Administrative Issues Journal

Volume 5
Issue 2 *VOLUME 5, ISSUE 2: WINTER 2015*

Article 2

12-2015

Redefining the Core Competencies of Future Healthcare Executives under Healthcare Reform

Dianne B. Love

M. Femi Ayadi

Administrative Issues Journal: Connecting Education, Practice, and Research (Winter 2015), Vol. 5, No. 2: 3-16, DOI: 10.5929.2015.5.2.1

Redefining the Core Competencies of Future Healthcare Executives under Healthcare Reform

Dianne B. Love, Ph.D
M. Femi Ayadi, Ph.D.
Healthcare Administration Program School of Business University of Houston - Clear Lake

ABSTRACT

As the healthcare industry has evolved over the years, so too has the administration of healthcare organizations. The signing into law of the Patient Protection and Affordable Care Act (ACA) has brought additional changes to the healthcare industry that will require changes to the healthcare administration curriculum. The movement toward a vertically integrated delivery system for healthcare has demanded that healthcare executives have a new set of skills and competencies. These competencies include management skills across hospitals, ancillary providers, physician practices, ambulatory settings, as well as skills in risk management and quality. Healthcare organizations can transform healthcare delivery through the power of technology and systems oriented care. This will require a new type of healthcare executive with new skill sets. This paper examines the skill sets of leaders of some of the leading integrated delivery systems in the United States through key interviews with twelve top executives. Based upon those interviews, c-suite executives in large healthcare systems were surveyed to identify the core competencies of the successful healthcare executive of the future and the graduate education requirement needed to achieve those competencies. The results of the study are used to provide suggestions on how the curricula of healthcare administration programs can be revamped.

Keywords: core competencies; healthcare executives; healthcare reform; Affordable Care Act; healthcare administration curriculum

As the healthcare industry has evolved over the years, so too has hospital/healthcare administration and the Master of Healthcare Administration (MHA) and Master of Healthcare Administration/Master of Business Administration (MHA/MBA) curriculum. In the first half of the 20th century, most hospitals were not for-profit, primarily religious or government owned. People with money could afford healthcare, while the elderly and poor were dependent upon charity care. Most hospital administrators had a public health, nursing, or social work background. The passage of Medicare and Medicaid legislation in 1965 (Social Security Act Amendment, 1965) provided funding for the poor and elderly to pay for healthcare. This also began the development of for-profit hospitals,

which gave rise to professional hospital administration, and the number of healthcare administration programs grew significantly.

The era of the 1980s gave rise to prospective payment for Medicare and Medicaid and managed care for commercial payors. With these changes from cost-based reimbursement to a fixed prospective payment system, healthcare became a business, and healthcare administration programs began to offer more business courses. This led to MHA/MBA degrees and MBAs with healthcare concentrations. In the 1980s, as well, hospitals began purchasing physician practices. There was an increase in ancillary services and providers, and integrated delivery systems proliferated. The Masters in Hospital Administration became the Masters in Healthcare Administration. This shift toward healthcare as a business saw the introduction of new courses into the MHA and MHA/MBA curriculum such as managed care, physician practice management, quality, and an increased emphasis on quantitative skills. Thus, the 21st century saw an increase in the number of physicians in executive positions and increased requirements that C-Suite leaders have for-profit experience even for not-for-profit hospitals.

The signing into law of the Patient Protection and Affordable Care Act (ACA) (ARRA, 2009) has brought additional changes to the healthcare industry and, as a result, will require changes to the healthcare administration curriculum. ACA has brought a move toward value-based purchasing from fee-for-service, an increase in risk sharing—such as bundled pricing, shared risk contracting and capitation—as well as a movement towards clinical integration and healthcare systems such as Accountable Care Organizations (ACOs), Physician-Hospital Organizations (PHOs), and Independent Physician Associations (IPAs). This movement toward a vertically integrated delivery system for healthcare has demanded that healthcare executives have a new set of skills and competencies. These competencies include management skills across hospitals, ancillary providers, physician practices, ambulatory settings, risk management skills, and skills in quality. The healthcare industry is also moving away from procedure-based fee-for-service medicine toward prevention and wellness and population management. This requires a new set of skills for healthcare executives such as predictive analytics, population management, change management, physician relations, quality and safety. The healthcare executive of the future will need both educational training and hands on experience in all of these areas in order to be able to navigate this complex environment and provide optimal performance at every facet of their organization.

An essential determinant of healthcare organizational performance is management competence (Fine, 2002). Ross, Wenzel, and Mitlyng (2002) suggest that “there is not another industry where the understanding of core competence is as crucial as it is in healthcare today.” Several organizations have developed competency models, including the American College of Healthcare Executives (ACHE), National Center for Healthcare Leadership (NCHL), Medical Group Management Association, (MGMA), Healthcare Financial Management Association (HFMA), Healthcare Information and Management Systems Society (HIMSS), American Medical Informatics Association (AMIA), and the Association to Advance Collegiate Schools of Business (AACSB). Healthcare administration programs use a combination of these competency models in their programs, in addition to receiving input from healthcare executives in the field. The purpose of this research project was to identify the core competencies of the healthcare

executive of the future in the era of healthcare reform and to use these competencies to provide input into the development of the graduate curriculums of healthcare administration programs so that the program graduates are ready to assume leadership in the new healthcare system. The study uses input provided from leaders of some of the leading integrated delivery systems in the United States.

METHOD

Key interviews were conducted with a focus group of leaders of some of the leading integrated delivery systems in the United States. The interviews assessed the leaders' views of the future. Twelve interviews were conducted with healthcare executives from both for-profit (25%) and not-for-profit (75%) organizations (Table 1). These in-person interviews consisted of open-ended questions in areas such as skills necessary for the future healthcare executives, what skills should no longer be taught in a healthcare administration program, and what future healthcare executives need in addition to coursework to prepare them as healthcare executives.

Table 1
Focus Group Interviews by Executive type

Type	Number
CEO	6
Chief Integration Officer	1
Chief Medical Officer (CMO)	4
Healthcare Executive Recruiter	1

The results of these interviews were used to develop a survey document. The preliminary survey document was tested on additional healthcare executives. The results of the test group were used to develop a final survey document. Survey questions were developed based on those interviews to identify the core competencies of the successful healthcare executive of the future and the graduate education requirements needed to achieve those competencies. The survey is provided in Appendix 1. The survey was sent to a random sample of chief executives officers (CEOs) of large hospitals and healthcare systems. Survey sample was from the American Hospitals Association (AHA) membership in the 2013 Guide Book and CD, compiled from the AHA annual survey of hospitals and other sources to provide a comprehensive directory of healthcare in America. Survey Monkey was used to send out and collect the surveys. The survey was conducted between April 2013 and March 2014. The online survey was sent to 210 CEOs from large multihospital systems in different regions of the country. A total of 39 executives responded to the survey, a 19% response rate. The survey results were analyzed using SAS software 9.2. The executives were asked to rank skills in order of importance from a list of core competencies in training healthcare executives. The ranking order was from 1 to 5, with 5 being the highest rank.

RESULTS

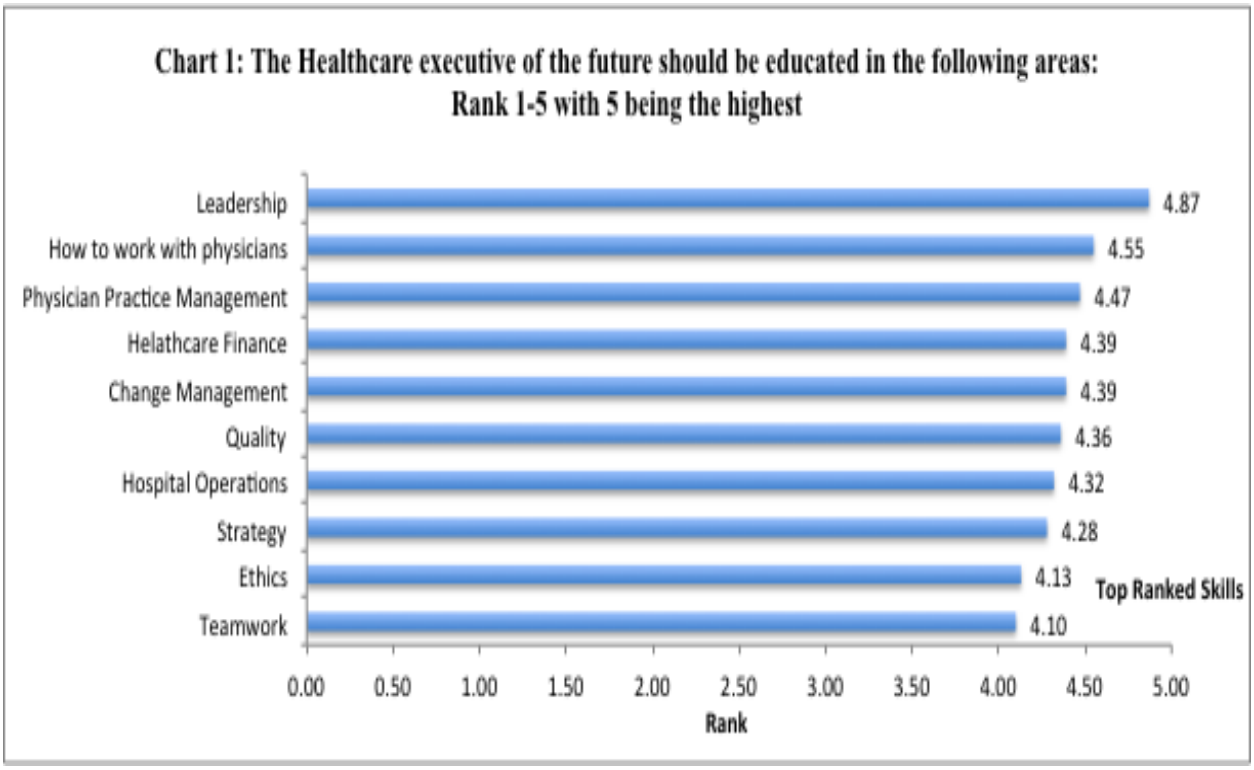
The list of skills is shown in Table 2 and grouped in order of importance to the survey respondents. The top ranked skills for future healthcare executives (see Chart 1) include: Leadership (4.87), How to Work with Physicians (4.55), Physician Practice Management and Physician Relations (4.47), Change Management (4.39), Healthcare Finance (4.39), Quality (4.36), Hospital Operations (4.32), Strategy (4.28), Ethics (4.13), and Teamwork (4.10).

Table 2
The Healthcare Executive of the Future should be educated in the following areas. Rank 1-5 with 5 being the highest.

Skill	Rank (*n*=39)
Top Ranked Skills	
Leadership	4.87
How to Work with Physicians	4.55
Physician Practice Management and Physician Relations	4.47
Change Management	4.39
Healthcare Finance	4.39
Quality	4.36
Hospital Operations	4.32
Strategy	4.28
Ethics	4.13
Teamwork	4.10
Middle Ranked Skills	
How to Manage Effective Meetings	3.97
Integrated Delivery Systems	3.84
Patient Safety	3.84
How to Collaborate to Drive Future Successful Systems	3.84
Risk Management/Population Management	3.74
Healthcare Planning	3.65
Healthcare Information Technology	3.58
Healthcare Policy	3.55
Ambulatory Care Development	3.53
Least Ranked Skills	
Healthcare Law	3.47
Project Management	3.45
Community Professional Relations	3.42
Value-Based Purchasing	3.37
Healthy Work Environment	3.37
Healthcare Continuum of Care	3.34
Post-Acute System Development	3.19
Mergers and Acquisitions	3.14

Skills ranked in the middle range (see Chart 2) include How to Manage Effective Meetings (3.97), Integrated Delivery Systems such as ACO, CI (3.84), Patient Safety (3.84), How to Collaborate to Drive Future Successful Systems (3.84), Risk Management/Population Management (3.74), Healthcare Planning (3.65), Healthcare Information Technology (3.58), Healthcare Policy (3.55), and Ambulatory Care Development (3.53).

The skills that were ranked the lowest in terms of importance for the future healthcare executives (see Chart 3) included Healthcare Law (3.47), Project Management (3.45), Community Professional Relations (3.42), Value-Based Purchasing (3.37), Healthy Work Environment (3.37), Healthcare Continuum of Care (3.34), Post-Acute System Development (3.19), and Mergers and Acquisitions (3.14).



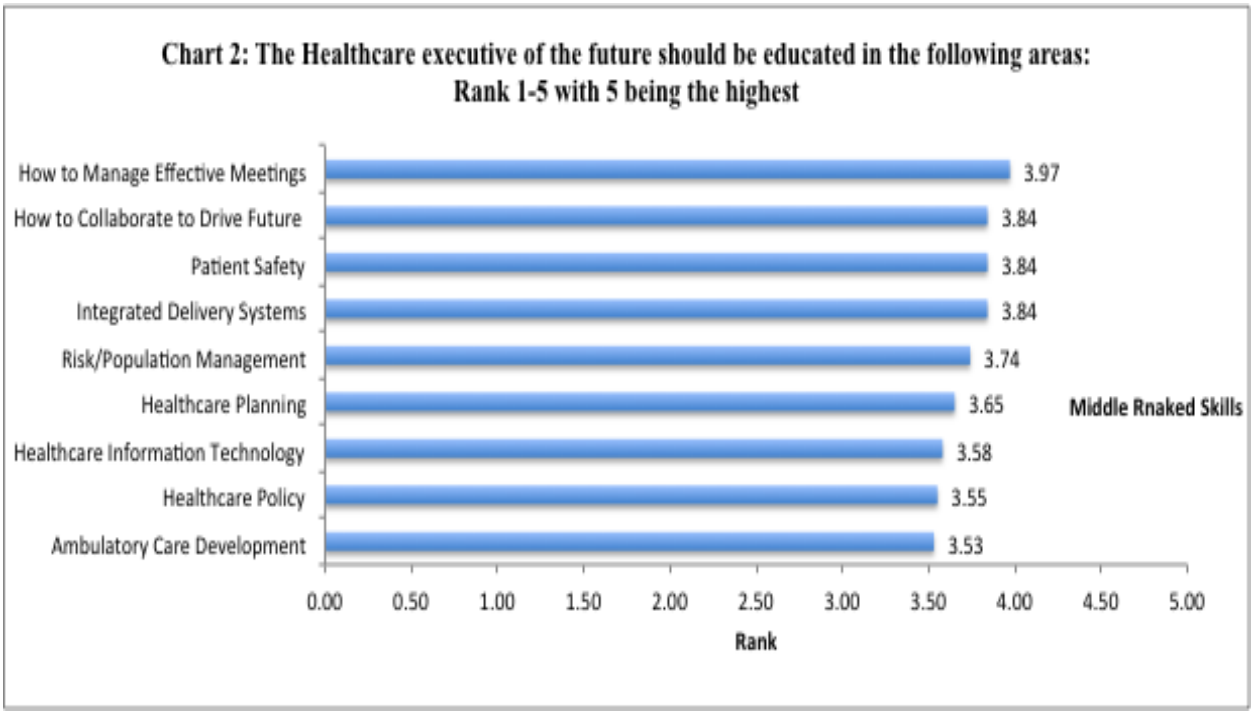


Chart 2: The Healthcare executive of the future should be educated in the following areas:
Rank 1-5 with 5 being the highest
How to Manage Effective Meetings
How to Collaborate to Drive Future
Patient Safety
Integrated Delivery Systems
Risk/Population Management
Healthcare Planning
Healthcare Information Technology
Healthcare Policy
Ambulatory Care Development
3.97
3.84
3.84
3.84
3.74
3.65
3.58
3.55
3.53
Middle Rnaked Skills
0.00 0.50 1.00 1.50 2.00 2.50 3.00 3.50 4.00 4.50 5.00
Rank

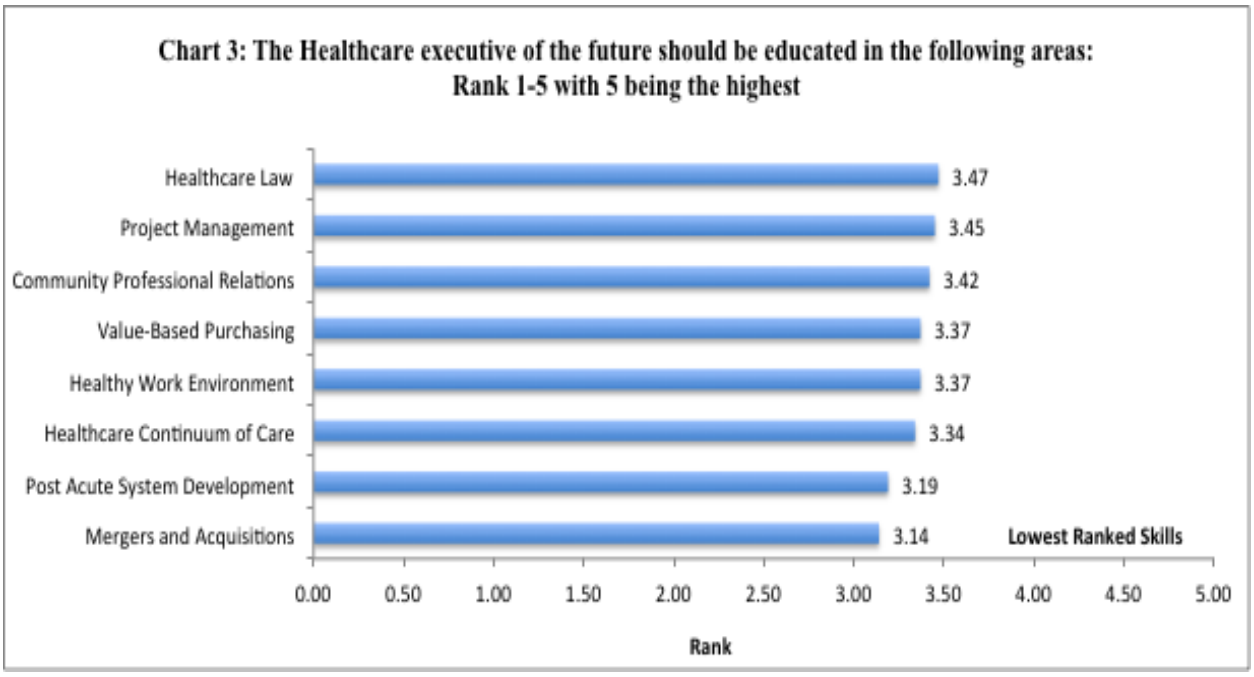
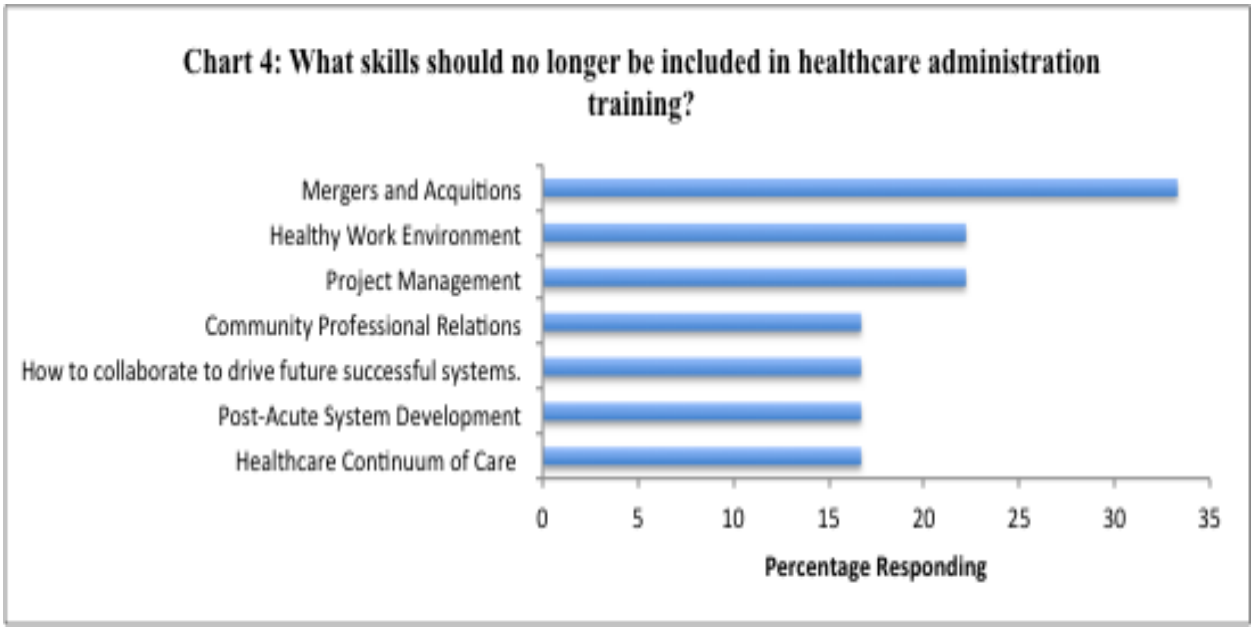


Chart 3: The Healthcare executive of the future should be educated in the following areas:
Rank 1-5 with 5 being the highest
Healthcare Law
Project Management
Community Professional Relations
Value-Based Purchasing
Healthy Work Environment
Healthcare Continuum of Care
Post Acute System Development
Mergers and Acquisitions
3.47
3.45
3.42
3.37
3.37
3.34
3.19
3.14
Lowest Ranked Skills
0.00 0.50 1.00 1.50 2.00 2.50 3.00 3.50 4.00 4.50 5.00
Rank

Executives were further asked what skills they felt should no longer be included in healthcare administration training (Chart 4). Their suggestions included Mergers and Acquisitions (33%), Project Management (22%), and Healthy Work Environment (22%). Seventeen percent of the respondents felt that Post-Acute System Development, Community Professional Relations, How to Collaborate to Drive Future Successful Systems, and Healthcare Continuum of Care should no longer be included in health administration education curriculum.



Not surprisingly, in addition to classroom education, the healthcare executives in the survey felt very strongly that future healthcare executives should be trained via fellowships/residencies, internships, and class projects to provide hands-on experience. In a recent report, Capelli, (2013) argued that work experience, specifically internships, tops the attributes companies look at when evaluating recent college graduates for a job, based on results from a survey of employers (*The Chronicle of Higher Education*, 2012). When asked what other suggestions the executives had for educating the healthcare executive of the future, they included the following topics: executive coaching, training the future healthcare executive in understanding the difference between leading and management; using practical, real world applications; and exposing students to people who have generated change. When asked what courses/training the executives could benefit from today, they included finance and insurance, latest in healthcare strategy and reform, change management, and analytics.

DISCUSSION AND CONCLUSIONS

The top ranked skill for the healthcare executive of the future was leadership. Leadership of the facility, leadership of ancillary providers, and physician side leadership is essential to the new payment models under the Accountable Care Act. The healthcare industry is going through the most significant change

since the passage of Title XVIII and XIX, which created Medicare and Medicaid in 1965. Physicians will have to change how they practice medicine. Hospitals will have to change how they utilize ancillary services and how they work with physicians. Physicians will have to be incentivized to keep patients out of the hospital, reduce the number of readmissions, reduce never events, and reduce the number of days the patients are in the hospital. The focus will be on prevention and wellness. Physicians will be rewarded financially for keeping patients well and managing the chronically ill patient. Specialists will no longer be rewarded for the number of patients they admit to the hospital or by how many procedures they do. The healthcare executive of the future will need to develop the leadership skills to be able to navigate these new complex environments, while providing optimal performance at every facet of the vertically integrated organizations.

Healthcare executives will have to work with physicians to get them to focus on quality, prevention, wellness, managing chronically ill patients, and following clinical guidelines established by the physicians themselves. The success of healthcare systems will now be based upon the physicians' willingness and ability to partner with the hospital to improve quality and reduce costs. This will require clinical expertise and understanding of the clinical process by the healthcare executive, and how to work as partners and not in a vacuum.

The importance placed on skills in physician practice management is not surprising given the importance of hospitals and physicians working together in the clinically integrated environment, whether within an ACO or PHO/IPA or some other type of risk sharing arrangement. Hospitals are purchasing physician practices and managing them as part of their integrated network. It is important for the healthcare executive to know how to manage those practices in an efficient manner in order to increase physician salaries. Physicians are generally being paid on production and Relative Value Units, (RVUs), and contracts with the hospital are for three years. If the physicians do not see an improvement in their salary during that three-year period, they may move to another hospital or to another physician ownership model.

The passage of ACA has brought a significant need for change, which is reflected in the importance placed on change management skills by the healthcare executives in the survey. The healthcare system is changing from the traditional fee-for-service, procedure-based system to a prevention and wellness, risk-taking system. Hospitals are no longer paid based upon how many procedures they do or how many patients are in their hospital. The performance of the hospital is based upon how well they manage the population they are responsible for, and how well they manage patients with chronic conditions. They are rewarded for keeping patients out of the hospital, not putting them in and keeping them in the hospital. The healthcare executive of the future will need to be able to help their employees adapt to these changes.

The financial success of a hospital, even a not for-profit hospital, is a function of bringing in more cash from patient services than they pay for the services necessary to provide those services. The old adage of *no margin, no mission* is more important than ever. In the new payment systems, all hospitals will be compensated based upon population management and quality, and, as such, resources will have to be allocated in a different manner. Hospitals will have to understand these new payments systems and

partner with employers and insurance companies to contract in a manner that incentivizes their employees and physicians to maximize revenue under these new payments systems. Risk sharing arrangements, capitation, and bundled pricing will be dependent upon understanding and modeling these financial arrangements.

Quality is also a top ranked skill, and physicians and hospitals are now being compensated based upon value-based purchasing and quality incentive payments such as Bridges to Excellence and Physician Quality Reporting Systems (PQRS). Both government and employers are demanding that they receive value for the dollars that they spend on healthcare and that those expenditures result in a more efficient and higher quality system. A significant portion of physician compensation is based upon how well they perform based upon a number of clinical indicators that improve the health and quality of life of the patients and lower the long term cost of care. Programs such as Bridges to Excellence provide bonuses to physicians for their clinical quality. For hospitals, Medicare reduces payment for readmissions to the hospital and for never events. Commercial payors base the annual increase to hospitals upon readmissions and contracting of hospital-based physicians. More governmental payors and employer groups are basing a significant portion of the providers' compensation on clinical quality indicators.

The ACA requires hospitals and physicians to share risk related to care outcomes and savings. These risk-sharing relationships will require significant investments in technology, workflow, and care management systems. The same factors of clinical integration driving shared risk arrangement and value-based purchasing will require collaboration, population management, and clinical and financial data analysis, as well as an understanding of the entire healthcare system. It is evident that the leading priorities in the era of healthcare reform include improving quality, sharing risks, and population management. In a survey of hospital and care system leaders about their priorities, improving efficiency through productivity and financial management was cited as the top priority (HRET, 2014).

In order for clinical integration and coordination of care to occur, there needs to be a movement towards population health management models. One of such models is the ACO model. Recently, the Centers for Medicare and Medicaid Services (CMS) issued quality and performance results showing that Medicare ACOs in the Pioneer ACO Model and Medicare Shared Savings Program have improved patient care and generated over $372 million in total savings for the program (HHS, 2014). In an ACO, providers who join the ACO become eligible to share savings with Medicare when they deliver care more efficiently. One such example is the Memorial Hermann Accountable Care Organization in Houston, Texas, which has a very large, high performance physician network. This ACO produced $52 million in savings from 2010-2014 (Fernandez, 2014).

The emphasis on population management models also demands a renewed need for analytic skill sets. Predictive analytics is used in healthcare to analyze data across the continuum of care to manage patient populations and improve patient care while avoiding financial and reimbursement penalties for hospital. For example, predictive analytics can be used to predict hospital readmissions.

The curriculum of existing healthcare administration courses can be redesigned to incorporate the new skills identified from the results of the survey. The focus on value-based purchasing requires physician

engagement. Courses on quality and safety should include value-based purchasing. Population based management should be covered extensively in epidemiology courses. It can also be emphasized and covered in introduction to public health and managed care courses. Change management can be covered in the leadership class as well as in the organization management classes. The topic of physician relations should be addressed in hospital operations and strategy classes. Predictive analytics need to be taught in statistics or decision science classes, while healthcare accounting and finance courses should introduce and emphasize concepts such as activity-based costing, physician compensation models, RVUs, bundled payments, and shared savings contracts. Clinical integration in integrated delivery systems such as ACOs, IPAs, and PHOs, should be incorporated into the managed care class. Shared savings contracts and some population management discussion can also be covered in managed care classes. Healthcare administration programs need to maintain relevance in their curriculum in the era of healthcare reform. It is critical that the healthcare administration graduates from these programs are equipped with the necessary skill to lead and transform the healthcare organizations of the future.

APPENDIX

SURVEY INSTRUMENT: Questions on Future Healthcare Executives

1. The healthcare executive of the future should be educated in the following areas. Rank 1 – 5 with 5 being the highest.

    Hospital Operations
    Leadership
    Physician Practice Management/Physician Relations
    Risk Management/Population Management
    Quality
    Health Information Technology
    Healthcare Finance
    Healthcare Law
    Healthcare Planning
    Healthcare Policy
    Integrated Delivery Systems (ACOs, CI, etc.)
    Statistics/Spreadsheets/Understanding Data
    Healthcare Continuum of Care (ASCs ,LTAC, HHA, DME ,Infusion Therapy, Pharmacy)
    How to Run Effective Teams/Meetings
    How to Work with Physicians
    Integrated Delivery Systems (ACOs, CI, etc.)
    Ambulatory Care Development
    Statistics
    Spreadsheets
    Understanding Data
    Post-Acute System Development
    How to Collaborate to Drive Future Successful Systems
    Community Professional Relations
    Teamwork
    Managing Change
    Value-Based Purchasing
    Strategy
    Ethics
    Merger and Acquisitions
    Safety Issues (Patient Safety)
    Project Management
    Healthy Work environment

2. Which of the above should not be included?

3. What other topics should be included?

4. In addition to classroom education, how else should the healthcare executive of the future be trained?

    Internship
    Residency/Fellowship
    Class projects
    Other

5. What topics in your MHA/MBA education do you think no longer should be included?

6. What other suggestions do you have for educating the healthcare executive of the future?

REFERENCES

American Recovery and Reinvestment Act (2009). Public law 111-5. Retrieved from http://www.gpo.gov/fdsys/pkg/PLAW-111publ5/pdf/PLAW-111publ5.pdf

Calhoun J. G., Dollett, L., Sinioris, M. M., Wainio, J. A., Butler, P. W., Griffith, J. R., & Warden, G. L. (2008) Development of an interprofessional competency model for healthcare leadership. *Journal of Healthcare Management*, *53*(6), 375-89.

Capelli, P. (2013). Why focusing too narrowly in college could backfire. *The Wall Street Journal.* Retrieved from http://online.wsj.com/news/articles/

Caron, R. M., Hooker, E. E., & Ulrich-Schad, M. A. (2013, Summer). Body of knowledge for health administration education: Teaching epidemiology in the age of health care reform. *Journal of Health Administration Education, 30*(3), 197-212.

Fernandez, D. K. (2014) Accountable Care Organization: Managing success. Presentation at American Medical Group Association 2014 Institute for Quality Leadership Annual Conference. Available online at http://www.amga.org/docs/Meetings /IQL/2014 /Breakouts/MHMD-Fernandez.pdf

Fine, D. J. (2002). Establishing competencies for healthcare managers. *Healthcare Executive, 17*(2), 66-7.

Gutty, P. (2012) *What healthcare managers need to know and how to teach them*. Harvard Business School working paper, Research and Ideas.

HealthLeaders Media Intelligence (2014, September). *Physician Alignment: New Leadership Models for Integration.* Retrieved from http://www.healthleadersmedia.com/slideshow.cfm?content_id=307901

Health Research and Educational Trust (HRET) (2014, April). *Building a leadership team for the healthcare organization of the future*. Chicago, IL: health Research and Educational Trust. Retrieved from www.hpoe.org

Herzlinger, R. (2013). Benchmarks for confronting the challenges for innovation in healthcare with a modern curriculum. A white paper. Harvard Business School.

HHS Press Release (2014). New Affordable Care Act tools and payment models deliver $372 million in savings, improve care. Retrieved from http:www.hhs.gov/news/press/2014pres/09/20140916a.html

Medical Group Management Association (2014). *The body of knowledge for medical practice management: A framework for success* (3rd ed.) Retrieved from http://www.mgma.com

/Libraries/Assets/Education%20and%20Certification/Certification/Body%20of%20Knowledge/BOK_brochure_2014_FINAL.pdf?ext=.pdf

Ross, A., Wenzel, R. J., & Mitlyng, J. W. (2002). *Leadership for the future: Core competencies in healthcare.* Chicago: Health Administration Press.

The Chronicle of Higher Education. (2012). The role of higher education in career development: Employer perceptions. Retrieved from http://chronicle.com/items/biz/pdf/Employers%20Survey.pdf

Wagner, K. (2014, August 1). Web special: Core competencies for a changing healthcare environment. *HFM Magazine* Retrieved from www.hfma.org /corecompetencies/

ABOUT THE AUTHORS

Dianne B. Love, Ph.D. (love@uhcl.edu) is an Associate Professor of Healthcare Administration in the School of Business, at the University of Houston- Clear Lake. Dr. Love holds a Ph.D. in in accounting from the University of Arkansas. She is a past president of the Texas Gulf Coast Chapter of HFMA and an adjunct faculty member at the University of Texas Health Science Center in Houston and the Physician Exccutive MBA program at Auburn University.

M. Femi Ayadi, Ph.D. (ayadim@uhcl.edu), is an Associate Professor of Healthcare Administration in the School of Business, at the University of Houston-Clear Lake. Dr. Ayadi holds a Ph.D. in economics as well as an M.A. in economics from the Andrew Young School of Policy Studies, Georgia State University. Prior to coming to the university, Dr. Ayadi was a health economist at the Centers for Disease Control and Prevention. Dr. Ayadi teaches health economics and Public health. Her research is published in journals such as American Journal of Preventive Medicine, Pediatrics, Medical Care, and Journal of Health Care Finance.

All correspondence to this article should be directed to M. Femi Ayadi. 2151 W. Holcombe Blvd. Houston, Texas 77030 Tel: 281-212-1712 Email: ayadim@uhcl.edu