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E-Briefings

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Welcome to The Governance Institute's E-Briefings!

This newsletter is designed to inform you about new research and expert opinions in the area of hospital and health system governance, as well as to update you on services and events at The Governance Institute.

In this issue:

Healthcare Forecast 2018: 10 Trends (and Implications) Board Leaders Need to Know

By Steven T. Valentine and Guy M. Masters, Premier Inc.

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This year will be notable for the mixed messages that will continue to come in from Washington, D.C., spurring uncertainty for healthcare organizations as they struggle with increased cost pressures, leadership and caregivers retiring or reducing hours, policy reimbursement changes, and the continued movement toward value-based care and payment. The future of healthcare is rapidly changing, bringing both challenges and strategic opportunities. Healthcare organizations will need to move with caution and speed to find a path that leads to success in this dynamic environment.

1. The Population Health March Endures

Hospitals and health systems will continue to invest in information systems, infrastructure, primary care, medical management, and new value-based care and payment models that reward population health management. They will look to further partner with community organizations to address social determinants and their relationship to a population's health. This effort will also support the continued development of programs to enhance "consumer stickiness" through improved patient communication and engagement methods, patient satisfaction incentives, repeat interactions, and easy and convenient access to care.

In the boardroom:

- Evaluate the population that is required for scale and adequate geographic coverage, including determining if partners are needed for success.
- Monitor and benchmark accountable care organization (ACO) and clinically integrated network (CIN) performance.
- Enhance collaboration with community organizations to address the social determinants of health.
- Have a plan that identifies community needs, the resources available to address them, and a payer contracting strategy to fund them.

2. Increasing Evolution of Value-Based Care Delivery Models

Healthcare organizations will increasingly be looking to develop and adopt new care and payment models. We expect to see increased use of primary care physicians, mid-level professionals, hospitalists, intensivists, laborists, SNFists, care managers, informaticists, data analysts, clinical protocols/pathways, EMRs, and other tools across the continuum. Public and commercial health plans will start to avoid paying for certain tests, diagnosis, procedures, and treatments at hospital-based/owned facilities, driving health systems to continue to diversify into freestanding diagnostic and treatment centers and/or price their hospital-based services to match market rates. Another developing trend is expansion into the full continuum of care, such as growing provider

networks to include retail health centers, urgent care centers, ambulatory centers, freestanding emergency rooms, telehealth, and post-acute care services (SNF, rehabilitation, home health, palliative care, psychiatric care, and hospice care). Risk-based alternative payment models (APMs), based on a provider's ability to deliver better value, will support and drive these changes.

In the boardroom:

- Monitor progression to new value-based care models as incentives shift.
- Pursue stronger alignment with employers and health plans to add value and enhance the patient experience.
- Encourage diversification into new care models, and enter partnerships with ambulatory and post-acute care providers.
- Watch for new value-based payment arrangements, and understand the incentives and compensation models the organization is using.

3. Health Plan and Payer Moves

Health plans will continue to pull out of health insurance exchanges without premiums and the re-insurance of "higher than expected healthcare costs" subsidized by the government. We predict that premiums will increase significantly higher than expected in order to cover the cost of caring for these populations. As a result, PPO high-deductible plans with employer health savings account support will continue to grow to keep premium increases tolerable, increasing patient empowerment around how they receive and pay for care. More of the payment will shift to the patient leading to greater consumer price sensitivity. Watch for more direct contracting arrangements between healthcare organizations and employers. These relationships will continue to grow and potentially redirect business in the market.

In the boardroom:

- Screen the organization's payer contracting strategy and ask about opportunities to contract directly with employers.
- Encourage management to work with local insurance brokers and employers to understand their benefits and interest in direct contracting.
- Monitor and understand the impact of efforts by health plans to implement value-based payment arrangements.

4. Physician Slowdown

The physician is still standing. They have endured the never-ending challenges of HMOs, reduced fee schedules, authorizations to treat patients, invasion into their office via collection of patient and practice pattern information, scrutiny by patients through numerous surveys, etc. MACRA is just around the corner. Physician performance data is being collected and within another year will begin to impact their Medicare payments. The baby boomer-aged physicians are tired. They have lived and practiced through the recession and saw their personal wealth shrink. Their investments have likely recovered and now they are looking forward to putting them to use, leading to retirements and "a slowdown in work" for 2018. The challenge and opportunity for hospitals and health systems will be the vacancies that pop up. To fill the gaps, the battle to attract, acquire, contract with, recruit, and retain high-value physicians will be ever more important. We can expect the same of C-suite leaders and nurses, as well as other caregivers.

In the boardroom:

- Develop or update succession plans for the medical staff, C-suite leaders, and board members.
- Continue to develop a robust, high-value network of physicians, which is essential to building a foundation that attracts new physicians, and to prepare to effectively manage physician practices and medical groups.
- Provide ongoing MACRA updates, education, and support; physicians should have an assessment of their practice to analyze the economic impact on their finances.
- Implement an educational program to enhance, develop, and improve the leadership skills of physicians, as well as for C-suite leaders and managers.
- Ask management for updates on the organization's physician alignment strategies. There should be a plan, metrics, and periodic reporting to measure progress and success.

5. Changing Landscape of Competitors

The healthcare market is changing. New partnerships in healthcare are surfacing, leading industry stakeholders to pause and try to understand the rationale behind each move. With recent announcements around insurers partnering with pharmaceutical companies and acquiring medical groups, or consumer wearable and healthcare tech companies working together, it is apparent that the fight for consumer loyalty and "stickiness" is accelerating. The digital connection between the patient and their healthcare manger is intensifying and is disruptive.

In the boardroom:

- Ask management to periodically report on industry developments in this area.
- Understand the organization's digital strategy to compete and gain "stickiness" from physicians and consumers.
- Assess what partnering opportunities are possible to pursue with the "digital players" for your organization.

6. Consumer Empowerment

Consumers are becoming more involved in their healthcare decisions as their economic cost-sharing proportion is growing. In response, multiple Web sites have been created to promote transparency and better inform consumers by providing pricing information, quality ratings, customer reviews, and other information on hospitals, physicians, and other providers and services. Two areas that should be on your radar are patient engagement and consumer stickiness. Engage patients to get them involved in their healthcare from the beginning, using your resources to provide prevention, diagnosis, chronic disease management, and monitoring services that support the total care experience. The stickiness aspect centers on getting patients to connect with your organization. This includes a patient portal, wearable devices, an accessible patient electronic medical record (EMR), educational programs, screenings, and pushing targeted materials to patients based on current and anticipated healthcare needs.

In the boardroom:

- Ask management to present the organization's consumer communication and engagement plan, and identify strategies connecting your organization to the consumer.
- Monitor industry developments in this area to track potential opportunities and threats.

7. The Accelerating Path from Volume to Value

The healthcare industry continues to experiment with various value-based incentive payment models in both public and commercial markets. MACRA's Quality Payment Program encourages creating new APMs, such as Medicare bundled payment models and ACOs that align with risk-based incentives. As a result, hospitals, for the most part, will see continued reduction in inpatient use due to fewer admissions and shorter lengths of stay. Efforts described in trend #2 address several of these activities. Even hospital-based outpatient volume has softened because it is being redirected to less costly alternatives, such as hospital-based ambulatory services, and some volume has moved from outpatient to the office or home. These shifts will continue.

In the boardroom:

- Understand and actively monitor the organization's plan to transition from volume to value.
- Educate yourself on how the Quality Payment Program will change incentives and metrics for physicians.
- Ask management to keep the board informed about the organization's volumes (admissions, length of stay, emergency department visits, outpatient, etc.), the ambulatory options in the market, and the changing payment incentives to use less costly outpatient services.

8. Cyber Risks

Cyber-attacks have reached into the healthcare industry and hackers have found a rich and poorly defended source of personal information. Ransomware, phishing, and human error have led to costly breaches for healthcare organizations. With numerous entry points into hospitals and health systems (wearables; patient, physician, and employee portals; medical devices; information exchanges/data warehouse; EMRs; etc.) the digital infrastructure is vulnerable. Expect the attacks to continue.

In the boardroom:

- Ask management to provide their cybersecurity plan and identify the resources required to stay current in this new cost center.

9. Continued Consolidation

This trend will continue. However, a trend now is for the potential health system/hospital to assess the performance of the potential new partner or parent sponsor. A look back at mergers over the last couple of years shows that many have missed the mark in achieving the advantages that were presented when the transactions were put together. The smaller organizations seem to be struggling a little more and the larger ones seem to be getting stronger as they apply their superior resources to capture market share and build brand recognition. Consolidation will continue in the hospital, physician/medical group, imaging, urgent care, and retail space. These areas are under pressure to enhance performance. Continued downward pressure on prices and revenue will also drive consolidation.

In the boardroom:

- Track your organization's financial performance, market position, and strategy execution.
- Monitor your market and what is happening with competitors for potential affiliations, partnerships, and alignments with traditional and non-traditional "market disruptors."

10. Cost Reduction and Management—Again

It's expected that cost management is a recurring top 10 trend. With the changes (reduced payments and incentives for care at lower-cost facilities) coming from CMS, value-based payment models, drug cost increases (more use, new drugs, and higher prices), more narrow and tiered networks, losses on owned physician practices, and volume movement away from the hospital, health systems and hospitals must double down on cost management.

In the boardroom:

- Continue to focus on new models of care, increase automation efforts where there are repetitive tasks, reduce expenses in non-patient care areas, negotiate vendor discounts, and collaborate with other organizations to enhance your market position.
- Ensure that management regularly provides to the board a standard dashboard report tracking cost and revenue metrics; it is management's responsibility to manage costs and the board's responsibility to ask questions and be kept informed.

Final Word: Future Snapshot

The 2018 healthcare environment will be significantly impacted by the new tax policy changes adopted at the federal level. Additionally, the slow unwind of the Affordable Care Act will persist and Medicare will continue to underfund and reduce payment for many services, and we expect the transformation to value-based care and payment to continue in 2018. Employers will look to reduce their employee healthcare spend. Health systems and hospitals will look to grow market share and expand their population base. Mergers will continue and surprises will pop up, meaning boards will need to work closely with their leadership teams and be flexible, innovative, and insightful as they make decisions that will shape the future of their organizations.

The Governance Institute thanks Steven T. Valentine, M.P.A., Vice President of Strategic Advisory Services, and Guy M. Masters, M.P.A., Principal, at Premier Inc., for contributing this article. Joe Damore, FACHE, Vice President of Population Health Management at Premier also contributed to this article. *They can be reached at (818) 512-0349 or Steve_Valentine@premierinc.com; (818) 416-2166 or Guy_Masters@premierinc.com; and (704) 816-5241 or Joe_Damore@PremierInc.com.*

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What to Watch This Year: Executive Compensation Alignment and Board Development

By Steven Sullivan, Pearl Meyer

Change is the only constant when it comes to the healthcare industry. Many had hoped for some clear direction with regard to the Affordable Care Act (ACA) in 2017 that didn't materialize, and as we kick off 2018, large-scale mergers such as Aetna and CVS offer the potential for new, further disruption.

Nevertheless, the industry has proven adept at moving ahead with transformation strategies in the face of uncertainty. The view that executive compensation—and particularly the use of long-term incentives—can be a tool to enact strategic business changes is taking hold, and boards of directors are rising to the challenge of guiding their organizations in entirely new directions.

As we look at the unique challenges this industry poses, there are two key areas for directors to watch this year: the alignment of funding models and long-term incentives and the maturing of board governance.

Alignment of Funding Models and Long-Term Incentives

While various legislative efforts seem to change by the day, there is little disagreement that there will

be continued diminishment of funding for Medicare and Medicaid. Provider organizations whose patients are more reliant on these programs are already challenged to provide their boards with operating budgets above breakeven.

Healthcare providers serving patient populations with a mix of employer-provided and commercial insurance plans are also feeling the pinch. However, they can more often generate some sustainable margin that can be invested in new or expanded lines of business with more favorable anticipated reimbursement rates, such as ambulatory care, behavioral health, partnerships with other types of providers enabling bundled services, etc.

It's in this tough budget environment that all healthcare providers, regardless of their place on the reimbursement continuum, have a common need to recruit, motivate, and retain quality leaders from among a limited pool of candidates.

Given the complexity and long-range nature of healthcare business strategies, there have been two noticeable changes to traditional executive compensation practices in the industry: 1) a greater reliance on variable compensation and 2) an emphasis on long-term incentive (LTI) plans. Boards are finding that LTIs can enable them to more broadly recruit based on potential high-end levels of pay, can provide a retention vehicle for successful executives, and when properly designed, can drive meaningful improvements to the new "Triple Aim" strategy of improved efficiency, quality, and patient experience. However, to be most effective, these long-term incentive plans may need to emphasize one factor over another, as determined by the organization's primary reimbursement.

Those hospitals and health systems more reliant on Medicare and Medicaid are quite often safety-net providers in the community and are not necessarily challenged by the need to grow market share as much as the need to evolve more efficient and effective ways of treating the flow of severe, often chronic cases they encounter on a daily basis. Their LTIs may emphasize driving cost out of the delivery system, while demonstrating levels of quality sufficient to maintain their reimbursement eligibility against CMS-mandated thresholds. They must also address patient experience, and may choose to establish or revitalize an existing patient rating program, which allows their patients' ratings of their experience to be compared against other providers. Patient experience may be established as a factor in their annual incentive plan or as a long-term incentive metric or plan modifier.

In contract, the strategy of many providers whose current and prospective patient populations are more likely to participate in commercial health insurance plans is to grow that patient demographic and market share. Critical to that goal is the organization's ability to demonstrate extremely high levels of clinical quality and patient satisfaction over a sustained period of time. As in many industries, achieving consistent high quality in direct care requires that it be built into the core culture of the organization, which is a multi-year proposition.

These organizations may establish LTIs driven by some mix of growth and clinical quality, so that their ability to increase either of the two can increase the other, as well as patient satisfaction. Since they must also address efficiency to preserve their ability to invest in growth opportunities, they may choose to also establish some measure of operating margin or earnings as funding mechanism for the overall incentive program.

In general, LTIs are more likely to be established at larger organizations than smaller; however, there is no reason for smaller mid-market provider organization to forego a long-term incentive plan in an effort to align strategy and pay. The key to successful implementation is a clear articulation of long-range strategy and mission, and translation of that vision into quantifiable and understandable measures and metrics. Also important is the calibration of long-term (and short-term) incentive award opportunities with proper competitive market positioning. For-profit and non-profit boards alike should closely monitor their executive compensation programs to ensure reasonableness of total compensation based on performance, as well as transparency to participants, regulators, and the communities served.

Maturing Board Governance—Transparency and Teamwork

Providing effective governance is the key responsibility for any board of directors. In most industries, for-profit directors typically have experience with the type of company on whose board they serve and their background allows productive engagement in their fiduciary and strategic responsibilities. On the other hand, boards of non-profit organizations are often comprised of successful local executives, business owners, and civic leaders who may or may not have direct experience in public company governance or the

organization's mission, but their networks and leadership capabilities serve those institutions well.

Boards in the healthcare industry, however, may or may not fit either of these norms and regardless of their experience, may be struggling to provide proper oversight because of the unique challenges of the industry, such as quickly evolving business strategies, emerging practices in executive compensation, and uncertain or inconsistent funding scenarios.

As an example, consider that industry veterans are now often appointed to for-profit healthcare boards due to their expertise in *adjacent* industries like insurance, hospitality, or retail, as those new skills are now needed in the healthcare space, but they may lack medical or healthcare administrative experience. Another scenario can include not-for-profit directors, who, because they are typically stewards of taxpayer or charity dollars, may have a rightly-held predisposition to very conservative budgeting. While a benefit in most non-profits, that experience could have the unintended consequence of holding up the investment in and advancement of needed new healthcare strategies.

Today's healthcare CEO—who increasingly brings a strong mix of medical and administrative acumen to the job—can play a large role in helping the board help the organization. Likewise, the board may bring the business and financial insight that can help management make better informed key strategic decisions. Both sides' abilities to participate in a meaningful dialogue will only improve with knowledge gained from the other.

To the extent that the board can establish an environment of trust with their CEO, he or she may feel more comfortable providing some valuable education regarding shifting payer and care delivery issues, and the organization's strategic initiatives that are in place to address myriad financial, quality, and patient experience challenges. Transparency concerning these challenges, and the organization's chances of success, will only occur when management believes there will be benefit to educating directors, and when the board is open to learning and applying medical and healthcare administrative knowledge to their business or non-profit management experience.

Further, as boards recruit new directors, they should understand whether there are missing skills or talents, in addition to evaluating candidates against some important broad factors:

- **Passion**: An ideal director will be passionate about the mission and purpose of the organization they serve.
- **Diversity**: It's become increasingly important for senior management teams and boards to have a range of points of view in order to best navigate complex issues and serve varied populations.
- **Experience**: Significant leadership experience tends to mold the most effective board members.
- **Executive/professional skills**: It's vital for boards to have a few individuals who have specific skills and experiences to guide complex legal, financial, or business issues. Some of the most critical skills are finance, accounting, audit, risk, marketing, IT, HR, and legal.
- **Availability**: An ideal board member will be able to make a serious time commitment to actively participate in both board- and committee-level work, including meeting preparation and attendance, as well as special projects/initiatives throughout the year.

Across all industries, there has been a steady increase in the time commitment and amount of activity and strategic work that is needed at the full board and committee levels. The changing skill sets required for effective oversight in the industry point to a related consideration for healthcare boards: compensating their directors. This is a common practice among not-for-profit and for-profit insurers but is uncommon among not-for-profit hospitals and health systems. According to The Governance Institute's 2017 biennial survey, 12 percent of hospitals and health systems compensate the board chair and 11 percent compensate other board members.[1]

Correlating with the demand for top-level talent and the director's workload is the need to ensure that board compensation programs for those that do pay their directors are competitive with the market. Both not-for-profit and for-profit healthcare organizations that pay their boards conduct periodic assessments of board compensation relative to other similar organizations and make adjustments as needed to ensure they can continue to attract and retain high-quality director talent with the backgrounds and experiences that the board requires.

[1] Kathryn Peisert and Kayla Wagner, *The Governance Evolution: Meeting New Industry Demands*, 2017 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute.

Looking Forward

While stability and predictability in the industry may not yet be in sight, providers and insurers are adapting to the realities of an uncertain healthcare environment. As they seek out new strategies and tools to manage the business of healthcare, board governance and executive compensation programs can have an increasingly influential role in this transformation.

The Governance Institute thanks Steven Sullivan, Principal with executive compensation consultancy, Pearl Meyer, for contributing this article. He can be reached at steven.sullivan@pearlmeyer.com.

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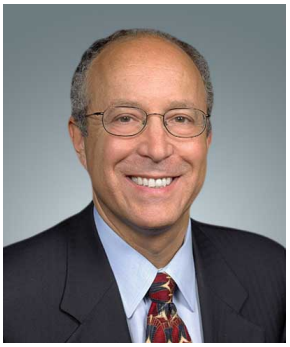
Governance Institute Advisor Spotlight: Todd Sagin, M.D., J.D.



In this series, we are spotlighting each of The Governance Institute advisors to give you a look into their roles, expertise, and experience in the industry. The advisors are healthcare experts, each with their own areas of focus, who work with members to help them solve their governance challenges—everything from developing leadership skills to building a competency-based board to assuring best-fit strategic plans and partnerships. Our advisory services include:

- Board education and development retreats
- Independent governance review and redesign processes
- BoardCompass® consultation and self-assessment retreats
- Phone and email consultations
- Specialized consultations

In this article, we highlight Todd Sagin, M.D., J.D., President and National Medical Director at Sagin Healthcare Consulting, LLC. Watch for future articles in this series to learn more about each of our advisors.

Industry Expertise

Todd Sagin, M.D., J.D., is a physician executive recognized across the nation for his work with hospital boards, medical staffs, and physician organizations. Dr. Sagin is a popular lecturer, consultant, mediator, and advisor to healthcare organizations. He is frequently asked to assist hospitals and physicians develop strong working relationships, as healthcare becomes a more integrated enterprise.

Over the past decade, he has engaged with several hundred of the nation's hospitals to work with their governing boards, medical staffs, and management teams to improve the quality of care they deliver. This work ranges from physician and board leadership education to strategic planning, and from strengthening medical staff affairs to building strong employed physician group practices.

He provides a variety of educational opportunities including facilitated retreats, keynote addresses, focused workshops, medical staff leader "boot camps," physician leadership curriculums, and board orientation programs. He also offers consulting services on topics such as:

- Unification of health system medical staff organizations
- Redesign of hospital medical staff structures
- Physician engagement strategic planning and facilitation
- Development of hospital employed physician group practices
- Development of expanded physician leadership structures for health systems
- Governing board assessment, training, and strategic planning
- Credentialing and medical staff quality audits performed for governing boards
- Medical staff performance assessment and accreditation readiness, medical staff bylaws and medical staff redesign, and medical staff affairs (including credentialing and privileging, peer review and performance improvement, physician competency assessment, and physician impairment and conduct issues)
- Services as a Fair Hearing Officer or facilitation of corrective action implementation
- Mentoring and coaching of physician executives and clinical leaders

Work with The Governance Institute

Dr. Sagin frequently writes for The Governance Institute's publications. He recently wrote articles on board oversight of the medical staff, the coming

tsunami of aging practitioners, executive coaching, and the unification of medical staffs in health systems. Last year, he wrote the white paper *Physician Leadership in Hospitals and Health Systems: Advancing a 21st-Century Framework* and presented a Webinar on "Combining Medical Staffs in a Multi-Hospital Setting."

He also leads the Physician Leadership Program at The Governance Institute's Leadership Conferences. This program is designed to strengthen the skills and knowledge of physicians who are engaged in medical staff, group practice, and performance management activities within hospitals and health systems. Specific subjects covered include unique issues faced by physicians in governance, use of dyad management structures to engage physicians in administrative tasks, the critical importance of addressing physician burnout and promoting physician resilience, and the many challenges physician leaders face when managing problematic colleagues.

In addition to his work with The Governance Institute, Dr. Sagin is also a speaker for organizations such as the American College of Healthcare Executives, The Leadership Institute, the National Association of Medical Staff Services, CTI Physician Leadership Institute, the Credentialing Resource Center, and others.

For more information or to schedule an advisory service, contact The Governance Institute at info@governanceinstitute.com or call (877) 712-8778. A detailed list of our advisory services can also be found on our Web site at www.governanceinstitute.com/AdvisoryServices.

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Upcoming Events

Leadership Conference
The Ritz-Carlton, Naples
Naples, Florida
January 14–17, 2018

Leadership Conference
Fort Lauderdale Marriott
Harbor Beach Resort & Spa
Fort Lauderdale, Florida
February 18–21, 2018

Leadership Conference
Fairmont Scottsdale Princess
Scottsdale, Arizona
March 11–14, 2018

Click here to view the complete programs and register for these and other conferences.

Upcoming Webinar: Healthcare Forecast 2018: Trends and Implications "In the Boardroom"

February 8, 2018
2:00–3:00 p.m. Eastern Time/11:00 a.m.–12:00 p.m. Pacific Time

This Webinar will discuss major areas impacting hospitals and healthcare systems in 2018 and beyond. It will identify actions boards should consider in collaboration with management to address issues and trends. As a result, attendees will be able to prioritize their organization's strategies by importance given anticipated trends.

Register for this Webinar.

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New Publications and Resources

Governance Notes (Governance Support Newsletter, December 2017)

One Jefferson: Accelerating Reinvention of Academic Medicine through Growth, Integration, and Innovation (Case Study, December 2017)

The Curious Case of the Healthcare Consumer (Webinar, December 2017)

The Governance Evolution: Meeting New Industry Demands (2017 Biennial Survey of Hospitals and Healthcare Systems)

BoardRoom Press: Volume 28, No. 6 (*BoardRoom Press*, December 2017)

ProMedica Tackles Public Health: Addressing Social Determinants as a Core Responsibility (Case Study Video, November 2017)

To see more Governance Institute resources and publications, visit our Web site.

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