GOVERNANCE INNOVATION: a five-part series

1 | Collaborative Governance

A resource from Integrated Healthcare Strategies, a division of Gallagher Benefit Services, Inc.

Integrated Healthcare Strategies
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Collaborative Governance is one of the five new models of board work that is essential for health systems to successfully move into an era of population health and value based payments.

The five are:

Collaborative Governance
Competency Based Governance
Generative Governance
Intentional Governance
Transformational Governance

This is the first of a five-part series of white papers on new forms of governance for population health management (PHM) by integrated health systems and accountable care organizations.

We encourage boards to circulate these white papers and engage in spirited conversations about how these models are being mastered in their board work, and what investments could advance them even further into the high performance governance domain.

This paper seeks to address these four questions:

- What is Collaborative Governance?
- Why is Collaborative Governance so important for health systems boards?
- How can boards overcome common obstacles to good Collaborative Governance?
- What are the three most important board actions to accomplish Collaborative Governance?

1 | Collaborative Governance

What is Collaborative Governance?

How can the board of a single hospital make a meaningful improvement in the health of a city – not only in terms of patients' health, but also with respect to crime, water, shelter, employment and other pressing urban issues?

It can't.

If, on the other hand, the boards of several hospitals – along with those of relevant Non-Governmental Organizations (NGOs) and private sector institutions – were ***to collaborate***, the city's collective good could be very well served. This is the simple proposition that underlies the concept of "collaborative governance" – defined as a structured process in which boards with a common interest engage in joint needs analysis, planning and implementation in service of the collective good, and then share accountability for outcomes.

Although the concept is relatively new to the health care field, its origins reach to the 19th century French concept of a "charrette," a reference to the carts or "chariots" used by Parisian design students working in teams.

In the present day, the term refers to collaborative sessions of design or planning activity, most prominently conducted by city and park planners to design neighborhoods and entire communities. The charrette brings together eclectic groups of people and virtually locks them in a room to solve a complex problem. Drawing from their divergent perspectives, they work through iterations of intense planning. In a relatively short period of time, what results is a higher-quality definition of the problem at hand than would otherwise be achieved, along with commensurately superior solutions.

Also fundamentally important is ***the sense of engagement and ownership*** created by such exercises. Over the past 15 years in the United States for example, the "healthy communities" movement has emerged, based on the belief in the prominence of cities and that cross-organizational, multidisciplinary and cross-sectoral collaboration results in the creation of programs that are more likely to be owned and sustainably implemented.

Over the past decade, a new form of governance has emerged to replace adversarial and managerial modes of policy making and implementation. Collaborative governance, as it has come to be known, brings public and private stakeholders together in collective forums with public agencies to engage in consensus-oriented decision making.[1] This paper explores the need for collaborative governance to help health sector governing boards build bridges among diverse organizations essential to the achievement of population health gains that are both more significant and sustainable.

Why is Collaborative Governance Important?

Collaborative governance enables community leaders serving on governing bodies of health related organizations to more fully and effectively engage in what is being referred to as "Collective Impact."[2] In an era of population health management, collective impact for sustainable health gain is essential. This impact is a function of diverse organizations coordinating their work to productively manage the social determinants of health described by the World Health Organization.[3]

"Collaborate" and "collaboration" mean a mutually beneficial well-defined relationship entered into by two or more organizations to achieve common goals. Collaboration is the process of various individuals, groups or systems working together but at a significantly higher degree than through co-ordination or co-operation. Collaboration typically involves joint planning, shared resources and joint resource management. Collaboration occurs through shared understanding of the issues, open communication, mutual trust and tolerance of differing points of view. To collaborate is to "co-labor".[4]

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1 For an extensive review of the literature see: Collaborative Governance in Theory and Practice Chris Ansell Alison Gash, University of California, Berkeley in JPART 18:543–571

2 To learn more about Collective Impact, see: http://www.collaborationforimpact.com/collective-impact/

3 See: http://www.who.int/social_determinants/sdh_definition/en/

4 Maureen Quigley, Local Health Integration Network / Health Service Provider December 15, 2008 Governance Resource and Toolkit for Voluntary Integration Initiatives page vii

How can boards overcome common obstacles to good Collaborative Governance?

During the past decade, several factors have served as obstacles to collaborative governance; four key factors are:

1. Board leaders and executives believe that inter-organizational cooperation is a zero sum process that only results in winners and losers. They are so driven to protect their mission that they fail to see their mission as an expression of the broader community's welfare.
2. There has been a lack of political and economic incentives to pool ideas, leadership and resources for the broader community's benefit.
3. Board leaders lack experience in effective cooperative problem definition and resolution.
4. Leaders are unable to establish joint action plans and metrics to guide and monitor progress to desired collective impact.

Overcoming these obstacles requires people and processes to be guided by certain principles and practices.

Principles of "Governance to Governance"

Collaborating boards can consider the following principles as a starting point in pursuing a dialogue within and between organizations related to governance collaboration/collaborative governance:[5]

- The need for boards to develop a new understanding of how to govern shared/integrated services – including interdependence and shared accountability with other health related organizations for integration initiatives within the region
- Understand the "Best Interest of the Corporation" as collaborating with others to improve the integration of health services delivery to effectively meet community health needs
- Health services Boards of Directors have the same fiduciary duty for the oversight of joint integration initiatives with other health related organizations as they do for the oversight of internal programs and services within their organizations
- New governance structures, formal agreements and reporting mechanisms may be required to facilitate joint accountability with other community health organizations for specific integration initiatives

[5] Ibid

Criteria to Measure Progress to Mission of PHM

Certain key criteria against which voluntary integration proposals can be assessed are: access, coordination, quality and efficiency.

- **Access.** Volumes relative to population health indicators, wait times relative to community health targets, distance (for primary, secondary or tertiary services), and choice.
- **Coordination.** Does the proposal advance coordination and collaboration? Has the continuity and coordination of services for the patient/client across the continuum of care been improved or adequately addressed? Have impacts on other affected services been addressed and improved (e.g. emergency departments)? Have impacts on complementary services been addressed and improved (e.g. obstetrics and pediatrics)? Is there a positive impact on the local public health system?
- **Quality.** Consistency with patient/client centered health care, patient/client and workforce safety, critical mass for program competence and sustainability, evidence of clinical best practice and high health outcomes, defined responsibility for system, organizational and clinician quality, and a quality measurement plan.
- **Efficiency.** Impact on use of resources and health system sustainability, cost (initial and ongoing) and availability of resources, cost-benefit (e.g. the greater the volume, the lower the price), and impact on labor and employment relations.

Board practices that help achieve these metrics can help guide the collaborative decision-making process, such as:

- **No surprises.** The purpose of transparent community health needs assessment (CHNA) is to identify integration opportunities at a very early stage in the process, to inform community leaders of the potential partnership, and to ensure that due diligence requirements are met by both the collaborative leadership group and the various health service providers.
- **Ethical**. Decision making about the plans and budgets must be free of conflicts of interest and avoid too much power concentration in the hands of single organizations or groups.
- **Equity**. Equity does not deal with the issue of ideal supply of services, but rather about levelling the field, even when services are in short supply. Ensure that any one person's level of access is reasonable relative to all others who need the service.
- **Diversity or cultural competence**. To guide what is to be done for whom, but also how the work can be done so all in the community can understand and fully participate and benefit from the collaboration.

- **Public accountability** and **transparency**. Plans and progress are openly reported to the community in mass media and new social medical systems.
- **Alignment** with local community health priorities.
- **Cooperation** and **coordination**. Diverse groups from schools to chambers of commerce, housing, and faith-based organizations.
- **Innovation.** May include partnerships with non-traditional and/or private providers to continuously challenge and enhance process, plans, and results.
- **Evidence-based decision making.** Ensures that decisions about health and health care are based on the best available knowledge.[6]

What are the three most important board actions to accomplish Collaborative Governance?

As you surface the concept of Collaborative Governance within your board and executive team, consider these three key initiatives:

Initiative 1: Co-produce and widely publish a rigorous and bold "**Community Health Needs Assessment**" that clearly identifies the goals and gaps to community health vitality.[7]

Initiative 2: Develop a "Collective Impact Partnership" governed by an inter-organizational committee, council or board to serve as "a neutral Switzerland" between the many health related organizations in a community or region. This cooperative body would serve three essential roles of the cross-community and cross-organization work for health gain: **The Champion** (to advocate for continued joint planning and investment for health gain); **The Conscience** (to constantly remind, celebrate and sanction all parties regarding the value and joint plans to guide the journey to community health gains); and **The Concierge** (to help assemble and allocate scarce resources to implement the joint plans toward shared goals).

Initiative 3: Establish and govern across organizations with a trust building style and culture that embraces these key enablers:[8]

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6 Insights from the Foster McGaw Award Program now offer many practical cases studies and guides for effective and efficient cooperation for community health. See: http://www.aha.org/about/awards/foster/index.shtml

7 For guidance on how best to conduct such assessments, see: http://www.phi.org/uploads/application/files/dz9vh55o3bb2x56lcrzyel83fwfu3mvu24oqqvn5z6qaeiw2u4.pdf

8 See: Governance Centre of Excellence, "Effective Governance Collaboration to Advance Integration: A Resource Guide" Prepared for the GCE Roundtable April 28, 2014

Enablers to Collaboration

Common Purpose / Vision	• Ensure the process and Board work always connect to a purpose and vision for the good of the broader community • Avoid being pre-occupied with structure before strategy or vision
Build on Strengths	• Build on the communities' and/or organizations' strengths in planning for the future
Start Small and Build	• Focus on shared problems and challenges • Don't try to do it all or be all things to all people: bite-sized successes can help build a stronger and broader foundation for future work together • Spend time getting to know each other, each organization's needs, desires, ideas, and goals before rushing into rigid planning activities
Balance Roles	• Respect the important role of the CEOs for guiding and supporting the collaborative process; but they should not dominate the process • Keep open minds and ensure balanced roles among all players to avoid allowing the larger organizations to dominate • Debrief all board members on progress (i.e., don't have it rest in the hands and minds of a select few) • Suspend turf and ownership until much later in the process
Engagement	• Engage frontline workers, patients, and physicians to share their ideas (and fears/concerns) before locking into our own ideas: it should be about them more than about us • Be open to include partnering opportunities with non-traditional social welfare organizations, social services, and educational players • Try to have the collaborative process be as voluntary as possible and not forced upon any party
Provide Training and Other Support	• Promote more education about developing, maintaining, and rebuilding trust • Guide collaborative planning with real stories about real patients and community members • Invest in "generative thinking" training and orientation for all participants in the process • Hard-wire informal socializing and informal meet-and-greet activities into the process in order to build relationships, and ultimately, trust, which will foster momentum and solid gains for future efforts • As collaboration plans gel, be sure to include objective and honest risk assessments so there are limited surprises or derailments by realties

Attachment

Street Smart Insights for Enhanced Collaborative Governance

Participants in a session on "Collaborative Governance" were invited to share their ideas about how leadership teams and governing bodies of health services organizations in Ontario, Canada might strengthen their approach to the exploration of wise collaborative governance in the coming years.

This paper summarizes the array of excellent insights shared by these participants. Leaders are encouraged to review these, add to them and then discuss how you might put them into action in your own organizations and collaborative processes in the next 2-3 years.

The lists of items are shared in random order to stimulate smarter thinking, conversations, and collaborative planning.

There are two lists, one that lists actions that could derail or serve as obstacles to successful collaborative governance (avoid these); and one a list of actions that are judged to have the potential to improve the chances for successful collaborative governance (invest in these)

Taboo's

Please avoid these actions that could frustrate collaborative governance.

Take time to read these. Try to edit them. Some can be combined.

Go through a group process to prioritize the ten (10) biggest obstacles, and then boil those down to the most essential five (5). The group can then discuss sensible actions that will remove, reduce or work around these obstacles. Once you have implemented action to move the process forward, and then do another list of the next most important five. By then the process will be achieving some early wins that can help sustain the longer term processes. Remember they are in random order.

1. Try to not have the drive for collaboration so pre-occupied by money and cost savings. (Think value, community benefit and service improvement)
2. Stay away from structure before we explore vision, strategies, and cultures. Don't rush to a final vision of the desired future state until we know each other and explore real opportunities
3. Avoid past rivalries, jealousies and historical differences before we explore shared views and interests in the needs of patients/persons we serve
4. Don't wait for the payers to drive us
5. Don't shut the door on new players, younger players, and vulnerable group players, as they may have some of the best ideas
6. Avoid unwillingness to change and look for a new mindset and lens to look at our challenges and opportunities
7. Don't say it will be easy or wonderful, as it may be a bit messy and difficult
8. Don't try to sell "IT" before we engage and explore what IT is
9. Don't have the group too large or cumbersome at the start, but be open to be inclusive as soon as possible
10. Respect heritage, but don't let it get in the way of building a new shared heritage that celebrates the past and embraces the future
11. Avoid integration for innovation, and start with focus on "Improvement"
12. Make sure this is not about merger (even if that may be part of the future)
13. Do not work without communicating often, openly, and well
14. Don't make this only about acute care and hospitals. Walk the talk about social determinants of health
15. Do not state… "That's fine as long as we do it our way"
16. Don't assume that bigger is always better
17. Avoid thinking we/you own the patient. We exist to serve, not milk the patient
18. Don't say we have to do this because the government told us to… drive it as a better response to the needs of patients and communities
19. Failure to invite a broad array of players to the table and process. Don't try to do it with the big bosses alone. Invite in the community, it is, after all, their community! Don't give lip service to eclectic invitations to be engaged
20. Celebrate successes together
21. Don't assume you know what it takes to earn/build trust with the other players, ask them and earn it

22. Guard against an executive committee doing all the work. Avoid disconnects with the rest of your boards. Keep us all informed and engaged in various ways
23. Don't let the perfect be the enemy of the good. Try some small steps and grow from there
24. Avoid listing why this will be tough or won't work in the first meeting. Emphasize the positives and visionary aspects first, without being naive
25. Don't rush into the process without taking time to know the other players. Do not assume we know their backgrounds, hopes, fears, aspirations, family experiences in health etc.
26. Don't go in with a closed mind, or with a fixed definition of the problem or challenge or solutions. Let it bubble up from the players/process
27. Don't come to the table of cooperation thinking your organization is the victim or the weakest link
28. Avoid structures that give too much weight and influence to the larger organizations, stay focused on what is right for the most people in our region/community
29. Don't assume that the larger organizations are the only source of good ideas for innovation and service improvement
30. Don't always hold meetings at the bigger organization, move the venues around. It helps us to get better acquainted
31. Do not rush the discussions. It takes time for trust to evolve, and then we can build on that for the joint planning process
32. Don't make promises you cannot keep (and look for some early wins as the longer term events and results evolve)
33. Language matters. Don't assume even the most basic terms like "team" mean the same to all players or potential partners
34. Funding service silos fosters competition more than collaboration
35. Most players worry about a loss of control, or that our prerogatives will not be given their proper recognition and value
36. Try to avoid fear of being eaten up by the larger organizations and avoid reinforcing this fear if you are the larger organization
37. Avoid focus on "the institution" more than the outcomes and "what is in it for the community or our patients"
38. Avoid rushing to plans without stakeholder engagement in meaningful "big picture visioning". Try to have us all own the desired future vision
39. Don't have a closed mind to the potential good that can come from collaboration, improvement and integrated approaches, even if contrary to policy at the moment. If we do well, the policy can then be adjusted
40. Guard against egos and narrow self-interests of the big players at table. Focus on the broader good for the community we exist to serve
41. Don't have one board dominate the process. Mix us up into work groups that cut across organizations and disciplines
42. Don't get stuck in history, but also be willing to celebrate what we all bring to the party/table/process
43. Do not attempt this work behind closed doors, be open minded and transparent, even when it might be a bit embarrassing
44. Avoid overlooking the important role played by primary care providers of all types, and of those that provide health
45. Do not meet without the CEO and other key executives, but don't be a hostage to the CEOs either
46. Do not threaten what the other partner holds dear
47. Do not propose partnerships that only benefit one partner
48. Do not assume that the benefits are well understood by the players. Celebrate the benefits and make sure they are clear to all
49. Don't take too long to deliver meaningful results, early wins, or activities that were promised. Not trying is worse than trying and failing and learning from the process

50. Avoid the "professional volunteer meeting attenders" that do not contribute or help carry the water once we decide something is needed
51. Do not start implementing without clear roles and responsibilities, shared in a balanced way among the organizations
52. Do not avoid measurable targets that the plans are to achieve, and once the targets are set, do not avoid measuring progress to plan and celebrating progress and being ready and willing to make mid-course corrections
53. Do not assume your organization knows more than the others
54. Don't fool yourself or the other players about your organization's strengths and weaknesses
55. Do not form sloppy goals, but do use SMART goals. Targets of accomplishment that are: **specific**, **measurable**, **attainable**, **relevant** and **time-bound**
56. Avoid wrong perceptions that your board is the only smart board
57. Avoid resentment, feeling forced to collaborate
58. Don't assume people are on the same page about the need or direction in the process
59. Don't assume "leadership" means the same to all players (some think it is telling others what to do)
60. Stigma can get in the way. Don't avoid having conversations about ethnic minorities, mental health patients and other special population groups engaged
61. Don't let the "operational vortex" suck you under
62. Don't just motivate, inspire
63. Don't force, facilitate
64. Avoid selecting board members that are too similar or you get group think
65. Avoid setting up governance process/strategies that are not built on clear roles and responsibilities
66. Avoid assuming you know what they want, how they think and what they feel can come from this cooperation. Ask and Listen not assume
67. Avoid the petty, and focus on the promising
68. Avoid a poorly planned or facilitated process that allows distractions and digression (but don't also be too rigid and tight or we stifle fresh ideas)
69. Don't be afraid to take some risks if they are in the interest of the health of the people and communities we exist to serve
70. Others?

Do's

Please try these actions that can enhance opportunities for more successful collaborative governance:

There are many sensible and bold ideas shared in the following list. Please consider how they can be grouped and refined. Remember that they are in random order.

Prioritize them to the ten (10) most important and powerful ideas. Then distill those further to the top five (5). Take those five and ask the group to identify ways these can best be understood and acted on over the next few months in your specific situations. Their engagement in such a process of reflection and joint decision-making has been shown to build a deeper sense of understanding and ownership of the path forward. That ownership of the challenge and the plan is critical to the successful implementation of the plan.

1. Focus on "person centered care" and patient centered needs
2. Understand the continuum of care, and the social determinants of health, in all we do for collaborative planning and board-to-board relationship building
3. Approach the dream with a humble heart
4. Make sure the process and our board work always connects to a purpose and vision for the good of the broader community
5. Consider trust making, not just deal making
6. Consider fears and loss of autonomy as real issues we will eventually have to address in the process
7. Invite 2-3 groups of 9 youth to consider the future they would like to inherit. Explore how we can make that happen. Then invite similar groups of seniors/elders to do the same exercise, but with a lens to define what could have been avoided and what must be the essential themes and principles to embrace as we plan for the future
8. Build on our communities' and/or organizations' strengths as we look to the future
9. Make sure the process is orderly, with several meetings to keep the momentum moving. Report wisely and well on progress of the planning process to diverse and eclectic stakeholders
10. Board conduct needs to mirror the codes of conduct in our organizations
11. Evaluate and measure progress to plan along the journey of collaborative governance
12. Focus on ***the why and the how*** more than the what as we start the process of collaboration
13. Keep open minds and balanced roles among all players, and avoid the bigger organizations trying to dominate
14. Invest in "generative thinking" training and orientation for all participants in the process
15. Guide our collaborative planning with real stories about real patients and community members that can gain from this hard work
16. Hard-wire informal people-to-people, socializing, and informal meet and greet activities into the process. Build relationship, to build trust which builds momentum and solid gains for future efforts when the going gets tougher
17. Have the process include "What if brainstorming." Be scenario builders for brighter and a bolder future for our kids and grandkids
18. Identify failure derailers and obstacles so we can be forewarned and forearmed

19. Suspend turf and ownership until much later in the process
20. Probably look at the things others in this room come up with as obstacles, and avoid them!
21. Look for win-win opportunities, and early wins to build momentum and enthusiasm about the possibilities, more than the problems
22. Drive for improvement and innovation for quality and safety along the continuum of care
23. Be honest and truthful as we work together to build trust among the diverse players
24. Ask frontline workers, the patients, and the community for their ideas before we lock into ours. It should be about them, more than about us
25. We can benefit from the coordinating committee to help shape and catalyze ideas for collaboration, but why wait for them?
26. Engage clinicians, invite their ideas and fears in the process
27. Engage boards, not just the Executive Directors to shape and guide the process
28. Stop talking and "Just do it!"
29. Be specific on tangible targets and early win activities. Success will lead to more successes. Keep the process accountable and acceptable
30. Consider how new social media and process web portals can help stimulate joint planning and idea generation
31. Explore our shared dreams and hopes and fears. Keep the big picture in front of us and keep going back to these dreams and plans as we make the journey
32. Hold a clear vision of what we have agreed to, and be creative on how we work together to get there
33. Park our histories, egos and turf protection issues outside the room/process. We can always come back to them later
34. Engage hearts and minds with open and powerful visioning about how we would like the system to look and behave in the future
35. Listen to learn, and learn to listen to each other and to the people in vulnerable populations we rarely see or consider in our planning
36. Boards must respect the important role of CEOs to guide and support the collaborative process, but not dominate the process
37. Spend time up-front getting to know each other, our needs, desired ideas and goals before we rush into rigid planning activities
38. Seek sensible and skilled external facilitators for the process
39. Payer and provider boards need to cast a bigger net to invite in more diverse players into the process
40. Collaborative process is not a destination, but a process that will be ongoing. We need continuing support in workshops and shared learning opportunities about collaborative governance
41. Consider how to use the "Charrette technique" in our processes
42. Consider organizing networking opportunities to get to know each other, do some field trips together to settings where they have done some good and innovative strategies, even out of our region
43. Be open to include partnering opportunities with non-traditional social welfare organizations, social services and educational players
44. Have some clear guiding principles to shape our joint planning work
45. Treat all parties as equal in the eyes of the community's health and well being
46. Communicate, communicate, communicate
47. Celebrate, celebrate, celebrate
48. Be transparent in the work, and celebrate progress to plan along the way

49. Use mutually understood words, concepts, processes and vocabulary. Words matter. Language matters
50. Trust our CEOs, but occasionally have board members meet alone with our counterparts and neighbors
51. Explore how that "Aikido" process might help us work through obstacles and problems
52. Have "improving the system" a part of our organizations' missions and plans
53. Spend more time in "Generative thinking" as we explore collaborative governance around the question of "What can we do to dramatically change the patient/family/person experience for health gain, not just health care?"
54. Try to have the collaborative process be as voluntary as possible. (not forced on us)
55. Build more personal relationships among us board members across the organizations involved in the process
56. Be open for results that may be different from the early vision
57. Listen to others' fears and hopes and desires as we launch the process
58. Promote more education about trust building and ways to earn it, keep it and rebuild when needed
59. Co-creation is key to sustained success, we must avoid "not invented here" resistance, and embrace shared ownership of good plans and progress
60. Think patient centered before bricks and mortar
61. Seek clear agreement on principles and rules of engagement to guide the process
62. Identify skilled enablers and champions within our organizations, but also be open to neutral third party facilitators
63. Identify deal breakers once we are moving the process forward, but not too early in the process
64. As plans gel, include objective and honest risk assessments. Let's not be surprised or derailed by realities
65. We need a "plan to plan", and the process must be sensitive to use the time and talents of all players wisely and well
66. Listen to what is not being said as well as what is being said
67. Follow-up in timely and transparent manners in all we do in the process
68. Debrief all board members on our progress. Don't have it all rest in the hands and minds of a select few
69. Don't try to do it all, or be all things to all people. Bite sized successes can help build a stronger and broader foundation for future work together
70. Focus on shared problems and challenges and avoid being pre-occupied with structure before strategy or vision
71. Use graphic artists and "story boards" to capture the process and progress in stories and pictures of the journey
72. Approach the process with an open mind, an open heart, and open meetings
73. Study examples in collaborative governance in other fields and other communities
74. Engage and trust our staff to surface opportunities and sensible obstacles to be thoughtfully anticipated and overcome
75. Others?

Thank you for all you do to enhance the health and health care in your local communities.

Take some risks as you take your journeys to smarter patient and person centered health gain and health care in your communities.

The Governance & Leadership practice of Integrated Healthcare Strategies uses proven, state-of-the-art governance design, educational programs, and tools to help boards use their time and talents more effectively. Our team of consultants have extensive experience in the assessment of board performance and in the development of strategies and systems to continuously enhance the governance of complex healthcare and hospital systems.

For more than 40 years, Integrated Healthcare Strategies (Gallagher Integrated), a division of Gallagher Benefit Services, Inc., has provided consultative services and people-based solutions to clients across the healthcare spectrum, including community and children's hospitals, academic medical centers, health networks, clinics, and assisted-care providers. Our Gallagher Integrated consultants and nationally recognized thought-leaders help organizations achieve their business goals, by ensuring top talent is attracted, retained and engaged, while measuring and maximizing human and organizational performance. With tailored solutions that extend well beyond single services, Gallagher Integrated offers the knowledge, guidance, and insights that organizations need to not only survive the rapidly changing healthcare environment, but to succeed in it.

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