore, faculty members generally have little understanding of the funds flow methodology, which limits the ability to use economic alignment to influence behavior. A number of AHCs with structured incentive mechanisms had great difficulty tracking the key measures to monitor performance and determine if they had earned incentive payments.

Fig. 7 | **Perception of Economic (Funds Flow) Alignment**

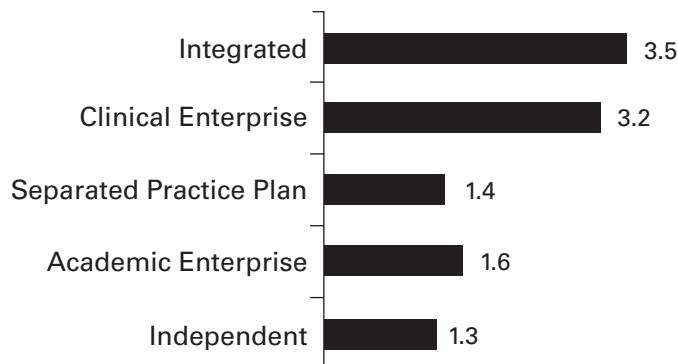
Scale: 1-4 4 = max. alignment



Many respondents reported limited coordination of operating budgets and performance reporting across the AHC. This gap was seen as contributing to the challenge of making informed and coordinated decisions. Fig. 8 suggests that this problem is particularly acute in organizations where there is greater separation of the AHC components. Some respondents indicated challenges integrating budgeting and reporting processes due to structural problems such as different fiscal years and financial systems that are not integrated. Some AHCs have overcome these challenges by increasing transparency and providing the resources necessary to make the information available.

Fig. 8 | **Perception of Economic (Budgeting & Reporting) Alignment**

Scale: 1-4 4 = max. alignment



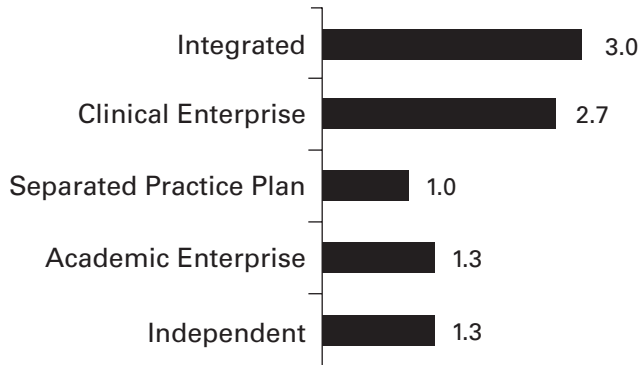
Observation #5: Management alignment is the weakest link in most AHCs.

The management dimension of alignment was measured in two ways in the survey: 1) the extent to which management structures for clinical activities are integrated across the practice plan and the hospital; and 2) the extent to which individual performance measures and financial incentives are aligned for key leaders. The participation of faculty and chairs in managing across an AHC is critical to establishing ownership and support for strategic and operational priorities, which is an important contributor to overall alignment.

Management Roles and Processes

Survey respondents indicated that management alignment was difficult to achieve because many operations managers were hesitant to involve chairs and faculty in managing resources across the enterprise. Many leaders saw particular difficulty with the concept of involving faculty in hospital management issues. Faculty members are generally unfamiliar with many of those issues, and many hospital operations managers and senior executives find the effort both risky and cumbersome. As seen in Fig.9, Integrated and Clinical Enterprise AHCs have moderate levels of management structure alignment while the remaining AHC categories have extremely low levels of management structure alignment.

Fig. 9 | **Perception of Management (Structure) Alignment**
Scale: 1-4 4 = max. alignment



Despite these findings, leaders did identify promising strategies used in achieving management alignment. These include:

- **Joint management models for key hospital resources**, such as peri-operative services; some AHCs position the Chair of Surgery to oversee the hospital’s surgical resources in collaboration with Anesthesiology, hospital nursing and administrative leadership.
- **Joint management of service lines** in which faculty leaders for key service lines manage professional and technical resources across the practice and hospital as a unified program in collaboration with an administrative leader who works for the hospital, practices and participating departments.

- **Creation of AHC-wide information sharing**, such as a monthly ‘numbers day’ in which performance data across the AHC is reviewed by executive leaders, chairs and key faculty to assess historical performance and discuss strategies to reach budgetary, quality, service and other performance goals. Some AHCs combine the use of a monthly ‘numbers day’ with a strong incentive compensation model; ‘numbers day’ meetings and reports track key metrics related to the size of the incentive pool and performance goals.

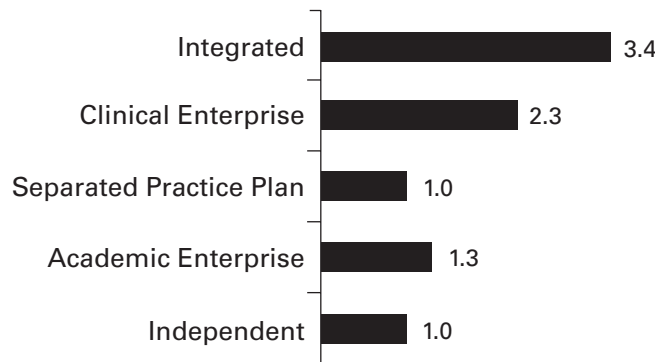
For some AHCs, meaningful involvement of the faculty in managing operations across the AHC represents a significant change in their historical operating model and culture. While change at this level can be challenging, pairing faculty leaders with strong operations managers often provides an organization with the benefit of faculty accountability without a corresponding loss of organizational control.

Leadership Performance Incentives

Many respondents reported that individual performance incentives were rarely aligned (*Fig. 10*). In cases where they were aligned, coordination was limited almost exclusively to senior executives. Moreover, they were typically viewed as being insufficient to motivate behavioral change, and were often not tied to overall AHC goals. Several AHC leaders recommended that incentives should be aligned at multiple organizational levels, including:

- Institutional level incentives, such as bottom line splits between units or tiered mission support with a guaranteed base payment and upside based on achievement of clearly established performance goals. Several AHCs use these approaches to provide unrestricted support from the clinical enterprise to the academic organization.
- Executive incentives, whereby all or most performance objectives and associated incentive compensation metrics are the same for the key leaders (e.g., the overall AHC leader, the Hospital CEO, the Dean, and the Practice Plan leader).

Fig. 10 | **Perception of Management (Incentives) Alignment**
Scale: 1-5 5 = max. alignment



- Department Chair/Service Chief incentives, which are linked to executive performance objectives. While these incentives are rarely used, a few AHCs have created incentive compensation programs that are aligned with executive performance goals for chairs and key center directors. These plans are designed to focus chairs on achievement of overall AHC goals while also encouraging them to actively support shared, interdependent performance objectives.
- Incentives for faculty leaders and related managers, though survey results indicate that very few AHCs drive incentives to key faculty and administrative leaders in a manner that aligns incentives across the AHC.

These findings suggest there is significant opportunity to create institutional and individual performance measurement and incentive plans that contribute to alignment across the AHC.

Where Do We Go from Here?

Numerous AHCs are currently evaluating changes to the governance and ownership structures of their key components in response to economic pressures and anticipated reimbursement changes, particularly expansion of bundled fee payment approaches. For example, a number of AHCs whose practice plans and university hospitals are separate entities are attempting to create clinical enterprise models that integrate the two clinical organizations. However, gaining agreement among the key constituencies required for approval of these changes (i.e., legislators, board members, chairs and faculty, and key executives) is difficult without agreement on strategic direction.

We believe alignment will be a key contributor to future success on a number of key dimensions for AHCs including financial performance, quality improvement and overall improved value to the population served. Alignment is much more than changing structure — it is having a leadership team and board who value all of the missions and can develop an integrated strategy supported by a collaborative management team and comprehensive economic relationships.

In our experience, alignment initiatives must start with an understanding and movement toward mission congruity and increased trust among leadership. This is accomplished by gaining agreement between all parties on a clear articulation of the overall AHC's mission, vision and strategy including a definition of the role of each part of the organization in realizing the vision and how the AHC will use its unique capabilities to differentiate itself from its competitors. Obtaining organization-wide agreement on these key elements provides a framework for determining how best to structure economic arrangements, management roles and processes, and governance mechanisms in those situations where governance can be changed. However, not all AHCs can approach alignment in the same way. Some can only begin the journey toward greater alignment by focusing on one of the four alignment dimensions at a time.

In many cases, organizations that successfully address one of the alignment dimensions can then leverage newly gained trust and collaboration to approach improve-

The key to success is to target progress where and when it is achievable.

ments in the other alignment dimensions. In our experience, focused collaborative efforts, such as gaining agreement on AHC vision and strategic direction, can help build trust among the parties which enables future efforts to restructure economic relationships and governance. For example, one AHC with a relatively fragmented governance structure and a history of poor working relationships among the key parties chose to develop a comprehensive strategic plan in hopes of improving the climate. The leadership team did not want to evaluate changes in funds flow or governance as part of the strategic plan. The strategic planning process helped build trust among the key leaders by using each party's true numbers and honest goals and plans and, after one year, significant success has been achieved in the joint implementation of the strategic plan. As a result, leadership now wants to assess potential changes in governance and economic relationships among the parties.

AHCs can use the findings from this study to evaluate the current state of alignment in their organization. The original survey is available upon request to AHCs that wish to conduct a complete alignment assessment at their institution and track change over time. This approach will identify ongoing opportunities for leadership to improve alignment. In our experience it is important that each AHC develop a definition of success in alignment that is consistent with its unique mission and strategic vision, and then routinely monitor performance against these metrics. *(See sidebar.)*

The survey respondents almost universally reported that overall alignment was an ongoing critical goal, while readily admitting that it is rarely possible along every dimension and at all times. The key to success is to target progress where and when it is achievable. If progress cannot be made on specific elements such as modifying governance structures, leadership can consider progress in aligning governance mechanisms or in other areas of the organization. The process of understanding and developing customized and achievable alignment is essential to leveraging strengths in all areas in the AHC. It is important to keep in mind that perfect alignment overall and in key dimensions is not achievable; but it is imperative that AHCs continue to strive to progress along the continuum toward that goal. 🌍

Case Example

One of the participating AHCs opted to use the survey to gauge perceptions among members of their senior team. The respondents included key clinical chairs as well as practice plan, hospital and medical school executives. The surveys were tabulated confidentially. Results showed an unexpected diversity of opinion regarding the level of alignment among the key parties and sharply different perceptions of the AHC's organizational structure and approaches to the four dimensions.

About The Chartis Group

The Chartis Group is an advisory services firm that provides management consulting and applied research to leading healthcare organizations. The firm is comprised of uniquely experienced senior healthcare professionals and consultants who apply a distinctive knowledge of healthcare economics, markets, and organizational dynamics to help clients achieve unequalled results.

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