

Financial Officers as Leaders:

Lessons from Army Medicine

By Timothy D. West, CPA, and COL Marcus W. Cronk

Although we seldom think of accountants as great military leaders, consider this message delivered to U.S. Army resource managers by the Army's Deputy Surgeon General, Major General David Rubenstein, at the 2010 Association of the U.S. Army (AUSA) conference in San Antonio, Texas:

I recognize that you are not seen as delivering direct patient care. However, I personally thank you for the role you play in Army medicine. I also want to thank you on behalf of a wounded soldier on a mountaintop in Afghanistan, an Army mom giving birth to a child, and an aging veteran at the end of his life in an Army hospital. Without your efforts to effectively allocate needed resources, encourage the efficient use of those resources, and highlight performance improvement opportunities, our clinicians could not deliver the high-quality care our soldiers and their families deserve. Thank you, and never forget the importance of your roles as problem solvers within the organization.

Too often, we envision leaders as heroic, natural born, and charismatic, motivating followers to act selflessly in pursuit of a common, just cause. But the heroic leader model fails to capture how most management accountants and other financial managers operate day by day. Based on our work with financial managers to better allocate resources across the Army's healthcare system, we've developed an alternative, and perhaps more salient, definition of leadership: *Leadership is a problem-solving, risk-taking endeavor to change how others think and act.*

What does this mean? Whenever finance professionals try to solve an organization's problems, they do take risks because solving problems involves change, and change creates winners (those who are better off) and losers (those who are worse off). Instead of being heroic leaders, management accountants can serve as "quiet" leaders who solve important problems and contribute to a better world by identifying and focusing on key performance measures that will motivate an organization to change.

Indeed, the quiet leadership of Army hospital fiscal officers was essential to implementing performance-based budgeting in 25 hospitals and 158-plus clinics (excluding battlefield facilities). In 2006, the Army replaced much of its traditional incremental budget system (current year budgets = last year's budget plus inflation) with its new Performance-Based Adjustment Model (PBAM). As shown in Figure 1, financial leadership was "in the house" once financial managers learned how best to contribute

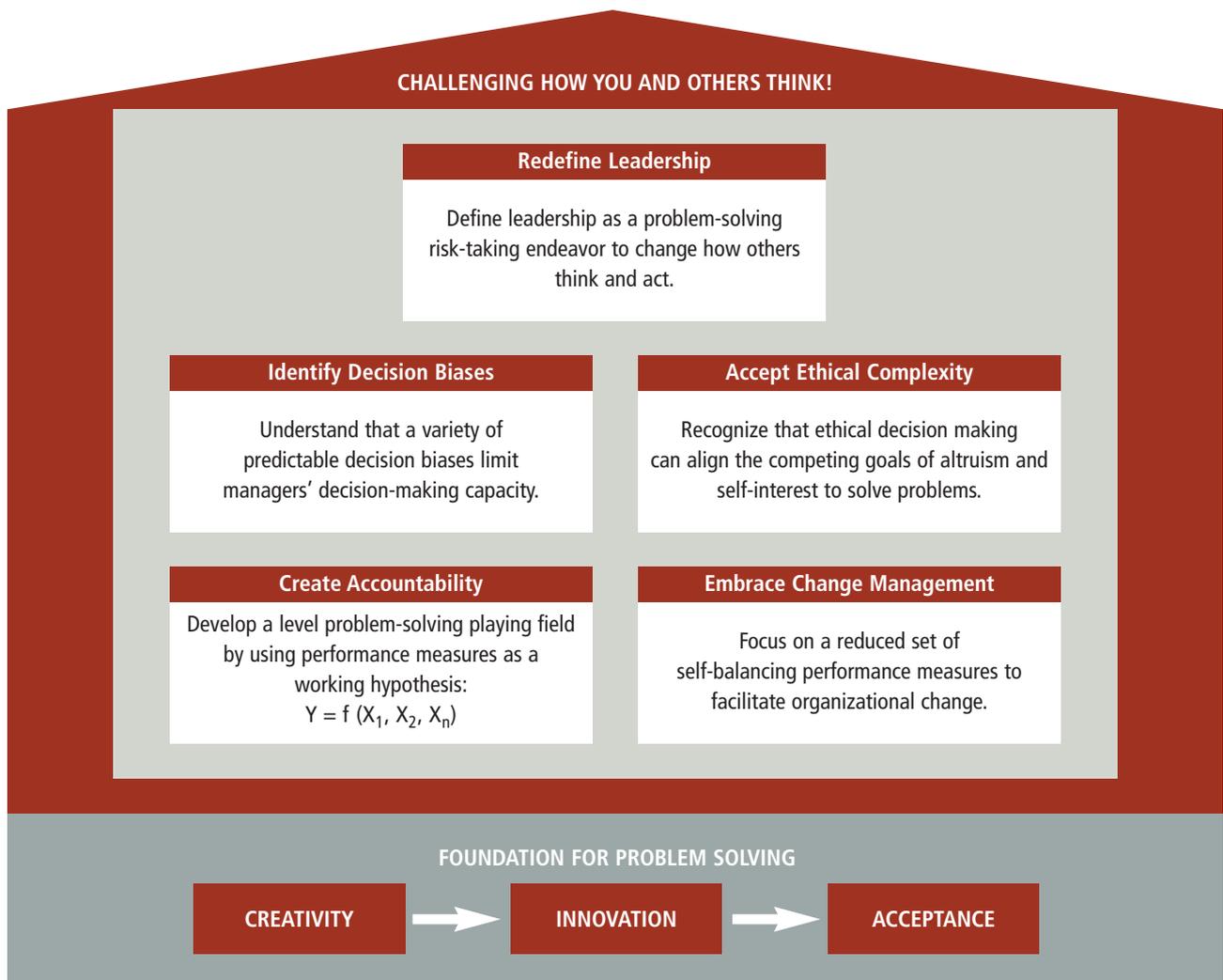
to their organization's core problem-solving team. Ultimately, however, financial managers had to convince others to use their proposed innovations.

In this article, we identify and examine the five most noteworthy hurdles that had to be overcome before managers (clinical and nonclinical alike) would accept PBAM. These same five challenges could well be among the major issues faced by any organization's managers who attempt to implement innovative accounting solutions to modify incentives and behavior.

Deploying a New and Different Funding Model

The Military Health System (MHS) comprises the Army Medical Command (MEDCOM), along with similar departments within the Navy and Air Force, and a network of civilian providers known as TRICARE. Worldwide, the MHS directly operates 59 hospitals and 364

Figure 1: Leadership in the House



Most accountants probably don't think of themselves as **heroic leaders**—individuals who “act boldly, sacrifice themselves for noble causes, set compelling examples for others, and ultimately change the world.”

clinics to support about 9.5 million beneficiaries with a Department of Defense (DOD) budget of approximately \$46 billion. The Army represents about half that amount.

Managers of military hospitals have several incentives to control costs. First, although MEDCOM's budget has increased, the demand for services has increased at a greater rate, in part because of two active war efforts. Second, the DOD designed competition into its system by offering medical care through both military (Army, Navy, and Air Force) facilities and the competing TRICARE network of civilian providers. Third, military hospitals have had mixed incentives relative to their fixed budgets. On one hand, they want to become more efficient to ensure they have sufficient resources to meet patient needs. On the other hand, if managers don't use their full annual budget allocation, their facility runs the risk of losing funds in subsequent years. Therefore, cost management is very important to these hospital managers. Like their private-sector counterparts, military healthcare managers must emphasize cost containment and efficiency because they, too, face both competition and limited resources.

To further manage resources more effectively, the Army implemented a new performance-based budgeting system in fiscal year 2006. Although MEDCOM couldn't change the way it received funds from Congress, it could adjust how funds were disbursed across the system. The Performance-Based Adjustment Model links funding to services delivered, at both the hospital and department level, rather than controlling spending through inputs (fixed allocations). Traditional incremental budgets provided *defensible* funding (when spending stayed within the budget), whereas PBAM represents *justifiable* funding that's linked to outputs (volume, complexity, and service

quality). Managers are evaluated on their use of resources relative to services provided based on performance measures that a wide range of stakeholders can understand. Drawing heavily on performance measures developed in a regional pilot study, PBAM was a new and different funding model for the overall system of Army hospitals and clinics.

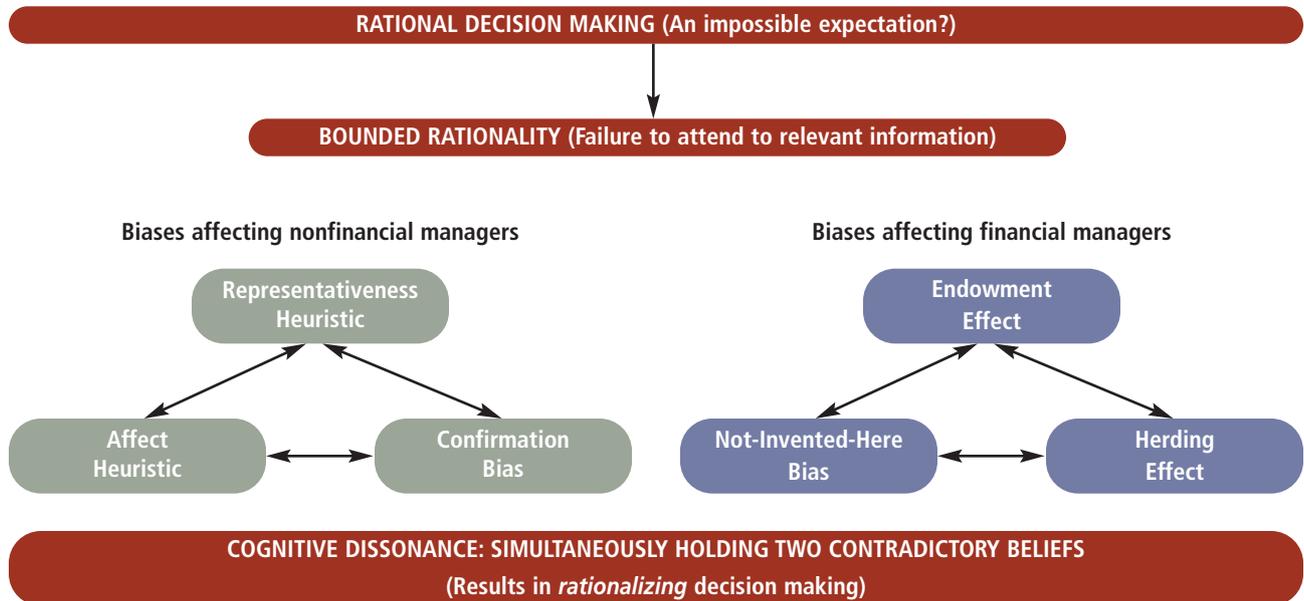
Overcoming Several Hurdles

Implementing PBAM successfully required effective leadership from hospital financial officers, who frequently were viewed by their clinical counterparts (physicians, nurses, and medical technicians) as gatekeepers who restrict resources—adversaries, rather than allies, in the effort to deliver quality healthcare. Accountants often reinforced this negative stereotype by sharing information with the clinical team via elaborate spreadsheets and bulleted PowerPoint slides that might communicate ineffectually, if at all. Achieving PBAM acceptance, therefore, was a significant learning experience for these financial officers.

Challenge 1: Redefine Leadership

Leaders often receive too much credit and too much blame, and too much may be made of their individual characteristics because the relative importance of seemingly essential traits or behaviors (intelligence, sociability, aggressiveness, popularity, etc.) depends on who's evaluating them. What's more important in this case is that most accountants probably don't think of themselves as heroic leaders—individuals who “act boldly, sacrifice themselves for noble causes, set compelling examples for others, and ultimately change the world,” as author Joseph L. Badaracco, Jr., stated in his 2002 book, *Leading*

Figure 2: Summary of Decision Biases



Although we only illustrate how six decision biases affected PBAM acceptance, a variety of additional biases have been shown to influence decision makers.

Quietly: An Unorthodox Guide to Doing the Right Thing. Our definition of leadership looks to engage a wider range of financial managers by focusing on the role they play in solving problems within their organizations. This resonated with MEDCOM resource managers and program analysts because it reflected their realization that solving problems is the essence of their work, whether or not they're perceived as heroic or get any credit.

Three aspects of our definition were useful when examining PBAM's creation, innovation, and acceptance. First, financial officers identified problems in terms of efficient delivery of clinical services. Second, the decision to create a financial solution to alter clinical behavior was risky. From high-profile changes in incentive schemes to low-profile changes in spreadsheet design and presentation, management accountants and other financial professionals take on a quiet leadership role and assume risk whenever they try to modify how others think and act. Finally, and not too surprisingly, physicians and nurses resist any change in the name of cost control that they perceive as threatening quality of care.

Challenge 2: Identify Decision Biases

Most accounting tools—such as net present value (NPV) and return on investment (ROI)—are developed with an implicit assumption that users of accounting information

are rational decision makers. In reality, as reflected in Figure 2, various predictable decision biases limit managers' capacity to make rational decisions. In the Army hospital setting, a coldly rational appeal to improve efficiency in the face of increasingly constrained resources didn't resonate with clinical managers, and colorful spreadsheets and PowerPoint slides failed to have the desired effect. Unfortunately, resource managers were steeped in these tools and essentially fell prey to the mistaken idea that “the problem with communication is the illusion that it has been accomplished,” as playwright George Bernard Shaw famously said.

It quickly became obvious that PBAM wasn't going to be adopted successfully unless preconceived ideas about the value of accounting information—held by both financial and nonfinancial managers—were overcome. Physicians and nurses (nonfinancial managers) were particularly susceptible to three decision biases. First, their emotional responses to people or information often caused them to take mental shortcuts when making judgments (what's known as affect heuristic). For example, a physician's bad experience with a resource manager involving cost containment persisted on an emotional level, causing the doctor to expect further negative encounters with accountants. Second, stereotypes of accountants seemed to cause nonfinancial managers to

place arbitrary constraints on accounting professionals (representativeness heuristic). Specifically, if financial officers aren't seen as consensus builders and decision facilitators, they may be considered part of the problem, not part of the solution, and may be excluded from the decision-making loop. Finally, managers tend to focus on information that supports their position while ignoring anything that contradicts it (confirmation bias). Therefore, nonfinancial managers were prone to ignore negative accounting information that failed to resonate because of how it was presented.

Financial officers' decision biases also threatened PBAM adoption. First, their investment in understanding the existing budget system created a sense of ownership in the system. These financial officers felt no comparable ownership in the PBAM system. Therefore, they overvalued the data provided by the traditional budgeting system relative to PBAM information (endowment effect). Second, both managers and organizations prefer ideas and solutions they personally generate compared to ideas others originate (the not-invented-here bias). PBAM implementation had to overcome two potentially limiting, not-invented-here barriers: (1) MEDCOM had to accept and support an idea that originated in a regional pilot study rather than in the MEDCOM executive suite, and (2) hospital managers had to accept and support an idea/solution mandated by MEDCOM. Although PBAM was required as the basis for resource allocation across the hospital system, managers at individual hospitals could choose the extent to which they used it to guide decision making. Finally, individual resource managers were influenced by their colleagues' reactions (herding effect) in accepting PBAM. Without support from resource managers as a whole, individual financial officers would have been reluctant to step up and support adopting an untried innovation.

Challenge 3: Accept Ethical Complexities

Accounting professionals often adopt a simplified model of ethics that implies choices are either right or wrong. But consider the following insight from bioethicist Daniel Callahan:

I learned right and wrong at my mother's knee, but she didn't teach me about the ethics of fetal tissue transplants.

The argument that ethical leadership or decision making depends solely on personal character or values is too simple. Ethics is more than simply right or wrong and certainly more than blind obedience to established rules.

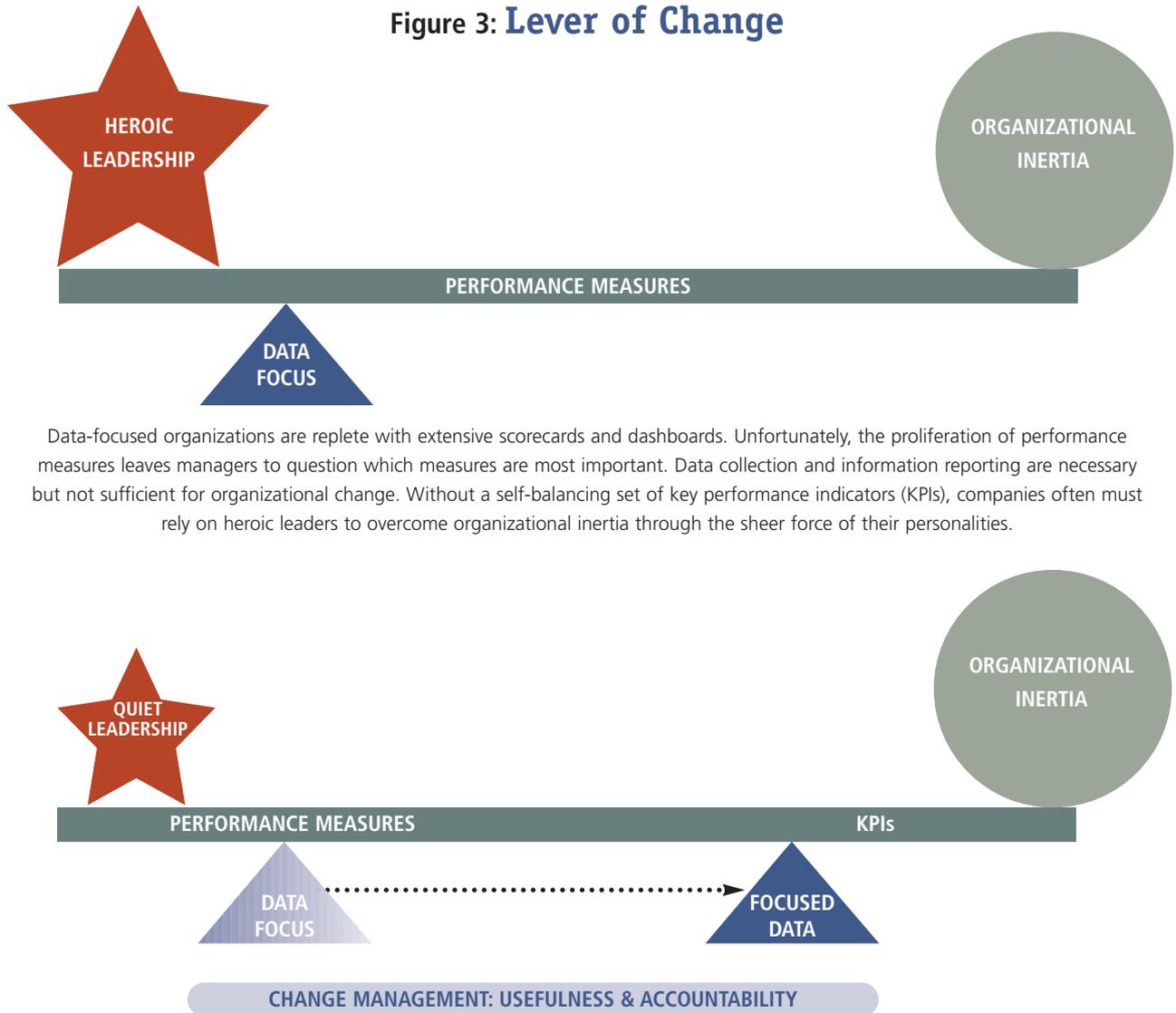
In a broader sense, ethics is a matter of stewardship, and quiet leaders may be asked to help change rules that are wrong or inadequate. Furthermore, overreliance on simple rules can be a way to avoid the hard work and risk associated with solving complicated problems. One unexpected consequence of the accounting scandals over the past decade has been the framing of accounting decisions as either right (not fraud) or wrong (fraud). The choice of accounting methods is more subtle, and the adoption of a new cost control system has powerful implications.

PBAM's designers recognized the ethical implications of measuring performance so, among other things, constructed a methodology to reward performance in four key medical specialties: mental health, obstetrics/gynecology, orthopedics, and primary care. Reimbursement rates

in these four areas were subsidized relative to comparable civilian rates to create funding incentives to provide these vital services. To discourage use of the emergency room (ER) as patients' primary point for system access, the ER reimbursement rate was "taxed" by keeping it significantly lower than comparable civilian rates. Incentives and disincentives were designed to affect clinical practice patterns and direct patient care away from the ER. Prior to PBAM, clinical managers were aware that patients overused ERs, which increased the overall costs of care and negatively affected patient satisfaction. Yet practice patterns didn't change.

When PBAM was implemented, however, these same clinical managers were told about the "weighted" reimbursement rates, clinical funding was adjusted to reflect performance, and practice patterns began to shift. The number of ER visits has declined, and access to care through scheduled clinic visits has increased. Essentially, resource managers assumed the role of activist accountants and changed behavior within Army hospitals; the rules were modified to solve a perceived ethical (stewardship) problem. The result has been a more efficient use of

Figure 3: Lever of Change



Data-focused organizations are replete with extensive scorecards and dashboards. Unfortunately, the proliferation of performance measures leaves managers to question which measures are most important. Data collection and information reporting are necessary but not sufficient for organizational change. Without a self-balancing set of key performance indicators (KPIs), companies often must rely on heroic leaders to overcome organizational inertia through the sheer force of their personalities.

Financial officers, as quiet leaders, can work steadfastly to change organizations from data-focused ones to ones with focused data. The selected KPIs must be self-balancing in the sense that they encourage managers to “do the right thing” by optimizing performance across the full set of measures.

scarce resources to care for soldiers and their families.

Challenge 4: Create Accountability

Clinicians resist administrative attempts to make them more accountable for the resources they consume. A common refrain is that reductions in resources affect quality of care negatively. In this case, clinic managers also argued that their departments were “unique” in the sense that intraspecialty performance couldn’t be compared across facilities (either military or civilian). Physicians viewed their own patients as sicker than those of their colleagues, thus requiring more care. Moreover, interspecialty comparisons were difficult in terms of resources consumed and were seen as truly inappropriate.

Given this backdrop, PBAM developed measures designed to place facilities and departments on an even playing field. Although clinic operations are complex, performance measures must be readily understandable if they’re to be accepted. Creating a resource allocation model to capture that complexity ran the risk of being too difficult for clinicians to utilize effectively, and the time needed to understand it might detract from time spent on patient care.

To counter these concerns, the creators of PBAM took a page from Medicare, which pioneered the use of acuity-adjusted volume measures as a basis for reimbursement. These measures acknowledge that all patient visits aren’t equal. For example, relative value units (RVUs) assign

weights to each patient encounter that reflect the complexity of the case. Physicians or clinics that see more-complex cases report higher acuity-adjusted volumes than those that see less-complex cases. Although this concept wasn't new, Army hospitals were innovative in applying it. Funding was now tied directly to physician workloads and individual efficiency, which made clinicians more accountable for the resources they received.

Nevertheless, the decision to forge a direct link between funding levels and workloads came with some risk. First, civilian-sector evidence shows that hospitals have an incentive to “overcode” in an effort to receive the highest possible reimbursement by selecting an acuity level that exceeds the actual case complexity. PBAM penalizes coding errors by reducing funding and essentially applies a continuous audit methodology to encourage coding accuracy. At the same time, the designers understood that successful health initiatives designed to prevent patients from getting sick could reduce some clinicians' workloads. Preventive healthcare services, potentially the lowest-cost care, might be viewed as inconsistent with clinic attempts to use up all available resources by maximizing patient volumes. In recognition of this situation, if hospitals met preventive healthcare targets, PBAM rewarded them with additional funding as a performance bonus.

Finally, program analysts were keenly aware of the importance of patient satisfaction. Clinicians couldn't simply increase the number of patients seen while sacrificing the quality of their contact with each patient. Therefore, hospitals could earn monthly bonuses that were tied to the results of patient satisfaction surveys.

Challenge 5: Learn to Embrace Change

Overall, MEDCOM analysts track more than 130 performance measures, which leads facility managers to often voice a common complaint: “Tell me which measures are most important, and I'll focus on improving those.” Too often, accounting professionals respond that all measures are important. This response just exaggerates the appearance of financial officers as information gatekeepers.

PBAM focused clinical managers on five key performance indicators (KPIs):

- ◆ Inpatient acuity-adjusted volume and efficiency,
- ◆ Outpatient acuity-adjusted volume and efficiency,
- ◆ Coding accuracy,
- ◆ Preventive health, and
- ◆ Patient satisfaction.

These KPIs essentially were self-balancing in that clini-

cians couldn't focus on a single measure without potentially underperforming on other measures. For example, rapid patient processing might increase volume and result in an improved workload metric. But it might cause the quality of care and patient satisfaction to decline, which would offset performance rewards. Instead, the performance metrics and the incentives tied to those metrics rewarded clinicians for doing the right thing: (1) increasing patients' access to care by increasing the number of available appointments, (2) emphasizing preventive health initiatives, (3) focusing on coding accuracy as the best way to capture true workload levels, and (4) rewarding efforts to improve and maintain high levels of patient satisfaction. Selecting a small set of KPIs resulted in a powerful data-driven lever of change that allowed resource managers, as quiet leaders, to positively affect how patient care was delivered across Army facilities (see Figure 3).

How Does Your Organization Compare?

Since MEDCOM implemented PBAM in 2006, its hospitals have realized quarter-over-quarter gains in terms of patients served and quality of care—gains not realized by the other components of the Military Health System. To achieve acceptance of this new incentive system, the military's financial professionals had to overcome difficult challenges, including redefining leadership for hospital financial officers, identifying decision biases, accepting ethical complexity, creating accountability, and embracing change, all while managing the turmoil of supporting an Army at war.

Now that you've finished reading this article, take a look at your own organization, which might be fighting its own “war” between those aggressively seeking to slash costs and those wanting to reinvest in the business. These same five challenges that the Performance-Based Adjustment Model addressed could well be among the major issues you'll face in attempting to implement an innovative financial solution designed to modify incentives and behavior. **SF**

Timothy D. West, CPA, Ph.D., is an associate professor of accounting at Northern Illinois University in DeKalb, Ill., and a member of IMA's Fox River Valley Chapter. You can reach Tim at (815) 753-6252 or tdwest@niu.edu.

Marcus W. Cronk is CFO of the U.S. Army Medical Command. You can reach COL Cronk at marcus.cronk2@amedd.army.mil.