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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.

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Changing Governance Roles in an Era of Value

By Rulon F. Stacey, Ph.D., FACHE

The past decade has seen the most dramatic growth in mergers and acquisitions (M&As) in the history of the healthcare industry.¹ The purpose of this M&A activity is to address the industry change to “value.”² Specifically, as healthcare organizations have searched for ways to simultaneously increase quality and decrease cost they have found that true value is created by identifying the best way to do something, and then making sure that everyone does it the best way. As we would expect, the benefit of driving variation out of our healthcare organization and then out of the industry is magnified in direct proportion to the size of the organization. Given the increased value that is created through an M&A strategy, most healthcare organizations in the country have sought to take advantage of consolidating in some fashion.

During the first several years of the industry push to consolidate, the M&A activity was vertical in nature—meaning that hospitals of different sizes were finding ways to integrate. Large hospitals or health systems would acquire or merge with smaller ones to form a still larger health system. However, in 2016 that is much less the case. The change in M&A today is more in the pursuit of horizontal

integration than ever before. Instead of hospitals alone coming together to form large health systems, these healthcare organizations are merging with other companies that before now were in entirely different industries. Today, it is not uncommon to see an integrated delivery network (IDN) that includes hospitals, physician practices, long-term care facilities, an insurance company, a pharmaceutical company, and much more.

The impact of these changes on governance is significant, and a well-informed board will take time to understand the changes that will now drive their organization. The change is centered on the fact that before the industry push toward value, each entity would have its own board, dedicated to advancing the benefit of that individual organization (see **Exhibit 1** on the following page). While governance issues surrounding such vertical integration were significant, such boards of the vertical industry organizations had the luxury of focusing on just that one business. However, that luxury is now gone as healthcare organizations work to provide care across the entire healthcare continuum.

As the M&A activity continues to grow, now horizontally more than vertically, the pressure on boards grows proportionally. Today an effective IDN board must understand that it has multiple responsibilities and accordingly, must consider much more than before. For an IDN board, the focus often changes to one board being the fiduciary of one organization with multiple different divisions—all of which used to be individual organizations (see **Exhibit 2** on the following page).

¹ Bill Woodson, “Behind Healthcare’s M&A Boom,” *Fortune Magazine*, August 8, 2015.

² During the 1990s the industry pushed to decrease cost, but then quality suffered. In the next decade, the industry pushed to focus on quality, but then healthcare costs were out of control and led to the passage of the Affordable Care Act (ACA). As an industry, we now understand that we need to push for both decreased cost and increased quality simultaneously. The result of that push is the “value” to the patient.

Exhibit 1: Pre-Value Governance Structure



Exhibit 2: Integrated Delivery Network Board



Board Considerations

As a board moves toward value in an effort to better represent the needs of its patients, I suggest four topics to consider in detail to help this transition from volume to value.

Align Vision

Nothing is more important to a fiduciary board than to ensure that every employee and every stakeholder has an aligned vision of what the new IDN needs to become. To create that vision the IDN board needs to go through a detailed process to decide what the organization needs to be for a successful future. Once you have a strong vision, the board needs to ensure that every person within the new organization understands the vision and their role in achieving the vision.

If you are part of an IDN that has an insurance division, a hospital division, and a physician division, then you have three divisions that will go in different directions without the vision to unite. To correct this, it becomes mandatory for the board to identify what it is that the new company does, and make certain that all employees are fixated on bringing that vision to reality.

In an era of value, the real goal is to keep people healthy rather than to fix them when they are sick. Many hospitals and health systems have spent a generation just thinking about fixing people and many insurance companies have spent a generation working to keep the costs of fixing people to a minimum. But today, hospitals, physicians, insurance executives, and everyone in an IDN has the unified goal of keeping people in your network healthy. An effective board will ensure that such a vision is set, and measures are taken to ensure that vision is instilled in each employee in every division.

Board Succession Planning

There has never been a more important time for boards to systematically plan who needs to be on their board. Every board should go through a process to plan in detail the backgrounds and skills that they need on their board in order for their board to be successful. Then, the successful board needs to go through an equally detailed process to ensure that they find the right people to serve. To better make this happen, keep in mind:

- The board members that were needed for a hospital company may be totally different than the board members needed for a true IDN.

- Boards may need to look in a different community, state, or even country to find the right person with the right background to serve on their board.
- As the intensity and commitment of serving on a board increases, more and more non-profit boards are paying their board members for their time. It is increasingly appropriate for non-profit boards to review whether or not their board members should be paid. Your compensation consultant can help you with that question.

Board Education

The continuing effort by a board to stay engaged in education is more important today than ever before. Boards that have an active and vibrant continuing education policy for their board members will *always* do better than those that don't. The best boards will have a good mixture of a budget for individual board members to go to educational events at least annually, and an opportunity for the board to receive training as a group in their annual strategy retreat (of course, this implies that effective boards always have an annual strategy retreat).

I once attended a board meeting where one of the board leaders suggested that continuing education for a board was "just a boondoggle" and that there was no place for such "outlandish" trips on the organization's expense. But to think that boards of a successful IDN could stay engaged and up to date on industry changes without significant education is impossible. Good boards provide for and *require* continuing education.

Board Member Evaluation

The change to value in the industry requires new and innovative designs for new and innovative companies. To accomplish this task requires more out of board members than ever before. Board members will need training, commitment to attend board meetings and committee meetings, ability to handle public scrutiny, and much more. Some members of the board simply will not be cut out for this. So, in a world of value created by an IDN hoping to address the needs of population health, ineffective board members simply can't stay. Of course, that statement suggests that:

- There is a process to identify ineffective board members.
- There is a process to improve their performance or remove them from the board.

Just as a CEO needs a job description and an evaluation to know where he or she stands in the

organization, a board member needs the same. If a board does not have a process to individually evaluate and address deficiencies in performance, attendance, conduct, or capability then one needs to be developed. In a world of value, a board of directors can't be a social club. It has to be an effective organizational dynamic designed to lead the organization into a world of keeping people healthy as opposed to fixing them when they are sick.

Questions for the Board

To know if your board is meeting the needs of an organization moving toward value, you need but ask yourselves some pointed questions:

1. Do we have a process to identify the specific talents we need on our board?

2. Do we have a process to find and incentivize the right people to join our board?
3. Do we have specific job descriptions to ensure that each board member understands their role?
4. Do we have a sufficient method of ensuring that our board members stay educated about the industry and the specific needs of their positions?
5. Do we have a meaningful process to identify poor performers on the board?
6. Do we have a meaningful process to improve the performance of a poor performer?
7. Do we have a meaningful process to remove a poor performer who can't or won't improve?

If the answer to any of these questions is "no," then this may be a good topic of discussion at an upcoming board meeting.

The Governance Institute thanks Rulon F. Stacey, Ph.D., FACHE, Chair, Board of Overseers, Malcolm Baldrige National Quality Award, and Faculty Member, Masters of Health Administration Program, University of Minnesota, for contributing this article. He can be reached at Rulon@RulonStacey.com.



Survey Finds Critical Gaps in Progress Toward Population Health and Value-Based Models of Care

By Rita E. Numerof, Ph.D., and Michael N. Abrams, M.A., Numerof & Associates, Inc.

U.S. healthcare organizations are entering a period of greater change and disruption than any industry this side of taxicabs. The traditional players across all sectors (payers, providers, and manufacturers) are wrestling simultaneously with not just the question of how to change, but how fast.

Population health has gained traction as an important solution to addressing the issues inherent in the current system. However, a national study released in January by Numerof & Associates, a healthcare strategy consultancy, finds most healthcare providers continue to lag in actually *implementing* population health management, despite broad agreement that it will be important for future market success.

Numerof conducted the study in collaboration with the Jefferson College of Population Health. The summary report synthesizes survey responses from more than 300 executives and interviews with over 100 key decision makers across U.S. healthcare

delivery organizations.³ It provides the first in-depth, national look at the pace of transition from fee-for-service to models based on fixed payments linked to outcomes.

Key Findings

Everyone is thinking about population health. More than half of respondents (54 percent) rated population health as "critically important" to the future success of their organization and nearly all (97 percent) said it was more than "somewhat important."

However, most organizations are still just testing the waters. The majority of respondents who reported their organization is in at least one agreement with a payer that includes some form of upside gain or downside risk said that 20 percent or less of their organization's revenues flow through

³ *The State of Population Health: Numerof Survey Report*, January 2016 (available at <http://nai-consulting.com/numerof-state-of-population-health-survey>).

them. That leaves population health still in the realm of “business model experimentation.”

In an interview, the head of strategy at a large health system said, “We’re not there yet and we continue to face hurdles, but we’re working on it and will hopefully continue to make progress.” Today, very little of this system’s business is double-sided risk—“considerably less than 10 percent.” About 30 percent of total payment is tied to what they describe as “value.”

Considering the expected pace of change, the gap for many looms large. Among respondents reporting agreements with upside gain and/or downside risk, fewer than one in five said that they account for over 40 percent of revenue. This leaves a large execution gap, as nearly half of these respondents expect such agreements to account for over 40 percent of revenue within two years. Moreover, two-thirds of respondents rated their organization’s ability to manage variation in cost at the physician level as “average” or worse.

Payers are not consistently willing to partner. The legacy of mutual distrust and antagonism between providers and payers is slowing the transition to new business models. According to the COO of a major healthcare network, “Most payers we’ve engaged are not enthusiastic to partner with us on population health.” Only 58 percent of respondents characterized payers as more than “somewhat willing” to enter into cost/quality risk agreements.

The lessons from the 1990s live on. During the interviews, some talked about “bad memories” from previous healthcare reform efforts, and how these are influencing organizational receptivity to change. According to a vice president at a nationally recognized academic medical center, “We’re in the early stages of our population health efforts...However, we’re hesitant given previous experiences with capitation. In the 1990s, we aggressively pursued capitated payments, resulting in about \$200 million in losses.”

There are clear regional variations. Across the U.S., there are regional differences in the progress providers have made toward population health management. In general, this tends to align with the local or regional political/regulatory climate. Most notably, providers in New England are typically much further along than those in other parts of the country. Compared to those in the South, more respondents in New England reported that their organizations were in an agreement with the

potential for both upside gain and downside risk (69 percent vs. 43 percent).

Nationally, if providers are moving ahead, it’s mission-driven. The economic incentives for change are tepid. In large part, progress comes down to clinicians and employees recognizing “it’s the right thing to do.” Those respondents describing their mission statement or culture as the primary driver for their population health efforts report a significantly larger proportion of revenues under alternative payment models, in contrast to organizations whose primary motivation is financial or market based. Nearly twice as many “mission/culture” respondents reported having at least 40 percent of their revenues flowing through alternative payment models vs. others (28 percent vs. 16 percent).

Competing “population health” definitions hold up progress. Organizations provided various definitions of population health. Some defined it more narrowly (e.g., primarily focusing on wellness), while others saw it as a much broader initiative that includes full accountability for patient populations in a given community. Several reported multiple definitions being used internally, resulting in heightened confusion across the organization.

Talking about her recent struggles with achieving alignment, a senior vice president of a large hospital system said, “There are many different definitions of population health in the organization, and this is part of the challenge.”

Overall, how population health is internally defined has real implications for the pace at which the organization can move forward on its value-based initiatives as well as what specific initiatives are prioritized over others. Not surprisingly, organizations with a clear and focused approach to population health management were generally much further along than those without clarity and focus.

Methodology

During the first phase of this work (i.e., the “qualitative phase”), which occurred primarily between January and June 2015, Numerof conducted 104 in-depth interviews with executives and key decision makers across healthcare delivery organizations nationwide. Special consideration was given to include a variety of viewpoints based on such factors as region, organization type, organization size, and individual role. Interviews were conducted via telephone using a structured interview protocol that explored areas including the

definition of population health, state of progress, roadblocks toward implementation, and rationale for pursuit.

In the second phase of this work (i.e., the “quantitative phase”), which was conducted between June and July 2015, we developed an online survey to validate and further explore key insights gathered during the qualitative phase. Approximately 8,750 individuals were invited to participate in the online survey. The target audience for the survey was defined as individuals working in U.S. provider organizations, including healthcare systems, hospitals, academic medical centers, and physician groups at the executive or vice president level.

We received 315 completed surveys, corresponding to a response rate of 3.6 percent of individuals and 11 percent of institutions. Respondents included C-suite executives across the entire U.S. in urban, suburban, and rural areas. They represented standalone facilities, small systems, and IDNs; for-profit and not-for-profit institutions; and academic and community facilities.

Going forward, Numerof and Jefferson have committed to conducting the quantitative survey on an annual basis in order to track the evolution of population health management over time.

Stay tuned for a special section article in the June *BoardRoom Press* that will go more in depth on the survey results and what boards can do now to move forward more quickly on implementation.

The Governance Institute thanks Rita E. Numerof, Ph.D., President, and Michael N. Abrams, M.A., Managing Partner, at Numerof & Associates, Inc. for contributing this article. They can be reached at rnumerof@nai-consulting.com and mabrams@nai-consulting.com.



Trust Your CEO—But Not Blindly

By Peter J. Betts, FACHE, Peter J. Betts & Associates, Inc.

Just imagine the board’s surprise when their new CEO told them the hospital was not doing as well as the financials reflected because losses were moved into the corporation housing the employed physicians. The financials for the physician entity were not shared with the board, nor were they included in the CEO-selected auditor’s report. The well-regarded CEO, who led the organization for 28 years, did not have a fiduciary relationship with the board because both sides of the relationship need to have faith and trust in each other. This board trusted their CEO too much and, while this is the exception, it illustrates the point that boards should know what they do not know.

The Board’s Responsibility

One of the board’s most important responsibilities is to select, guide, and evaluate the chief executive officer. The board’s proper role is one of setting policy, planning, establishing goals, and intervening when corrective action is indicated. The day-to-day operations of the enterprise are delegated to the CEO. This means the board must have a great deal of faith and trust in their chief executive—but it must not be blind.

Boards rely upon external financial auditors, which they, and not management, need to engage and for whom they define the scope of the audit to render an opinion as to whether financial statements are presented in accordance with pre-established criteria. While finances are very important, the board relies on internal management reports on all of the myriad activities and programs that produce the bottom line. Knowing where an organization is relative to quality, satisfaction, governance, employee and medical staff relations, market position, and information systems, among others, is mission critical. But these issues somehow fade in importance relative to the financial statements. An audit may find the hospital or health system is losing money but does not delve into critical non-financial operational aspects that drive the financial results. Unfortunately, most boards do not have a qualified and objective audit (assessment) of the balance of the organization. How well are we doing producing the product for which we exist (patient care); how good are our plans to continue to improve and grow; and do we have the right resources in place and are they properly managed to reach our goals? An assessment is time and effort well spent if it is not adversarial, done in the spirit of full reporting, to identify opportunities and, in the spirit of independent governance and

knowledge-building inquiry, not as an “I gotcha” with management.

A board should not believe it is fulfilling its responsibility to the organization and the community without conducting a periodic assessment of all the critical success factors. Assessing financials is relatively easy (do the figures add up, did we meet budget) and numerical goals are black or white. Measuring the other key success factors is challenging but eminently doable.

As an individual who has spent over 30 years in the CEO’s chair, I can assure you that it is impossible for the CEO to know everything that is happening in an organization that is considered to be the world’s most complex and difficult to manage. Having faith, confidence, and a fiduciary relationship with your CEO is key, but it is both prudent and a good business practice to independently assess mission-critical operational components, as there may well be significant issues about which your CEO is unaware and, therefore, unable to report upon. A strong CEO with a collegial relationship with the board should welcome such an assessment as it will generally lead to a stronger organization. The board needs to be a role model to management and the medical staff and undergo an assessment as well because its annual self-evaluation is not truly objective. Even well-run hospitals and health systems can always improve.

What Is an Assessment?

An assessment is a future-oriented, systematic, and independent evaluation by a qualified expert from outside the hospital or health system of key organizational activities, with a report of the results and recommendations to the board. This effort includes an assessment of board and medical staff effectiveness in addition to management. The assessment needs to be completed with the full cooperation of the board, medical staff, and management, with the understanding that the objective is to identify opportunities for improvement and not to point fingers.

The advantages of an assessment include:

- The ability to make the organization more profitable, efficient, and effective in the future with improved internal/external relationships, quality/safety, and patient/employee/physician satisfaction.
- Making leadership aware of presently unidentified problems, which may present significant present or future risks.

- To build trust and confidence by validating the effectiveness and efficacy of present operations and plans for the future.
- To provide the hospital or health system with a “second opinion” from qualified and objective outsiders.
- A well-developed action plan drawing on the findings, if properly implemented and managed, will help to ensure the organization is a high performer.
- The assessment report and action plan can be the basis for improving communication and trust between the board, management, and the medical staff.

The disadvantages of an assessment include:

- Depending upon how detailed the assessment will be, it can be time-consuming and expensive.
- It can be disruptive, taking time and resources away from day-to-day operations, and be perceived as threatening to those in decision- or policy-making positions.
- An assessment may result in changes to the organization, and change is generally difficult.

When Should an Assessment Be Done?

Like a strategic plan, an assessment should be undertaken every few years as the results may well impact budgets and plans. When the CEO departs, especially if asked to leave or long tenured, is a particularly good time for a number of reasons, including:

- To help the board ensure the mission and vision of the hospital or health system are on point and the position description and criteria for the replacement CEO are tailored to today’s needs.
- All too often, a new CEO reports findings to the board that are surprising. It is far better for the board to demonstrate its leadership by knowing of any critical issues before recruiting a new chief executive so this knowledge can be utilized to help ensure the candidate of choice has the needed skills.
- An assessment will produce a plan to maximize strengths and address weaknesses. Implementing needed corrective action will help to stabilize the organization, better position it for success, and make it more attractive to strong candidates. Accomplishing any needed “heavy lifting,” such as adjusting staffing levels, negotiating sensitive physician and union contracts, or closing a program prior to commencing recruitment is important, as no new CEO wants to join an organization and be

faced with essential but politically unpopular decisions.

- An assessment will produce a series of goals the board will want its new CEO to achieve during their first 12 to 18 months.
- An assessment and a financial audit prior to the arrival of a new CEO will document what happened under the prior CEO's watch. As it can take some months for problems to surface, the new CEO may be held responsible for something that occurred before they arrived.
- Succession planning does not guarantee an internal candidate will be ready to meet today's challenges. Knowing what those challenges are is critical.
- Selecting a professional interim CEO external to the organization, who is qualified to lead an assessment, will allow time to take stock, implement needed decisions, plan, and complete a search for a new chief executive. Doing what has always been done by recycling the old job description, goals, skills, and experience is seldom the best plan.

Boards Need to Have a Firm Grip to Build Trust

Boards depend upon their CEO for leadership, but it is their ultimate responsibility to describe the path going forward. Knowing what needs to be done, establishing goals, holding those responsible accountable, and providing the appropriate support and rewards are among the board's greatest responsibilities. A properly done assessment will ensure the board has a firm grip on the organization by being fully informed, focused on short- and long-term goals, and leading the implementation of an action plan to achieve its vision for the organization. Effective communication of an agreed-upon plan with measurable objectives, definite due dates, and clearly assigned responsibility is the foundation of building a trusting relationship. Building trust also recognizes that management cannot do it alone. Confidence is built by consistently meeting the action plan goals and deadlines. Develop the plan, stick to it, and make changes only if you must, but by mutual agreement.

The Governance Institute thanks Peter J. Betts, LFACHE, President, Peter J. Betts & Associates, Inc., for contributing this article. He can be reached at peter@peterjbetts.com.



Upcoming Events



[Leadership Conference](#)

Fairmont Scottsdale Princess
Scottsdale, Arizona
April 17–20, 2016



[Governance Support Forum](#)

Marriott Marquis San Diego Marina
San Diego, California
August 7–9, 2016



[Leadership Conference](#)

The Broadmoor
Colorado Springs, Colorado
September 11–14, 2016

[Click here](#) to view the complete programs and register for these and other conferences.

Upcoming Webinar

Overcoming the Financial Risks of Bundled Hospital Payments

Tuesday, April 5, 2016

2:00–3:00 p.m. Eastern/11:00 a.m.–12:00 p.m. Pacific

[Click here to register.](#)

On April 1, 2016 the federal government will launch an unprecedented expansion of board responsibilities by mandating that hospitals take additional financial risks for Medicare patients' total hip and knee replacement costs. Similar voluntary CMS risk-models have been in place for a few years, but the Comprehensive Care Joint Replacement (CJR) bundle is now mandatory for over 800 hospitals.

This Webinar will describe both risks and great opportunities for organizations that are prepared to increase efficiencies by collaborating with their physicians. It will explain how CJR and other CMS bundle payment initiatives will reward healthcare organizations and their medical staffs for delivering high-quality, cost-efficient outcomes, the net saving of which can then be legally shared with physicians. The program will also discuss ways in which hospitals and physicians can align their incentives and share financial opportunities, and the role of the board in developing strategic goals and holding management accountable for success in bundled payments.

New Publications and Resources

[Evolving Roles and Responsibilities of Boards in Health Systems](#) (Webinar, March 2016)

Designing Governance for the Future: The New St. Luke's Health System (Case Study, February 2016)

[Click here](#) to view the **written** case study.

[Click here](#) to view the case study **video**.

[Endeavor to Succeed: Building and Leading the Next Healthcare Generation: Insights from the 2015 Chairperson, CEO, & Physician Leader Conference](#) (Conference Proceedings, February 2016)

[Board Committees, 2nd Edition](#) (*Elements of Governance*®, February 2016)

[BoardRoom Press, Volume 27, No. 1](#) (BoardRoom Press, February 2016)

[Resource Catalog](#) (Winter/Spring 2016)

To see more Governance Institute resources and publications, visit our [Web site](#).