The Gundersen Health System 15 Years in the Making:
A Retrospective on a Path to Success

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In the face of mounting macroeconomic pressures, competitive market strategies, and legislated health reform, community healthcare providers—especially hospitals and physicians—are integrating their business models at an accelerating rate.

LARGER, COMPLEX, INTEGRATED community health systems are now forming. Those leading integration efforts (typically leaders of health systems) report flying blind, thinking that there is no road map for integration. They’re often unaware there are those that have gone before (“trailblazers” of integration) and their lessons learned are available for guidance.

This special section provides a 15-year retrospective of the integration journey of Gundersen Lutheran Health System (now Gundersen Health System). It delves into the challenges of community health systems today, with reference to Gundersen Health System’s approach to these same challenges over the last 15 years. The goal of this article is to provide those on the front end of their integration journey with the benefit of learning from the experience of an integrated community health system that has succeeded with its journey to date and is positioning for its next 15-year run.

Gundersen Health System Today

In 2012, Gundersen Health System is a fully integrated community health system headquartered in La Crosse, Wisconsin (a primary service area of 250,000 with a secondary service area of 400,000). It employs 447 physician full-time equivalents in 90 clinical specialties. It owns and/or operates three hospitals with 300 beds located in La Crosse. All staff are employed by the health system in over 50 locations. The health system serves 20,000 inpatients annually and generates 1.5 million ambulatory patient encounters from Western Wisconsin, Southwestern Minnesota, and Northwest Iowa.

Gundersen Health System’s principal competitor is another integrated community health system owned and operated by the Mayo Clinic (formerly Franciscan Skemp). Gundersen serves approximately 60 percent of its target market. Competition exists in peripheral geographic markets where Gundersen owns and operates clinic sites (see Exhibit 1 for geography served).

Over the 15-year span of time covered by this article, annual operating revenues have increased from $229 million in 1996 to $820 million in fiscal year 2011. Gundersen Health System is organized as a tax-exempt, not-for-profit organization providing $37 million in total charity and uncompensated care in fiscal year 2010. The system is governed by a unified board of directors composed of six community members and four physicians from the health system. Nine physicians on a board of governors work with the directors to oversee health system operations (see Exhibit 2). The chief executive officer of the health system is a practicing physician who has been with the health system for 27 years.

Drivers of Provider-Side Consolidation and Integration

The provider side of the U.S. healthcare delivery system is consolidating, as is the payer side of the industry. Larger, more complex, integrated community health systems are forming in response to obvious and less than obvious “drivers.”

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The obvious drivers are:
• A recent downturn in the U.S. economy that affected healthcare, influencing decreased utilization and diminished operating revenue flow to the insurers and providers of care
• A commensurate upward spike in the number of uninsured, causing increases in community health system rates of charity and uncompensated care
• Downward pressures on healthcare reimbursements due to the governmental payers and fewer, but larger commercial payers exerting negative pressures on price and utilization
• Push toward electronic medical record, purchasing clinics to cover larger service territory, shortages of physicians in rural areas, and uncertainty of rural clinics and critical access hospitals

Less obvious but, nonetheless, meaningful industry dynamics include:
• The economic vulnerability of independent, private medical practice business models caused principally by “lightning strikes” by payers on reimbursements and related operating economics²
• Waning interest by physicians, especially those emerging from training, in the private practice of medicine³
• Seismic shifts in the clinical practice of medicine (shifts from inpatient to outpatient clinical practice models)⁴, ⁵
• Acceleration of the incidence of chronic disease in the U.S. population, which is overpowering a system of financial incentives focused on the treatment of the acute event

Some in the industry would suggest that providers are experiencing the “perfect storm” — the clash of poor health services demand meeting unsustainable total health cost inflation rates. While causal theory abounds and is debated, most agree the economic effects on healthcare in the U.S. are excessively inflationary and unsustainable.

Facing the Big Decision: Gundersen Clinic and Lutheran Hospital
In 1995, the Gundersen Clinic (then an independent, multispecialty clinic of 318 physicians) faced a “fork in the road.” Despite nearly 100 years of successful independent operations, market dynamics and economic realities forced leaders to make a strategic decision within a three-option matrix: 1) go it alone, which meant an acceleration of competition with its long-time hospital partner, Lutheran Hospital; 2) merge with Lutheran Hospital; or 3) attempt to consolidate all community providers (another smaller multispecialty clinic and a faith-based hospital) into one, unified, integrated community health system. Absent successful culmination of one of the three options, prevailing economics could have led the Gundersen Clinic to collapse due to:
• A lack of integration and control of the totality of the economics (revenues and expenses) of community healthcare (including the hospital components)
• The clinic’s historic development and ongoing funding of regional outreach satellites
• The clinic’s historic funding of clinical specialties and related services that were profitable for a hospital, but produced negative margins for a large clinic
• Ownership by the hospital of the more lucrative clinical revenue sources
• The clinic’s commitment to its historic mission, including community access to high-quality, affordable healthcare, clinical research, and teaching

At this point they had to make a move in order to survive; a seismic strategic shift in community healthcare design and delivery was required. The decision was integrating with Lutheran Hospital—thought to be the more practical and controllable option among the three considered—and a complete and total unification and integration of clinical services, finances, assets, and staff.

The Initial Integration Considerations
Whether 15 years ago or today, the anxiety around integration is the same. Leaders of Gundersen Clinic and Lutheran Hospital each had their own concerns. Some of the most common appear below.

The hospital community board’s concerns:
• The physicians will take all the money that rightfully belongs to the community.
• The physicians will control the organization to serve themselves, not the community.
• The community will have no influence over the direction of healthcare for the community.
• Physicians might not serve the mission needs of the community.

The physicians’ concerns:
• There is no reason to change. The physicians should control healthcare.
• Community board members don’t understand the practice of medicine. They will destroy the physician culture.
• Some non-physician will control us and our professional autonomy will be destroyed, which could lead to being fired by a hospital administrator.

The key negotiating issues that emerged were:
• Governance (a proxy for control)
• Physician compensation (who controls the money)
• Daily operations (who tells whom what to do)

Today, little has changed; the same dynamics apply. Interviews with physician groups and hospitals facing the “fork-in-the-road”

integrated decision identify the four big issues as:

- Governance
- Compensation
- Control of operations
- Terms, conditions, and price paid for clinic assets purchased

What typically emerges with integrations are governance and business models that demonstrate remarkable consistency across integrated health system designs. Gundersen Lutheran, in the initial phase of development, was no exception; key characteristics of the initial design were:

- A full merger of assets (the Gundersen Clinic was a tax-exempt, not-for-profit entity at the time of integration, as was Lutheran Hospital). An asset sale was not available to clinic physicians.
- A unified governing board was formed consisting of six community members and four physicians from the clinic. While regulatory guidance may have permitted a 50/50 board (community and physicians), physicians elected to grant the community a 60/40 majority over initial board composition.
- The clinic CEO (a physician) was appointed CEO of the newly formed health system.
- A board of governors was formed composed of nine physicians and the chief administrative officer to oversee health system operations. This body was accountable to the governing board. Such a structure has been used in other integration models, but is less common.
- Operations were consolidated to reflect an “equitable” integrated operating management model (an integration of leaders from the clinic and hospital).

6 When the Gundersen Clinic integrated with Lutheran Hospital it operated as a not-for-profit, tax-exempt organization having converted from a for-profit clinic in the 1980s. Most medical clinics that integrate with not-for-profit, community health systems operate as for-profit entities owned by physicians. For physicians to receive “fair value” for assets owned, a community health system will often purchase assets from physician owners then effect an “integrating event” through employment agreements with physicians.

7 Regulatory guidance and legal opinion at the time of the integration pointed to an ability for the prospective, new, integrated health system to operate as a not-for-profit, tax-exempt organization with up to 50 percent of the board of directors comprised of physicians who would also be considered “insiders,” according to IRC definition—providing these insiders were not permitted to exercise vote (control) over decisions conveying “personal benefit” such as compensation plans.

An Attempt to Make Integration Work: The First Five, Formative Years

All newly formed integrated health systems endure a relatively rocky initial three-to-five-year phase marked by:

1. Digestion of transaction costs and the realization of what financial productivity means in the integrated model. There are costs related to everyone “getting their sea legs.” Debate ensues over what “physician productivity” means and what it takes to “recoup the costs of integration.” Panic often sets in when all parties realize the effects of integration on the income statement and balance sheet; accounting methods frequently reflect a financial loss on physicians (which is often an unfortunate artifact of the accounting architecture).

2. To the extent that independent physicians remain in the mix (i.e., members of the hospital medical staff), they often threaten retaliation in the form of defection and/or competition. This was not the case for Gundersen Lutheran, as all were employees of the clinic at the time of integration, although, threats of defection, by some, would come later.

3. Governing boards become confused as they enter uncharted waters, feeling like they have no experience in this area; they don’t know what to monitor, measure, or direct.

4. Staff (and physicians) act out—all sides jockeying for positions and control of the new territory.

8 Legal/structural designs of integrated health systems will frequently “house” physician services in controlled divisions or subsidiary corporations with limited, allocated revenue streams (sometimes limited to professional services revenues only). Full clinic operating expenses are allocated by accounting rules and conventions (e.g., physician compensation and benefits, support staff compensation and benefits, supplies, facilities expenses, and allocated, corporate support services). Ancillary services typically contained within larger, freestanding clinics are often allocated and are operated from licensed hospitals within the IHS, for purposes of capital efficiencies and provider-based billing. Consequently, proper applications of accounting rules and practices will typically show “losses” on physician services. So, long as the community health system design properly integrates and controls physician services and captures all IHS revenues and expenses within consolidated accounting rules and practices, “losses” on the physician services side of the IHS may be irrelevant, to the extent that physicians (and other licensed providers) are sufficiently productive with well-managed operating expenses, and the IHS performs to required financial goals and metrics on a consolidated basis.

For Gundersen Lutheran, the first five, formative years were marked by:

1. The governing board (directors) and the board of governors (the operating board) meeting separately with insufficient integration of thought and efforts. There was no successful “bridge” between the two structured components. The gaps in cooperation and collaboration led to duplication of efforts at best and suspicion and mistrust at worst. There was confusion between the roles and purpose of governance and operations. This confusion translated downward. Those in the trenches questioned the legitimacy and effectiveness of those steering the ship, as well as the value of integration, overall.

2. The management model needed work. The historic separation of the clinic and hospital encouraged the continuation of two separate and parallel administrative structures and operating systems. Managers (and staff) of the clinic and hospital were frequently confused over roles, responsibilities, and accountabilities. The new model required collaboration toward a unified and common mission, vision, and strategy. Some leaders (and managers) remained psychologically rooted in the past. Some feared moving to the new model in case it failed and all returned to the “old world.”

3. Territorialism emerged. Two management teams squared off (the “clinic people” and the “hospital people”). The focus of effort and energy was on internal battles, not progress in the market where it belonged. Health system board members became embroiled in these battles, fueled by old loyalties and relationships with clinic and hospital leaders.

4. The prospects of consolidating operational and administrative functions for the better meant “somebody wins and somebody loses.” The reality of “two-of” had to be faced (e.g., two finance executives, two human resource executives, two chief financial officers, etc.). The need was for a unified leadership model with all committed to the “new world.”

Leaders had to step up. Tough decisions were required. The organization was eager to see if the current leaders could be decisive and successfully lead. The confidence of “the ranks” was at stake, as they worried whether or not they (the leaders), could really pull this off.
In addition to the internal stressors experienced in the first five years following integration, “externalities” affected the organization:

- The Balanced Budget Act of 1997 (P.L. 105-33. 105 Stat. 351) exerted significant downward pressures on hospital operating margins, which the new organization was counting on to support the significant one-time costs associated with the integrating event.
- Increasing market competition from the other local hospital and physician group acquired by Mayo.
- Local, large businesses (such as the Trane Company, Heileman Brewery, the University of Wisconsin-La Crosse, Viterbo University, and Western Technical College) all needing to dampen health cost inflation rates in a market that, by most measures, was over-supplied with health services.
- Health system ownership of a small HMO struggling to compete with a small number of larger, commercial payers in the market.

This first five-year period was marked by turbulence and volatility. Fortunately, the design of the integration allowed for no easy way out (i.e., no turning back). Costs of reversing the deal were too high. All needed it to work.

Ensure the mission and vision remains clear and inviolate. They are the beacon in the fog.

A Clear Vision, Stable Governance, and a Leadership Platform: Moving into the Middle Five Years

Integrated health systems almost always survive the early years. The successes typically outnumber the failings by a wide margin. Why? Sheer tenacity and lack of a plausible alternative most of the time.

The recipe for success in the early years is remarkably similar for all, including Gundersen Lutheran:

- Accept that there is no turning back. “We’re in it for the duration.”
- Remain focused on the patient. “What do our patients expect from us?”
- Do not spend too much time with “the cynics.” They are a cancer in the organization. Move them out. (This sets the right example for others to observe.)
- Keep the board and management focused on “in-the-trenches” operations and financials. You need a successful short-term to be able to have a long-term.
- Financial performance is a requisite. The credit markets are watching. While there are the obvious costs associated with integration, organizations cannot afford to allow financial performance to sag unreasonably the first few years following.
- Dispense with the territorial disputes. There is no time for this.
- Celebrate the successes when they occur. Employees need to see where and how the organization is “winning.”
- Keep investing in forward progress. Demonstrate that the organization is moving ahead on the strategic plan.
- Leaders need to be visible and internal communications must be frequent (whether good or bad). Leaders cannot over-communicate during such times. Treat physicians, other clinicians, and staff like adults.

Above all, ensure the mission and vision remains clear and inviolate. They are the beacon in the fog. Physicians and staff will cling to them. Leaders need to reinforce them. Furthermore, ensure that organizational values are clear. Values drive culture. Culture drives behavior and is the sustainer for the organization in challenging times.

When the Turbulence of Integration Subsides, Strategy Emerges: The Next Five-Year Phase

Strategy becomes the compass for forward progress of an integrated health system. It is the road map for the future. It guides organizational behavior and investments.

The integrated health system model holds strategic potential far beyond the more traditionally fragmented, independent medical staff and community hospital model of healthcare delivery.

But, before Gundersen Lutheran could direct a vision into a longer-term strategy, it needed to address senior leadership design and staffing. It needed to get the governance/leadership model right.

With the integration, and for the first five years following, the existing president of the clinic (a physician) was CEO of the integrated health system. The chief operating officer of the clinic became the chief administrative officer of the health system. People holding leadership positions in the hospital at integration were slotted into key positions in the integrated model (e.g., hospital HR vice president moved to system HR vice president and clinic chief financial officer moved to system chief financial officer).

Despite attempts to equitably integrate senior staff from both organizations into the new leadership design, concern on the part of some community board members influenced attitude and board behaviors. The result: they felt the clinic had too much control. While not an uncommon dynamic in the first few years following integration, it is an unproductive dynamic as the integrated organization attempts to move forward.

Another Chance to Get Organizational and Governance Structure Right

With the retirement of the first CEO in August of 2001, the board of directors and several members of the board of governors thought it was time to seek a new CEO from the “outside”—a predictable response from health systems formed from mergers of hospitals and clinics, which is typically an attempt to level the playing field going forward (e.g., “you won the first round of CEO selection, now it’s time to bring in someone from the outside we can all agree on to lead us forward”). Going to the outside for the next CEO seems logical, but is not always the right answer, especially 10 years ago when the pool of integrated health system leaders was very shallow (as it is today to some extent).

Then, as fate would have it, three weeks following, the senior administrator left due to a health-related issue. Bottom line, the organization was in turmoil, again. Board perspectives were fractured. Some called for dissolution of the organization (a reset to the previous model). Entire clinical departments (physicians) threatened to leave. Employee confidence was shaken and the financial model was threatened.

Board leadership stalled; some wanted an outside CEO brought in (“a savior”), others wanted an insider. The physician who was second in command (executive vice president), a practicing subspecialist and long-time installed leader, was appointed interim CEO in 2001. The “interim” title was a negotiated settlement at the time (an expedientious way to handle a difficult decision within a fractured board).

Then, in January 2002, there was a scheduled reelection of physician seats on the board of governors. Physicians eligible to vote believed it was time to make a change to move the organization forward—an attempt to harmonize the views and efforts of the board of governors with those of the board of directors.
Gundersen Strategic Plan 2009–2014

Mission: We distinguish ourselves through excellence in patient care, education, research, and through improved health in the communities we serve.

Vision: We will be a health system of excellence, nationally recognized for improving the health and well-being of our patients and their communities.

Values:
- **Integrity:** Perform with honesty, responsibility, and transparency.
- **Excellence:** Achieve excellence in all aspects of delivering healthcare.
- **Respect:** Treat patients, families, and coworkers with dignity.
- **Innovation:** Embrace change and new ideas.
- **Compassion:** Provide compassionate care to patients and families.

**Key Strategy 1: Demonstrate superior Quality and Safety through the eyes of the patients and the caregivers**

**Targets:**
- Be nationally recognized by patients, employers, and communities for delivering superior value
- Achieve and sustain all quality measures at the 95th percentile or have zero defects and 100 percent reliability
- Have no preventable: deaths, infections, pain, suffering, waiting, or waste
- Be the preferred community-based academic health center for medical and nursing education in the upper Midwest
- Demonstrate a commitment to patient-centered and evidence-based medicine through all of our education and research programs

**Key Strategy 2: Demonstrate superior Service through the eyes of the patients and our caregivers**

**Targets:**
- Be a recognized leader in providing patient and family-centered care
- Achieve and sustain the 95th percentile in all service measures
- Ensure that all patients get the care they need when they want it
- Collaborate to measurably improve the health of our communities
- Be a leader in the healthcare industry in environmental sustainability
- Be a national leader in the effective and efficient use of technology to support quality, value, and growth

**Key Strategy 3: Become a Great Place to Work through the eyes of our employees**

**Targets:**
- Develop an engaged workforce that is inclusive, embraces change, and is prepared to respond to future healthcare demands
- Develop leaders with the skills needed to transform healthcare
- Establish Gundersen as a destination place for the most talented
- Be a leader in the health and safety of our employees

**Key Strategy 4: Demonstrate lower Cost of Care through the eyes of our patients and their employers**

**Targets:**
- Reduce our cost per episode of care each year striving to achieve breakeven on non-governmental business at 150 percent of our Medicare payment
- Engage our staff in improving efficiency and reducing waste (e.g., rework, unused inventory, excess waiting, duplication of effort, or unnecessary handling or travel)
- Actively partner to reduce the cost of healthcare for our community through increased focus on prevention, wellness, and coordinated care
- Maintain or exceed our current A+ bond rating

**Key Strategy 5: Achieve Programmatic Growth that supports our mission**

**Targets:**
- Evaluate, enhance, and implement new or existing services and programs
- Identify and evaluate opportunities that increase our penetration in existing and emerging markets
- Improve our regional referral process
- Increase patient access to care
- Steadily increase our market share
- Actively partner with community members to improve the quality of life and further the economic strength of our region

**SPECIAL SECTION**

The lessons learned in the middle five years were:
- Leadership appointments in newly formed integrated health systems are oftentimes a negotiated settlement. Frequently, “each side” gets one of the two top jobs (the board chair or CEO position). While frequently a practical settlement, those who assume these positions cannot come to the positions with the attitude of protecting “the clinic” or “the hospital.” Such attitudes will cause stalemates and organizational inertia, which a newly formed organization can ill-afford. Integrated health systems must move quickly past the paranoia of “who will get the best of whom” moving on to the important business at hand.
- The issue of the first CEO being a physician or not is important, but more important is who will be the best first CEO, given the circumstances that apply. Rarely, if ever, has a complex integrated health system formed and a new CEO is immediately brought in from the outside. It is also rare that physicians will support and promote “one of their own” for such an important position if they feel there are no qualified candidates.
- While the first CEO is important, equally important is the first board chair who must be a strong and steady force in the inevitable first three or more “formative years.”
- Physicians serving with community members on the new board cannot be viewed as representing physician...
constituencies from "the clinic." They have a fiduciary responsibility to the whole.

- The CEO must identify a "partner" who can function as the chief operating officer of the organization. Loyalty and trust must underpin this relationship (familiarity typically helps).

The Last Five Years: Setting Clear Principles for Success

Over the last five years, Gundersen "emerged from the wilderness" having overcome:

- Second-guessing the model (integration)
- Spending organizational time, effort, resources, and "energy units" on protecting the organization from itself (in-fighting, galloping paranoia, fractionation of the board of directors and board of governors, physicians, and staff)
- Searching for the right operating model
- Sharpening of the mission and vision
- Finding the CEO for the long-term
- Convincing the organization that leadership can get it right

With a solid governance and operating business philosophy and model in place, the organization executed on a strategy set in a framework of few guiding principles. These principles were converted to action through an organization unified by a clear mission statement: "We distinguish ourselves through excellence in patient care, education, research, and through improved health in the communities we serve." With the mission clear, leaders led from a set of clear principles.

**Principle #1: Commitment to the business model.** The organization committed to the fully integrated model of community healthcare delivery. All abandoned the notion of an "organizational break-up" as a fall-back position. Most other integrated health systems reach the same conclusion. Protecting the right to break up may "feel right," but it causes organizational inertia preventing it from the big and bold steps it must take to advance.

**Principle #2: Commitment to a vision.** The organization committed to accountability for the health of the communities served. It saw itself as more than a merger of a hospital and clinic. Mature integrated health systems realize that the whole is greater than the sum of its parts. It is not merely a place where physicians earn an income. It has a greater responsibility and accountability. The vision serves the mission and the better talent is attracted to both the mission and vision. "Living the mission" is core institutional value—one that guides future decision making. Leaders live the mission. The rank and file watch for this behavior.

**Principle #3: Commitment to "the system" as the provider.** Whether it's Gundersen, Geisinger, or the Cleveland Clinic patients (and the community) become reliant upon and are loyal to a "system of care." Healthcare professionals collaborate as teams to serve patients. The management model is collaborative as well, relying upon a team approach. Integrated health system leaders see and exploit the potential of the "system as strategy."

**Principle #4: Commitment to a culture of quality, built upon a platform of transparency and continuous improvement**—an ongoing accountability of all to the highest standards of quality, with a corresponding commitment to "rapid-cycle" movement to evidence-based standards of clinical and management best practices. Leaders are in a constant state of innovation within the organization. Innovation doesn’t settle down or cease after a few years following integration. While this principle may seem to be a statement of the obvious, take special note of the related commitment to "rapid-cycle" adoption of evidence-based best practices. Mature integrated health systems are in a constant state of organizational performance examination with a commitment to a continuous search for industry best practices.

**Principle #5: Commitment to a customer-focused experience, including timely access to care across the system.** Once a health system commits to becoming a high-functioning integrated system that provides comprehensive care, it must, at the same time, commit to "balancing" its clinical services portfolio to ensure timely access to care across the system. Integrated health systems operate as, "closed economic systems," except for clinic services deliberately excluded from the design (for example, solid organ transplants). If a system primary care physician makes a referral from a satellite location to cardiology, both the referring physician and patient should expect timely access and a coordinated experience.

**Principle #6: Commitment to a consistency of clinical programming across care sites.** Gundersen—as with most integrated health systems—organizes clinical care by clinical service lines (e.g., oncology, cardiovascular, stroke, musculoskeletal, etc.) to ensure that patients receive a consistent standard of care across sites. A high-functioning healthcare system is not a collection of freestanding care centers operating from self-styled strategies and clinical models. Each is organized to provide a common and unified care standard and experience across sites. This approach is consistent with a unified "brand promise." Execution of this principle may be more difficult than it appears, especially as integrated systems extend their geographic reach. Some fall prey to allowing too much "local autonomy" by site. High-performing integrated systems view each site as an integrated component of the whole and not an independent, autonomous operating "affiliate."

**Principle #7: Commitment to sustainable financial performance.** Regional integrated health systems, such as Gundersen, operate as closed, self-contained systems of care. To survive long term, they must design care models, community missions, and geographically dispersed business models within a framework of a durable, sustainable financial model. Leadership must commit to a level of financial performance that sufficiently builds and sustains balance sheet strength, including the protection of balance sheet capacity sufficient to finance ongoing recapitalization of the asset.

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base to standards sufficient to meet mission, vision, and strategic goals, while enduring the vagaries of economic cycle variation, such as that endured by Gundersen during the economic recession beginning in 2008. To do so, requires management discipline, which requires all physician leaders to understand clinical care within a context of reconciling economics and finance.

**Principle #8: Commitment to the value of people as the principal asset of the organization.** The operating expense structure of integrated health systems demonstrates that it is principally a “people business.” Upwards of more than 60 percent of the operating expense structure is “people costs,” including physician compensation and benefits. Mature health systems recognize the value of culture in strategy. Culture is often best defined as “how we do it here.” During the last recessionary cycle, Gundersen made it through with no staff layoffs. That doesn’t mean there was no belt-tightening or challenges to organizational economics. It means that “the people” were the source of innovation to endure an economic downturn. During this period, a large percentage of physicians agreed to no increase in compensation to help weather the economic storm.

**Principle #9: Commitment to internal incentive alignment, especially physician compensation.** Successful integrated health systems rarely need to pay at the top of the market for talent. The value of the integrated system to professionals extends beyond money. Furthermore, the model allows for greater freedom to design provider compensation models to better align the incentives of practicing professionals with the goals of the organization—this is an organizational design characteristic that is frequently under-appreciated by those who don’t operate from the integrated model. Research of integrated health systems, with longer operating tenure, demonstrates that how the organization is paid for physician (provider) services doesn’t dictate how it compensates physicians for their efforts. This operating characteristic will provide the system needed flexibility to redesign compensation models in a reforming healthcare marketplace.

**Principle #10: Commitment to “growing our own leaders.”** The complexity of strategy and operations of integrated health systems requires longer-term visions and plans. Consequently, there is great risk from frequent turnover of leaders. Moreover, larger, successful integrated systems tend to have longer-serving senior leaders with turnover more likely served by internal candidates; they tend to “grow their own.” Culture, history, institutional memory, and long-term investments in the future are principal characteristics of successful integrated health systems. An examination of the larger, successful, longer-standing integrated systems in the U.S. shows that more likely than not, the CEO is a physician—often one with considerable tenure with the organization.

**Summary: Looking Ahead**

While 15 years ago, it was impossible to have full clarity of the healthcare marketplace ahead, leadership of the Gundersen Health System had foresight sufficient to craft a health system design capable of enduring under-expected and unexpected economic, regulatory, and policy dynamics and related pressures. While healthcare professionals today may be uncertain about the road ahead, they should rest assured that the only real certainty is that things will change. Any trillion dollar growth industry is destined for change, especially one with the public’s health and finances at stake. Gundersen has forged its past and bet its future on the integrated model of community healthcare. It is not alone. Others preceded Gundersen on the path and more are following. As Gundersen looks ahead, its confidence in the integrated model stems, in part, from its resiliency and ability to accommodate to the inevitability of a healthcare marketplace destined for more change.

Observation and critical examination of integrated models of healthcare organizational design have demonstrated common characteristics that should be instructive to those considering a similar path. The high-functioning, integrated designs share these characteristics:

1. An ability to accommodate, with speed, to virtually any change in payer reimbursement model or method
2. An ability to change or modify internal incentive designs (especially provider compensation) to adjust to external incentive shifts
3. An ability to innovate healthcare “manufacturing” (care models and methods) to improve quality and safety while enhancing operating efficiencies
4. An ability to improve capital efficiency even as the nature of the business demands

These and other lessons learned by the Gundersen Health System, and others like it, provide a useful road map for those healthcare systems contemplating the future. But, while these characteristics are important abilities and capabilities of high-functioning integrated health systems, when all is said and done, Gundersen attributes much of its success to the physicians declaring their commitment to each other for the sake of patients and the organization. The concept then spread to be an effective tool system-wide. The nature of the compact is its value in providing clarity to the behavior of the organization and the people who compose it. It translates mission, vision, values, and strategy into everyday behaviors, including results expected from these behaviors: clinical quality, patient and customer service, safety, resource stewardship, and value. This compact is a cornerstone of organizational culture.

Many resist the fully integrated model. Given any reform scenario of the U.S. healthcare system (and industry), it’s challenging to imagine how any alternative organizational design will be able to stand the rigors ahead. It’s even more challenging to imagine how the historic, traditional, and fragmented model of community healthcare can create a structure, culture, and spirit sufficient to carry forward under the healthcare economic, policy, and market dynamics ahead.

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