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Provider collaboratives:
Working together to navigate the changing health care delivery system

Executive summary

The word *collaborate* originates from the Latin word *collaborare*, "to labor together." Collaboratives—organized groups or entities that work together towards a particular goal—are not a new concept in the health care industry, but they have been increasing in number over the past few years. Are provider collaboratives actually meeting their goals, or a fad that will go away? Are they helping health systems compete in today's changing payment landscape? What makes a provider collaborative successful?

We analyzed nine provider collaboratives' track records to answer these important questions. Our research found that, after investing appropriate time and resources into forming a collaborative, many are starting to see progress against stated goals and are evolving to expand their scope. Many collaboratives are attractive to hospitals and health systems which are evaluating options to remain independent yet gain scale-related benefits; among these are cost savings ranging from tens to hundreds of millions of dollars from supply chain optimization and better resource utilization. Other benefits can include building the right foundation to participate in value-based care models, or improve population health, share best practices, and engage in advocacy efforts.

Both "early days" collaboratives and those that are more established recognize that the road to success can be a lengthy one, and that success does not happen overnight. And, not all collaboratives result in lasting relationships. Some have attempted to align, but failed and chosen to dissolve. From our interviews and analysis we learned some important lessons for building a strong, sustainable provider collaborative:

- Having the right team with the right skills is critical, and engagement and buy-in must come from the top. CEO support and participation is necessary for collaboratives to endure.

- Success doesn't happen overnight. Patience, persistence, flexibility, and a long-term vision are essential.

- Strong collaboratives are dynamic. Many begin with one set of goals that shift over time.

- Cost savings are important, but achieving value or return on investment (ROI) from a provider collaborative extends to strengthening relationships, learning best practices, gaining clinical improvements, and creating a unified, more powerful voice.

- Collaborative members value the relationships they've built and see them as a defense strategy against future challenges in the changing health care market.

Our view is that provider collaboratives will continue to evolve—shaped by market forces, health care's transition from volume to value, and providers' desire to gain scale benefits and maintain local governance/control. Collaboratives can provide the necessary infrastructure and capabilities that many providers need to participate in value-based care, and can lay the groundwork for identifying clinical and cost improvements. Health systems' desire to remain independent and focus on their communities is unlikely to go away. Collaboratives can offer an attractive option for health systems to do this by maintaining local governance.

What are provider collaboratives and why are they important?

The number of provider collaboratives has been increasing in recent years in response to payment model shifts, provider and health plan consolidation, the need for data and IT investments, and increasing cost pressures.

Collaboratives are attractive to many hospitals and health systems which are evaluating options to remain independent yet achieve the benefits of scale. These partnerships can allow members to invest in capabilities that deliver significant financial benefit without the loss of control often seen in a full asset merger.

With a new horizon ahead for health care in 2017 and beyond, the continued pressures on health systems to grow, cut costs, and make expensive investments in data and IT, systems are likely going to accelerate the formation of collaboratives. However, it is important to note that not all of these arrangements are lasting. Some collaboratives have been successful for 10 years or more. Other providers have attempted to align, failed to do so, and chose to dissolve. What makes a collaborative work? What lessons can be learned when things do not go well?

Specifically, we sought to understand:

- The strategic rationale of forming health system collaboratives in different contexts
- The most common initiatives collaboratives pursue
- The different types of collaborative operating models and governance structures
- Critical success factors and common challenges to achieve the expected impact

Who we talked to

We interviewed 15 individuals from nine different provider collaboratives geographically dispersed across the US. The respondents are in leadership positions in the collaborative (Executive Directors, Presidents and CEOs) or in the member organizations (Chief Business Development Officer, Assistant Vice President, Chief of External Affairs, and two CEOs).

Provider collaboratives defined

For the purpose of this study we define a "collaborative" as a group of independent yet aligned hospitals or health systems that form a legal partnership in pursuit of common goals and initiatives. Some collaboratives may include a health plan or physician groups as members.

Many collaboratives tend to be among not-for-profit or academic hospitals in the same geographic region. However, some are comprised of health systems from around the country, with the goals of learning best practices and creating a collective voice that is not necessarily confined to a shared market or geography.

A provider collaborative is a formal partnership built on common ground. Goals may range from sharing experiences and best practices to generating cost savings and operational or clinical efficiencies. Similarly, initiatives may range from provider education or data sharing to forming an ACO or partnering with a health plan to develop a new offering or network.

The collaboratives that we interviewed vary in:

- **Maturity:** The longest-running collaborative formed in 1979 and the newest formed in 2016. The median age of the collaboratives we spoke with is four years.

- **Legal structure:** Five of the participating collaboratives are Limited Liability Companies (LLCs), three have contractual arrangements, and one is a Shared Services Cooperative. (See definitions below.)

- **Number of members (health systems, health plans, or physician groups):** The median number of health systems per collaborative is six. Just two of the nine collaboratives have more than 13 health systems.

- **Number of dedicated employees:** A majority (six of nine) of the collaboratives have six or fewer full-time employees. Only one of the nine did not have any exclusively dedicated staff; however, three of the collaboratives had begun with no exclusive staff and added staff as they evolved.

- **Geographic region:** The sample is geographically diverse, with collaboratives that have a presence in each US census region. A majority of collaboratives are on the East Coast or Midwest and are non-rural.

Provider collaboratives have similar goals, regardless of market

The health care organizations we interviewed had similar goals for forming or joining an existing collaborative (Table 1 on the following page); in particular, gaining scale to:

- Reduce costs and improve efficiencies,

- Support value-based care and population health,

- Educate members and share leading practices, and

- Provide a collective voice for advocacy.

These scale-related benefits can help providers to achieve their ultimate goal—meeting the "Triple Aim" of improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.

Each collaborative we looked at engages in business and clinical initiatives to help its members work more efficiently and cost effectively. Many collaboratives create and implement initiatives that a hospital or health system likely could not do independently, leveraging the combined strengths of their member institutions.

Collaborative legal structures

Limited Liability Company: A non-corporate business whose owners actively participate in the organization's management and are protected against personal liability for the organization's debts and obligations.[1]

Shared Services Cooperative: A business organization owned and controlled by private businesses or public entities that become members of the cooperative to more economically purchase services and/or products.[2]

Note: The quoted comments throughout this paper are by interview respondents, unless otherwise cited.

Table 1. Examples of provider collaborative goals and initiatives

Goals	Initiatives to support the goals	Interviewee comments
Reduce costs and improve efficiencies. By forming a collaborative, health systems can remain independent yet have the benefit of scale to negotiate purchasing agreements, make technology investments, and share resources. Often, cost-saving opportunities take advantage of relative geographic proximity of member organizations (e.g., consolidating laboratory services, streamlining laundry, translation, supplies).	• Arranging for **group purchasing** or developing a Group Purchasing Organization (GPO). Targets for supply-chain optimization often are large, predictable-volume items (e.g., physician preference items, high-priced items). • **Pooling resources** (monetary and human) from different member organizations to develop a data analytics infrastructure. • **Sharing services**, such as a reference laboratory, contracts for employee benefits, clinician credentialing, telemedicine solutions to access specialized clinical expertise, and common platform for clinical engineering.	"GPOs help the collaborative members manage their costs by combining purchasing volumes and streamlining supplier negotiations. They may also implement efficiencies to the supply chain."

Improve population health and support value-based care. Many health systems realize that they could provide better, more affordable health care for populations in partnership with others than alone. They leverage collaboratives to improve the size, breadth, and quality of their networks; support value-based care arrangements and insurance partnerships; and to share leading practices to improve clinical outcomes.	• **Clinical outcomes** initiatives, typically centered around sharing data and leading practices on how to improve workflow, operations, and technology. Examples include:
	  – Training and sharing care coordinators and nurse navigators
	  – Providing tools to help consumers with end-of-life planning and care; for example, "Your Life, Your Wishes" (http://yourlifeyourwishes.com/index.html) a website, application, and materials developed by the AllSpire collaborative
	  – Improving cancer care through better prevention and care collaboration platforms for oncologists
	  – Implementing targeted clinical quality improvement (such as reducing catheter-associated urinary tract infections) or disease-specific initiatives (CHF, COPD)
	  – Enhancing clinical protocols and care models (e.g., trying to reduce variation in care) to maintain quality and improve efficiency
	  – Using telehealth, remote patient monitoring, telepsychology, and mental health initiatives
	  – Sharing data on PACS (picture archiving and communication system) for the short- and long-term storage, retrieval, management, distribution, and presentation of medical images
	  – Improving emergency department (ED) performance
	
	• **Business analytics:**
	  – Understand total cost of care drivers
	  – Identify variation
	  – Enable patient population risk stratification
	  – Understand social determinants of health* and how to collect that patient information
	
	• **Clinical and health services research objectives:**
	  – Potential near-term opportunities for joint health services research
		"You can have the best predictive analytics and understand how sick a patient is, yet that may not be enough. Their home support and transportation and other barriers really weigh in whether they will need more focused care coordination or not. We are working on how to get Social Determinants of Health data into our system as well so we can further refine how we focus our efforts on streamlining the care of our patients."
		
		"With clinical trials and major research projects, we can do research with a much narrower scope if we have a larger total pool of patients."

Provide member education, disseminate best practices, and share knowledge. Collaboratives can provide a platform for helping member health systems stay informed, share information, and connect with colleagues.	• **Education about industry trends, state and federal regulatory, and policy changes** (e.g., new payment models, insurance market issues, network adequacy issues) • **Communication platform and forum (e.g., confidential listserv) and networking meetings** to pose questions, share information, test/pilot new ideas	"We are a good source of info, good networking, and we pick up trends a lot sooner than other organizations; often quicker than the hospital association."
Create a collective voice for advocacy. Some collaboratives want to have a collective voice to shape policies.	• **Advocacy**, primarily at the state level, to influence public policy and the role members could play to effect change. In a collaborative that serves members in two contiguous states, advocacy efforts focus on both states.	"As a delivery system with a single voice you can only go so far, but the collective voice of the collaborative has emerged as one of the more important elements of our activities—our advocacy."

Collaboratives deliver value via cost savings, improved quality, supporting value-based care, and "soft measures" like strengthened relationships

We found that many provider collaboratives broadly define the "value" they create. The benefit to members is sometimes very direct, such as saving $1 million on a new supplier contract. However, interview respondents also cited "softer" measures, such as establishing trust, clinical collaboration, and engaging leadership, as adding considerable value.

Cost savings can be achieved, but it takes time

In some collaboratives, the member organizations' executives—in particular, CFOs—have high expectations for cost savings. This is especially important for initiatives involving group purchasing and shared contracts. At the time of our interviews, executives from many of the collaboratives said they had already realized cost savings. However, a few others expressed concern about the pressures to reach financial goals. All interviewees acknowledged that the road to cost savings takes time and recognized that savings will not be achieved overnight.

Among collaboratives that have achieved cost savings, most result from working together for operations, information technology, sharing laboratories and pharmacies, and group purchasing or supply chain. For example, efforts to improve operations have resulted in savings for several collaboratives. One collaborative saved $128.2 million in operations costs after three years of establishment.[3] They achieved the savings by members working together on clinical engineering, information technology, and supply chain initiatives ($103.4 million savings in clinical engineering, $16.8 million in information technology;

$8 million in supply chain/contracted services).[4] Sharing reference laboratories also generated savings ranging from $600,000 to $1 million per year for various collaboratives we interviewed. One collaborative has reported that by having members work together on revenue cycle function, they decreased the number of insurance denials by more than $3 million a year.[5]

Many collaboratives also have lowered costs by focusing on their supply chain. By negotiating with one supply distributor on behalf of its three member hospitals, one collaborative cut its supply costs by nearly $3 million.[6] A few collaboratives have recently created their own group purchasing organization (GPO) instead of using an external GPO. While results are not yet available, the interview respondents say their forecasts show that cost savings are very likely to be achieved.

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Collaboratives can help their members transition from volume- to value-based payment models

Many independent health systems expect that the shift from volume- to value-based payment models will present new demands in terms of accountability for population health outcomes; however, the pace and direction of payment reform remain unclear. Many collaboratives with a population health strategy reflect this view, but their commitment falls across a continuum (Figure 1). Some are "actively integrating" and gearing up for participation in full-risk payment models. Others are "laying the foundation," anticipating that they will have the necessary infrastructure in place when it is needed. A few are dipping their toes into the process by "building relationships and trust"—educating their members about payment reform and providing avenues for clinical and cost improvements.

Figure 1. Collaboratives' continuum of preparedness for value-based care and population health

Building relationships and trust

- No plans for data analytics infrastructure
- Member awareness about payment reform is low; need exists for member education
- Members do not participate in risk-based contracts with private or public payers

Laying the foundation

- Developing data analytics infrastructure
- Selecting clinical improvement initiatives
- Individual members may participate in risk-based contracts with private and public payers
- Ensuring adequate geographic coverage

Actively integrating

- Data analytics infrastructure in place or in final stages
- Data-driven, targeted clinical improvement initiatives underway
- Multiple investments in care standardization
- Collaborative has risk-based contracts with private and public payers
- Some have developed their own insurance products, including direct-to-empoyer strategy
- Ensuring adequate geographic coverage
- Building a network

Source: Deloitte Center for Health Solutions analysis

To execute on a value-based care strategy, regardless of a collaborative's level of commitment, several considerations can be important when building a support infrastructure:

• **Contiguous geographic service areas among members**, so that patients have access to care and leakage is minimal.

• **Data analytics, access to claims, and ability to analyze clinical and claims data together**, to identify practice variation and opportunities for improvement. Clinical data alone is insufficient, as it does not include the cost component. To understand cost and quality drivers, access to payer data becomes essential. Participating in value-based contracts is a typical avenue to access data and develop that knowledge.

• **Ability to share clinical data**, is a prerequisite for conducting data analytics and for providing care jointly. Standardizing EMR platforms among member organizations can be an option, but it is not always a practical approach, so some collaboratives and their analytics partners build data interfaces and crosswalks.

A few collaboratives with a population health strategy have not been aggressively pursuing cost savings, focusing instead on their core goals. For instance, one interviewee said:

"Maybe we should do something together for commodity services, purchasing, and laundry. Job number one is the issue of ACO performance, anything else is ancillary. It's very clear that there is this ability to do things together from an ancillary standpoint and we could save millions of dollars and add value, but we have just not done that because it's all about job number one."

Collaboratives derive value from sharing data and best practices for clinical pathways and operations.

Many collaboratives are forming central pharmacies and therapeutics committees comprised of physicians, pharmacists, and other clinicians from the member hospitals. One collaborative has a therapeutic committee that has so far screened nearly 4,000 drugs to begin creating a common drug formulary. The members agreed to implement weight-based dosing of antibiotics, which generated savings of $2.8 million annually and advanced the goal of improving antibiotic stewardship.[7]

Another collaborative significantly decreased the use of an expensive (and often unnecessary) procedure by sharing clinical data and leveraging the collective knowledge of a multi-disciplinary team. Data analysis showed that member hospitals had a higher-than-desired utilization of magnetic resonance imaging (MRI) for acute lower back pain. A multidisciplinary team—physical therapists, primary care providers, orthopedists, chiropractors, and others—reviewed the clinical evidence, identified leading practices, and developed clinical guidelines.

Soft measures of success

- ✓ Established trust and strong working relationships

- ✓ Leadership engagement (participation from the board, getting decisions made)

- ✓ Member satisfaction and perceived value as it relates to advocacy, sharing best practices, staff, and resources

- ✓ Member retention and requests from other health care systems to join

Critical milestones

- ✓ Infrastructure and governance in place

- ✓ Progress on goals, initiatives or early wins

- ✓ Positive operating margin

Source: Deloitte Center for Health Solutions analysis

Collaboratives see improved quality ratings and patient satisfaction ratings

Many collaboratives measure success in the areas of value-based care and patient safety by improved quality and outcome measures. For example, the providers from one collaborative consistently outperform national and regional benchmarks for publicly reported process and outcome measures for congestive heart failure (CHF), community-acquired pneumonia, and surgical care infections.[8]

Members view strengthened relationships and other soft measures as highly valuable

When asked about other ways they assess value or success, respondents cited a number of soft measures and milestones. (See sidebar.)

Some unintended benefits or "wins" have come about from the relationships built in the working groups. A few collaboratives described how meetings between clinicians often led to discussing how to share protocols and borrow leading practices from other groups. In another example, one hospital implemented a Telestroke[9] program (telemedicine for stroke patients or physicians) after discovering how successful it was at a member hospital.

Learning from experience: Insights from existing collaboratives on forming and operationalizing a collaborative

"The thing about a collaborative is that there is always great energy at the beginning. Theoretically and conceptually they are very appealing. But the honeymoon fades fairly quickly, because then you get to the part where you have to do the heavy lifting."

The potential benefits of forming a collaborative are becoming increasingly evident but implementing and sustaining one can be challenging. One respondent said that "a collaborative fails three times before it becomes successful." Here are some key takeaways gleaned from our interviews:

1. Choose partners carefully

Select collaborative members that have chemistry and a common vision. Many of the hospital and health system CEOs we interviewed said they had been meeting or working together for years with peers in their region of the country. These existing relationships led to the subsequent formation of a majority of the collaboratives. Also, many hospital and health system members said that sharing common visions, respecting each other, and having a strong desire to work together are important factors when forming a collaborative. When collaboratives are looking for potential partners, they often consider a health system's reputation, financial stability, market area, patient population, capabilities, and willingness to work on similar clinical initiatives as factors for determining a good fit.

"You build trust, you build knowledge, and then you get the ability to put the hard conversations on the table."

It may appear that it is easier to form a collaborative among equals; and it is true that some collaboratives have members that are similar in size, structure, and services. However, a number of collaboratives have diverse memberships: big and small organizations, academic and community hospitals, physician organizations, and ancillary providers. Such member diversity can be both an advantage and a challenge: While members can provide different perspectives, they may also have different goals and seek different benefits. Frequently, members are competitors, at least to some degree; our research participants emphasized that this contributes to a healthy group dynamic.

We also heard that who *not* to partner with matters. For example, "If [an organization] has great potential, but no one got along with their CEO" it would not be a sustainable partner.

Lead from the top. The participation of CEOs, other C-suite executives (e.g., COO, CFO, CIO, CMO, and CQO), and legal counsel (for review of governing and operating agreements) is critical to the formation of a successful collaborative. Interviewees said that agreeing on legal, infrastructure, and governance components is often the first and most important step when forming a collaborative.

2. Engage the right people: dedicated staff and working groups with diverse skills.

Include diverse personality types and skill sets for the collaborative staff and working group members.

Specific insights around staffing include having:

- *A dedicated staff.* Some collaboratives started out without a "leader," opting to have the CEOs of the various organizations work together for months or years before they hired a dedicated president/CEO. Almost all of the collaboratives in our interviews currently have a dedicated leader who is not an employee of any member organization. A majority of respondents said that having dedicated staff—with 100 percent of their time focused on the collaborative—worked better than having staff with "another day job."

- *The right skills mix.* For collaborative director and mid-level management positions, knowledge of collaboratives is less important than problem-solving and facilitation skills. Some collaboratives said that relevant technical expertise (e.g., supply chain or purchasing) did not always come with the soft skills necessary to engage with the board members or help facilitate decision-making with C-suite leaders.

- *Someone to manage member relationships.* Having dedicated staff to manage relationships has often been overlooked. One interviewee noted that it is essential to have someone to focus on "how we are going to create and maintain relationships, how we are going to build social capital." This responsibility could be under a President, External Affairs, or Chief of Staff title.

"The success of [a collaborative] is largely built on the trust board members have in each other and how well they work together. There's a culture and a chemistry that works, because what we are doing is so unique and unprecedented, it's really built on how well these board members work together."

What does it take to form a collaborative? Checklist of key activities

Step 1: Agree on the terms
What does the legal agreement look like?
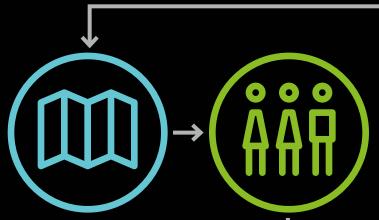
What type of governance model will it have?

Step 2: Establish a shared vision
What are our common goals?

Do we want to add other partners?

What factors do we consider for inclusion?

Step 4: Form the team
How many direct resources do we need?

What is the right mix of skills?

Who will help us manage relationships?

Step 3: Define priorities
What initiatives do we want to establish?

What capabilities does each organization have to support the initiatives?

• Be willing to recognize that every organization does not have the best solution in every category. The most appropriate members should take the lead on different initiatives

What technical infrastructure is in place?

What data inputs do we need from members?

Can we share data (for population health and analytics)?

What clinical improvements do we want to see?

Step 5: Establish committees/task forces
How will we operationalize our initiatives?

What support functions do we need?

What is the preferred platform for sharing best practices and/or brainstorming ideas?

Step 6: Review, revisit, and rescope
How will we evaluate success?

What is our process for making adjustments as necessary?

3. Define focused initiatives, capitalize on each other's strengths, and focus on quick wins

• *Include staff from different service lines/backgrounds to working groups:* We heard how important it is to have dedicated participation, but collaboratives need a strategy to get collaborative staff and working group members with the right expertise and incentives to lead initiatives. One collaborative leader told us, "If you are looking at a way to reduce the cost of 'xyz' service and the only people in the working group are directors of those services, you are going to be told you can't get any savings. So you have to identify which level executive needs to be in the group, who participates as a subject matter expert versus a decision-maker/strategic partner, and work from there."

• *Different perspectives help advance ideas and coach group members to "speak the right language."* Some collaboratives say it is helpful to have a blend of CMOs, Chief Legal Officers, Senior Business Development executives, and CFOs in their various working groups. A cross-functional, multidimensional team helps to "drive the conversations and push ideas down the road." This can be particularly helpful to individuals learning how to communicate needs to the leadership in a different discipline than their own. For example, "if a working group member needs advice on how to talk to a CFO, you have representation at the table who can give advice on tactics for communication."

Strive for a balanced portfolio and early wins. Virtually all interview respondents agree that "everything takes longer than you want it to." Competing priorities, difficulty reaching consensus, and tackling too many initiatives at once were the most common reasons for delays. Operating an effective collaborative takes time because member health systems have to overcome, in some instances, 100 years of entrenched culture and processes.

The process can be aided by striving for a balanced portfolio of initiatives—a combination of quick wins that can achieve short-term goals and longer-term projects that address more difficult issues. Early successes are important to keep members committed and excited about the collaborative. "We tried to do some very extravagant cost saving [projects] first. I wish we had started with standardization of the trash bag, with something basic. We don't have that win yet."

Don't bite off more than you can chew. Some collaboratives say they got caught in a trap of trying to do too much at once. Excitement about all the possibilities created a barrier to moving forward. For example, one collaborative learned it is better to start with a "universe of 20-some possibilities and narrow that down very quickly to eight. Then let's explore four out of these eight and put a timeline on them."

Be prepared for and learn from failures. One collaborative said, "If you don't have areas [that] you weren't able to succeed at, then you haven't really pushed the envelope enough….I know we are stronger because of it, because we learned along the way." Another insight:

"Be willing to and capable of setting up a method where if you can fail fast and move on… you think something looks interesting but then it's not; it's okay to say 'It's a no for that,' instead of grinding away to figure out how to make it perfect."

4. Build a robust and transparent governance model

Among the collaboratives interviewed, each has a governing board that makes decisions and sets strategic priorities.

Key considerations when creating a governance model are:

- *Board size.* Typically, the size of a collaborative's governing board reflects the number of its members. The boards of our interviewed collaboratives have representation from each member organization and often include C-suite or hospital administrator-level individuals. Also, while having a board is common, governance models vary. (See Appendix.)

- *Voting rights.* A collaborative's decision-making structure and voting rights often correlate with its size. We found that collaboratives with fewer members are more likely to make decisions by consensus, while those with a larger number of members tend to use a simple majority vote. In most cases, each member receives an equal vote, regardless of their organization's size. In several cases, however, a collaborative's founding members have certain privileges that supporting members do not (e.g., voting to accept new members, terminate existing members, or decide to end the partnership).

Collaboratives are using analytics to assess their investments and the impact of the specific projects and initiatives, using market data for comparison.

- *Working groups.* While all collaboratives interviewed make decisions at the board level, tactical work is accomplished by various committees, working groups, roundtables, and task forces. The number and types of committees and working groups vary by collaborative; however, their purpose is often linked to a specific initiative or their function. (See Appendix.)

Use data to support decision-making. Using data analytics is imperative to help collaborative members understand and communicate variations in cost, quality, and utilization, and where to focus their initiatives. Collaboratives reported using robust and comprehensive data to support population health efforts, understand current spend, and identify opportunities for cost savings in supply chain and operations (such as ED wait time or throughput).

One collaborative invested in a cloud-based system that allows it to merge clinical information from their electronic health records (EHRs) with claims data and use analytics to help identify where it has unexplained variation in care, cost, and utilization. This capability is important, an interviewee said, because hospitals are better prepared to take on downside risk when they understand where they have variation in cost and outcomes.

Another collaborative uses data analytics to longitudinally benchmark value-based measures across members and allows for comparative analytics through an interactive, web-based reporting portal. Collaboratives are also using analytics to assess their investments and the impact of the specific projects/ initiatives, using market data for comparison.

Ensure member commitment. In hindsight, several respondents thought that they should have expedited execution and moved from a "networking club" to a true collaborative more quickly. Engaging a third party advisor or hiring an Executive Director for a collaborative can provide that push—most said they wished they had done this sooner. Another suggestion is to structure membership rules so that there is "either a cost to leave or a missed opportunity that is very meaningful and compelling, so that people don't commit and then back out."

5. Be flexible and shift focus as needed

Each of the collaboratives we spoke with stressed the importance of being flexible and dynamic. Several of the collaboratives stated that certain goals were not initially on their radar but over time, their priorities changed and they shifted focus. For instance, some collaboratives originally came together to reduce costs by sharing purchasing contracts. However, when ACOs were gaining in popularity, several collaboratives decided they could be a platform for their members to start participating in risk-sharing models. As they developed trust and rapport, they moved on to jointly sharing risk in accountable care arrangements. So, even though supporting value-based care was not an initial goal, it has become one for many of the collaboratives in our study. Another example is a collaborative that formed for advocacy reasons, but their relationship evolved to where they now share and compare data—a starting point for conducting analytics and making clinical improvements.

Changes in focus happen for both external and internal reasons, such as regulatory and market developments, expanding or shrinking member composition, and the need to demonstrate value as the organization evolves. As one respondent stated:

"You have to flex and adapt to the changing environment and the changing issues that delivery systems are facing."

Hurdles to success

A collaborative may fail—it dissolves or members reassess and realign the relationship—for a number of reasons. Our research suggests some reasons for failure are more common than others.

The collaborative does not achieve goals in a timely manner. A majority of collaboratives we spoke to want to speed up execution. "How do we find ways to move faster, quicker, more successfully in a variety of arenas?" Since the pace thus far hasn't been as fast as they'd like, future goals include "cutting the cycle time in half in the next wave of initiatives, and the wave after that, cut it in half again." One reason that collaboratives believe progress is slow is because they are trying to do too much out of the gate and spreading employees too thin.

Members leave. Membership turnover—especially in the case of founding members or members with a critical mass—can be a barrier to long-term success.

Collaboratives need a "number [of members] that allows [them] to be financially viable." Members also may leave because the project work was not aligning with their needs. For some collaboratives it is important that membership reflects the entire industry or a geographic region; when a member drops out it can delay or prevent goal achievement.

Not enough funding. A poor funding strategy or loss of capital can decimate a collaborative, especially those initially funded through short-term grants.

Several other factors may contribute to a collaborative's failure: maintaining a limited, single purpose or scope; inability to reach scale; lack of staff resources or major leadership and skills gaps; and legal issues resulting from regulatory oversights or missteps.

What are some of the key reasons collaboratives fail?

Although this study focuses on existing collaboratives, collaboratives have failed and dissolved. Based on the publicly available information, we identified a few important lessons and pitfalls to avoid:

- Membership turnover, especially founding members

- Inability to develop a sustainable funding strategy

- Lack of staff resources or major gaps in skills and leadership

- Violation of regulations, legal parameters, or lawsuits

The road ahead

The collaborative leaders and members we interviewed are generally optimistic about their organization's future, given their progress on existing and new initiatives.

Assuming that the transition to alternative payment models continues to accelerate, we may see new collaboratives form, driven by health systems' need to develop value-based care capabilities and build robust, high-performing provider networks. Cost saving activities may play an important role, to help fund or offset investments in data analytics and clinical integration. Our research suggests that early cost saving wins can be a strong motivator for sustained member engagement and do not have to detract from the main goal.

As collaboratives progress along the value continuum to the "actively integrating" end of the spectrum, they may need:

• **Actuarial and insurance expertise to develop insurance products.** Unless existing collaborative members have experience operating a provider-sponsored health plan, developing insurance expertise in-house likely won't be feasible. Many of the considerations that apply to individual health systems wishing to create provider-sponsored health plans would also apply to provider collaboratives. For a detailed discussion, please see Deloitte's publication, "Collaboration meets innovation: Executive perspectives on provider-sponsored health plans."[10]

• **Desire to cover a full continuum of care** (including primary, specialty, post-acute, and ancillary services). The experience from the collaboratives organized as clinically integrated networks suggests it is possible to have nonhospital providers as affiliate members; however, it may require a different membership and governance structure to account for varying member size and influence. The most likely approach would be to confer special privileges to founding members or those with largest capital contributions. However, opening membership to these new entities has the potential to dilute the mission and create tension among members. Therefore, contracting for clinical services may be a preferred option, especially in markets where these providers are consolidated.

• **Continued investments in data analytics.** This will be especially important as collaboratives establish clinical integration with community providers. And as collaboratives sharpen their analytics capabilities, they are likely to see continued improvements in cost and quality.

Our view is that provider collaboratives will continue to grow and evolve, shaped by market forces, health care's transition from volume to value, and providers' desire to gain scale-related benefits and maintain local control. Collaboratives can provide the necessary infrastructure and capabilities that many providers need to participate in value-based care payment models, and can lay the groundwork for identifying and capturing future clinical and cost improvements.

Provider collaboratives will continue to grow and evolve—shaped by market forces, health care's transition from volume to value, and providers' desire to gain scale-related benefits and maintain local control.

Appendix A. Provider collaborative governance structures

Components	Details
Governing board	All nine collaboratives have a governing board responsible for decision-making and strategy. • Each board has representation from all member organizations. • The smallest board has six members; the largest has 40. • Board members consist of CEOs, CFOs, hospital administrators, anti-trust attorneys, VPs of strategy, physicians, and a member of a hospital or health system's board. • The majority of boards meet either in person or via phone on a monthly basis; the board that meets most frequently in person does so biweekly. • One collaborative hosts an annual retreat for its board to discuss/resolve larger issues and disputes.
Committees, roundtables, workgroups, and task forces	All nine collaboratives have supporting committees, roundtables, workgroups, and/or task forces with specific aims. • Many but not all collaboratives have formal advisory committee structures in place to implement tactical work. • Others have professional roundtables or discipline-focused workgroups to share leading practices and/or brainstorm ideas. • Some committees have their own governance structure; some report to the board. • Development committees brainstorm new initiatives. • Operations committees prioritize existing efforts. • Public policy committees review policy and regulatory impacts. • Advisory sub-committees often focus on functional details such as IT, finance, and contracts. • Workgroups are discipline-focused (e.g., population health, pharmacy, supply chain, data governance, telemedicine) and have the dual purpose of action and discussion. • Some collaboratives form task forces for ad hoc needs, such as issuing and reviewing RFPs.
Decision-making and voting rights	All nine collaboratives ensure voting rights for each member organization. • Many collaboratives make decisions on a consensus basis; however, some do so by majority vote (e.g., seven votes out of 10 board members). • In one collaborative, decisions are consensus-based; however, all member organizations are not required to participate in all initiatives. • Founding members in one collaborative have greater authority than supporting members.

Source: Deloitte Center for Health Solutions analysis

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Endnotes

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