E-Briefings
Volume 15, No. 4 • July 2018
A SERVICE OF nrc HEALTH

This newsletter is designed to inform you about new research and expert opinions in the area of hospital and health system governance.

In This Issue:

The Next Title in Your C-Suite?
Understanding the Emergence of the Chief Consumer Officer

By Giana Rada, Brian Wynne, and Ryan Donohue, NRC Health

Key Board Takeaways

- Employ an executive who is "consumer obsessed" and will ensure the customer's expectation is represented in every board discussion.
- Close the gap between teams responsible for acquisition, satisfaction, retention, and advocacy.
- Create a consumer committee of the board; emphasize to board members that they are consumers outside healthcare—what are *their* consumer expectations and how does the health system need to change to meet those?
- Shift at least 50 percent of the organization's strategy to focus on consumerism within two years.
- Ask management/consumer committee to keep the board informed on the holistic story of your organization's ability to meet customer expectations, deliver the emotional and functional expected outcomes, and earn consumers' trust and loyalty.
- Ensure board member succession plans prioritize individuals who see the importance of informing strategy with customer expectations.
- Ask the right questions:
  - Can we be more intelligent in our consumer engagement operations (i.e., driving volume to care settings already likely to yield good experiences)?
  - Are we developing an organizational culture that prioritizes the voice of the customer proactively as opposed to retrospectively?
  - Do we have a strategy to influence decisions and intervene with the right people at the right time in the right place?

"The system is broken, and better is possible" was Dr. Atul Gawande's sentiment after accepting the CEO position for Amazon, Berkshire Hathaway, and JPMorgan Chase's healthcare venture. This new venture will focus on cutting healthcare costs and reconstructing the delivery of care for employees and "potentially, all Americans."[1] It is no secret that these companies operate in a way in which many hospitals and health systems view as futuristic—notions of acquisition through behavior-based segmentation, and a comprehensive, longitudinal view of their consumer's decision-making pathways, satisfiers, and drivers of advocacy for their brands. This new healthcare entrant consistently looks to one group for innovation and strategic direction: their customers.

1 Jeff Pruitt, "Amazon Knows Something Many Organizations Don't: Its Customers," *Inc.*, September 28, 2017; "Amazon, Berkshire Hathaway, and JPMorgan Chase Appoint Dr. Atul Gawande as Chief Executive Officer of Their Newly-Formed Company to Address U.S. Employee Healthcare," J.P. Morgan, June 20, 2018.

To keep that inherent focus, Amazon has staffed its executive team with leaders who are customer *obsessed*, ensuring that every decision has an outside-in focus. Companies like Amazon have long cared about customer loyalty and it stands to reason that this focus would extend to their new healthcare venture. Comparatively, a 2017 study revealed that the vast majority of health systems committed at least a quarter of their strategic plan to a consumerism component and that 75 percent expect more than half of their strategic plan to focus on consumerism in the next three to five years.[2] It is evident that healthcare leaders believe a customer-centric service and care delivery redesign is a key aspect to remaining competitive, but a very crucial question remains: Will our customers wait for three to five years before we begin basing the majority of our strategic decisions on customer expectations or will they take their loyalty elsewhere?

Amazon's promises to leave substantial marks on our industry certainly up the ante for hospitals and health systems to not just be consumer centric but consumer obsessed. At the foundation, the way a customer currently experiences the healthcare industry is not often represented in how we digest insights, organize oversight responsibility, communicate and share information at all levels. As healthcare organizations grow, the various teams responsible for engaging with, influencing, and designing for the customer must ensure cohesion in order to truly piece together what customers holistically expect from a relationship with the brand. Many hospitals and health systems would openly agree that internal silos exist, whether or not the detriments of these silos on their ability to see customer's expectation and outcomes holistically have been realized. This article will provide considerations to the following question: **Could your organization benefit from a Chief Consumer Officer?**

Understanding and Responding to Today's Consumer

Most hospitals and health systems are well aware that consumerism continues to be one of the largest stressors to their organizations due to consumers' increased purchasing power as a result of shouldering more out-of-pocket costs each year. In a recent study, the Kaiser Foundation found that the average deductible for consumers with employer coverage rose to $1,505 in 2017, up 396.7 percent since 2006, and that 24 percent of consumers enrolled in employer plans pay over $1,000 in out-of-pocket costs each year.[3] Most of this increase is due to employers offering high-deductible health plans, meant to shift more of the cost to consumers. This enacts discernment of care like seeking alternative care options, delaying care, or opting to go at it alone—which too has had impacts for which healthcare organizations must compensate.

Shifting burden of cost onto consumers has exposed consumers to the price of healthcare, naturally leading to more discernment. In 2014, total annual health spending was $659 less per person in high-deductible health plans than in those in conventional plans, and use of inpatient hospital care and outpatient care was lower than those with conventional insurance—13 percent and 10 percent respectively.[4] As an industry we achieved more discernment, but at what cost? In 2014, what was largely unknown was if that reduction in use was for needless tests and procedures or deferment away from truly necessary care. A 2017 study conducted by a team of researchers at Indiana University–Purdue University Indianapolis found that high-deductible health plans were associated with a significant reduction in preventative care and a significant reduction in office visits. In summary, a reduction in both appropriate (needed) and inappropriate care.[5]

NRC Health's 2018 primary research shows that deferment rates for necessary (appropriate) care sit at 22.3 percent of the total population with the leading reasons for deferment being "unable to pay" (27 percent), "willing to manage on my own for now" (27 percent), and "concerned about out-of-pocket expenses" (20 percent).[6] The researchers at Purdue uncovered that a significant amount of consumers with high-deductible health plans lacked

Will our customers wait for three to five years before we begin basing the majority of our strategic decisions on customer expectations or will they take their loyalty elsewhere?

2 Maria Castellucci, "The Consumer is Wielding Greater Power, but Hospitals Aren't Ready, CEOs Say," *Modern Healthcare*, December 9, 2017.

3 *2017 Employer Health Benefits Survey*, Kaiser Family Foundation, September 19, 2017.

4 *Ibid.*

5 Jeff Lagasse, "High-Deductible Health Plans Curb Costs, Usage, Research Shows," *Healthcare Finance*, October 5, 2017.

6 NRC Health Market Insights Consumer Research Study, 2018.

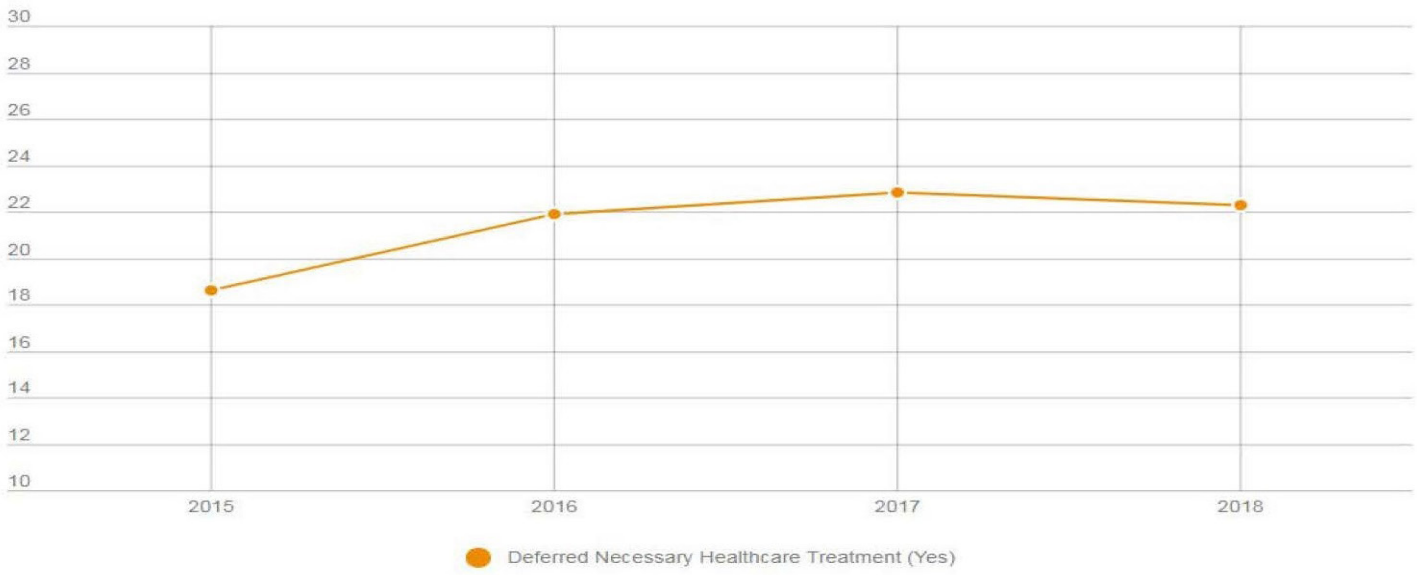
education that out-of-pocket costs would not be incurred when utilizing preventative care.[7] Although shifting the burden of cost to the consumer is in fact lowering costs in healthcare by way of less utilization upon initial consideration, unhealthier populations that end up in costly sites of care (i.e., emergency departments) is an issue of concern because of this deferment. Access to information outlining consumerism decisions, opportunities for education, and the long-term effects it has to the organization's economic goals can only be achieved through getting much closer to your customers, and must have considerable attention backed by appropriate strategy to remediate.

On the other hand, hospitals and health systems face a separate and equally critical opportunity to influence the bottom line with those who *do* choose to seek care, especially the commercially insured consumer segment. Healthcare organizations are putting extraordinary effort towards influencing the decision of customer groups, particularly privately paying customers, but other risks surface—will the experience deliver on the brand promise, and is their expectation understood? Too many times, the silos that exist within an organization's departments and their responsibility for separate parts of the customer's engagement with the brand cause massive inefficiencies in data accessibility, ability to glean intelligent and comprehensive insight, and result in decisions made based on incomplete assessment.

Consider that today, those responsible for driving new volume into the organization are oftentimes doing so without knowledge of the type of experience they are driving new patient volume into, because of operational issues like easy access to information sources and department responsibility existing in isolation. The systems that are placing impressive effort towards driving acquisition of private paying consumers still experience a considerable gap between the acquisition and experience stages. What happens when those efforts of driving volume fall to care settings that are not adequately prepared to meet the customer expectation? Silos and lack of a singular managing party lead to a lack of visibility of customers' comprehensive expectations and difficulty mapping patient journeys; this results in wildly missed expectations and patients seeking care elsewhere. A holistic patient journey identifies obvious ways to ensure loyalty with populations the health system desperately needs to earn as loyal customers. Similarly, those engaging with customers during a care experience do not have visibility to the impact their actions have on the overarching brand reputation that drives reutilization and referrals. Meaningful work comes as a result of seeing the larger impact your actions have. Without a cohesive story about a

7 Lagasse, 2017.

Exhibit 1: Consumer Reported Healthcare Deferment Rate



Q: Have you or anyone in your household delayed any healthcare treatment in the last six months?
Source: NRC Health's Market Insights study, 2015–2018, 2018 n size YTD 148,931 consumers.

Exhibit 2: Customer Confidence in Healthcare

Source: NRC Health's Market Insights study, December 2017.

customer's journey, that impact is difficult to see.

Customers will often give healthcare providers one chance to meet expectations while functionally delivering a good outcome. The patient population at large currently has little confidence in the industry's ability to do so (see **Exhibit 2**).

The Role (and Opportunity) of the Chief Consumer Officer

As organizations shift to meet consumer demand, many will find it easy to become singularly focused on one of two things: creating individualized experiences or optimizing the brand promise. It is rare that the two evolve in tandem. Healthcare organizations should consider a role that unifies their customer acquisition, experience, and retention efforts with singular oversight. We believe the industry will see an influx in the role of a Chief Consumer Officer or even a "consumerism" subcommittee formed by the board.

Several organizations have recognized this opportunity. Premier Health (OH), Centra Health (VA), and Peidmont Health (GA) have operationalized their consumer-centric strategy by creating a Chief Consumer Officer role and bringing marketing teams and patient experience teams under one department responsible for the holistic customer experience. What risk remains for organizations that do not organize a role in charge of marrying action, data, and go-forward strategy with regards to their consumer-centric organizational strategy?

Lack of focus could continue to erode customer trust, have a negative impact on revenue, further build up internal walls between departments against all efforts to break them down, and have an impact on staff engagement and satisfaction. Without accountability of an executive leader driving systemic information, change, and improvement it is probable that the organization will be unable to achieve centricity of performance insight, centricity of customer feedback, and cohesive outbound engagement efforts to staff and the community.

Hospitals and health systems certainly have the competitive edge against new entrants due to long-standing reputations of service to the community, and the competitive edge can be accelerated through pointed focus of becoming customer obsessed. This dedicated attention to the impact of customer behavior will ensure that the holistic impact of consumerism is accurately represented in the boardroom and strategic plan creation.

The Governance Institute thanks Giana Rada, Solutions Architect, Brian Wynne, VP and General Manager, and Ryan Donohue, Corporate Director of Program Development, NRC Health, for contributing this article. They can be reached at grada@nrchealth.com, bwynne@nrchealth.com, and rdonohue@nrchealth.com.

Employed and Independent Physicians in Integrated Health Systems: The Same or Different?

By Kevin J. Egan, J.D., and Daniel K. Zismer, Ph.D., Castling Partners, LLC

A common question from leadership of health systems pursuing integration strategies with physicians is whether or not employed physicians and independent physicians are the same. An often-heard follow-up inquiry is, "If they are different, what does that mean?"

Let us begin by considering a brief case vignette derived from practical experience. Consider these facts: a physician employed by a health system in its early stages of integration becomes a behavior problem in a clinic setting. Over time, the problem rises to the level of board awareness. During board discussion, the chair asks, "Why isn't the medical executive committee dealing with this issue?" The board is surprised to learn that a problem of this nature is not always the job of the medical executive committee.

While, at times, it is still the duty of the formal hospital medical staff structure to address the practice and behavioral issues of employed physicians, much of the time, the health system (as the employer) is now the first point of responsibility.

Answers to the following questions provide a basis for expanding board understanding of these issues:

1. **Integration of physicians into systems continues; what does this mean for the board?** The world of healthcare continues to march to the beat of integration, with physician integration into health systems continuing at a rapid pace. By all measure, this integration, often driven by practice acquisitions and the direct employment of new physicians, will only accelerate. Accordingly, board members must recognize these changes and view hospital medical staffs in a different light.
2. **What does the term "hospital medical staff" mean today? Are employed physicians members of the medical staff?** Leadership needs to understand what the concept of a medical staff encompasses in a conventional and historical sense, while recognizing that hospital medical staffs are changing. Employed physicians are indeed full members of the hospital medical staff, but employed physicians are fundamentally different from independent physicians because of the contractual link they possess with the hospital or system. Like the independent physicians of the past, the employed physician is attached to the system through hospital medical staff membership. However, an employed physician possesses an additional and often overriding set of important contractual obligations and rights not held by independent physicians.
3. **How should the hospital medical staff handle behavior problems of an employed physician?** Remember that an employed physician possesses a *contractual* link with the system as well as an attachment through hospital medical staff membership. For example, when a physician behavior problem emerges with

Key Board Takeaways

As boards contemplate the difference between employed and independent physicians at their organizations, they should keep the following in mind:

1. Health systems will increasingly become the employer of choice for a large proportion of the "medical staff." Employed physicians are, simultaneously, system employees and members of the hospital medical staff. Independent physicians of the hospital medical staff are not system employees.
2. Employed physicians have roles, rights, responsibilities, accountabilities, and obligations that distinguish them from independent physicians affiliated with the hospital medical staff.
3. Boards or leadership of systems should almost never rely solely upon hospital medical staff structure to address performance issues of employed physicians. The system-employer has a direct interest and contractual duty to address any such behaviors itself.
4. Systems need not demonstrate "community need" to recruit and directly employ physicians. Community need justifications pertain solely to a system's extension of financial support to recruit independent physicians to supply provider capacity. extension of financial support to recruit independent physicians to supply provider capacity.

an independent physician, the only path to address and correct the problem is through the hospital medical staff and its disciplinarily process. With an employed physician, there is a contractual way to correct troublesome behavior or address quality concerns. Depending upon the terms of an employment agreement (which often vary greatly), leadership may choose to utilize the contractual option or the medical staff remedy to correct problems. It is vital that the impact of contractual language be considered carefully as employment contracts are prepared.

4. **Do independent members of the hospital medical staff possess the same rights as employed physicians?** Yes and no. Remember that independent hospital medical staff members possess the same procedural rights arising out of hospital medical staff membership, as do employed physicians. However, as mentioned above, the contractual link between employed physicians and the system or hospital will likely provide additional contractual rights and duties to the employed physician. For example, an independent physician with behavioral problems will only be subject to discipline by the medical staff itself. In contrast, an employed physician will likely also have a contractual duty to behave well and the board would likely utilize the contractual term to discipline or discharge the poorly behaving physician.
5. **Are independent physicians automatically parties to managed care contracts of the system?** Managed care contracting is complex, but it becomes even more challenging when distinctions between employed and independent physicians are considered. Employed physicians are bound contractually to participate in the managed care contracting arrangements of the parent system. This is not the case with independent physicians. Independent physicians will need to seek out desirable managed care linkages on their own or join independent practice associations (IPAs) for these purposes. Antitrust issues lurk in this context and must be carefully respected by independent physicians, who cannot remain independent and simultaneously share market and pricing data.
6. **Can independent physicians compete with the hospital?** Independent physicians can and do constantly compete with hospitals, systems, and employed physicians. Both compete for market share and programmatic dominance.
7. **Do independent physicians have the right to know the strategic plans of the employed physicians?** No. Independent physicians are indeed independent. Legally, they are separate economic actors who have separate business goals and strategies. The antitrust laws prohibit the sharing of data that inhibits competition in the marketplace. The antitrust laws are potentially criminal, so all must tread very carefully.
8. **Must the system consider the number of independent physicians in recruiting plans?** Yes. Most community health systems are tax-exempt entities and a series of IRS restraints operate in this setting. One of those rules requires that hospitals prepare medical staff development plans to justify the use of non-profit assets in recruiting independent physicians. The focus of these plans are the overall quality and size of the full hospital medical staff, both employed and independent practitioners. Note that recruitment assistance for independent physicians is keyed to the presence of established community need. In contrast, a system may directly employ as many physicians in various specialties as it desires; community need does not have to be established for direct employment.

When systems engage physicians directly as employees, related responsibilities, accountabilities, and obligations beyond the traditional physician/hospital medical staff affiliation come into existence. As such, the role of the hospital medical executive committee is confined to matters that apply to all members of the medical staff regardless of method of affiliation with the hospital.

Physician employment creates and defines another level of relationship between the parties, which, in many ways, is primary, as the physician is first an employee of the system and secondarily a member of a hospital medical staff. The system as employer is, by definition, involved in all matters relating to physician-employee conduct and performance even if those matters are covered by hospital medical staff bylaws. Moreover, the system-employer has full access to all facts pertaining to the employed physician's conduct even when medical staff confidentiality rules might otherwise restrict access.

Board members possess a fiduciary duty to recognize and understand this relationship and exercise due care in their oversight of physicians as employees of the organization that they govern.

9. **Must compensation be the same for both independent and employed physicians?** No. The salaries of employed physicians are set by the system and must be both commercially reasonable and equal to fair market value. A failure to do so in strict accordance with IRS guidelines exposes both board members and senior leadership to the risk of federal sanctions. The system or hospital does not set salary levels for independent physicians and, consequently, the income of the two groups may vary greatly. Note also that none of the regulatory restraints present when establishing the compensation of employed physicians are present regarding the income of independent physicians; they are free to earn as much as they can.
10. **Must the hospital treat all independent physicians equally when granting clinical privileges and providing access to clinical resources?** No. Systems and hospitals are independent businesses and have their own economic interests to consider when making these choices. For example, a hospital will often contract exclusively with a single group of physicians to provide services like anesthesia or those needed to operate the emergency department. By doing so, the hospital is making a business choice to exclude some independent physicians from performing these services or practicing in portions of the hospital. Boards should treat both groups of physicians equitably but need not do so equally.

The world of healthcare continues to march to the beat of integration, with physician integration into health systems continuing at a rapid pace.

11. **Must systems include independent physicians in any branding program or marketing effort?** There is no legal obligation to market independent and employed physicians in the same marketing program. In fact, to do so for independent physicians at no cost may raise regulatory flags. That having been said, there is a fine line separating prudent cooperation from outright exclusion. If independent physicians wish to participate in a system-wide branding project, it may be prudent to allow such an effort as long as the independent physicians pay their share of marketing costs.
12. **Does the medical executive committee of the hospital medical staff have anything to do with employed physicians?** Yes. The committee certainly does have a role in governing, credentialing, and disciplining employed physicians. However, a hospital medical executive committee may not play any role in the contractual or operational relationship between the employed physician and the employer. This may mean that a board finds itself dealing with an employed physician's difficulties, simply because he or she is an employed physician. Further, a board will want to be advised of any proceedings initiated against an employed physician by the hospital medical staff. A well-crafted employment agreement will contain provisions requiring that the employed physician advise the employer-system of the pendency of such an action.

Governing boards should consider convening a special session that includes senior leaders and legal counsel for purposes of establishing a common understanding and unified position as to how the organization's relationships with employed and independent physicians are, at the same time, both alike and different. Such a session should be organized and facilitated around the issues clarified in this article. Time spent delving into this point has increasingly proven to be well-spent as systems move forward with continuing efforts to integrate with physicians as employees and develop useful structures and business models designed to emphasize the employed physician.

The Governance Institute thanks Daniel K. Zismer, Ph.D., and Kevin J. Egan, J.D., Managing Directors and Co-Founders of Castling Partners, LLC, for contributing this article. Castling Partners, LLC is a premier healthcare consulting firm that often assists system boards in considering and working through challenging integration issues such as the ones described in this article. Dr. Zismer can be reached at daniel.zismer@castlingpartners.com or (612) 850-4545 and Mr. Egan at kevin.egan@castlingpartners.com or (218) 820-1525.

Op-Ed: A Case for Non-Profit Board Compensation

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

For decades, community hospitals and health systems have taken great pride in their local ownership and control, and rightfully so. The care delivery process is personal and intimate, and can be that much more meaningful when delivered by a community, to a community.

The volunteer governance structure that places community members on the boards of local hospitals is equally important. But in a decade of healthcare reform, consolidation, and potential clinician shortages, many of the opportunities that used to be available to community hospitals are falling by the wayside. Local control and community governance are often among the casualties.

The reason isn't very complicated. With reform comes a demand for hospitals and health systems to simultaneously drive out costs and improve quality. To do so, providers have had to find ways to identify and then standardize best practices throughout their organizations. This requires a discipline on the part of board members and executives that we have not previously seen in non-profit healthcare.

To be successful in today's healthcare environment, a community hospital board must know much more than simply their local community. Rather, they need to fully understand the transition to value-based reimbursement, rationalization of services, financing mechanisms, quality metrics, customer satisfaction processes, physician employment mechanisms, and more—all in a rapidly evolving landscape. Rarely does one community have all the resources needed to fully staff a hospital or health system board. Moreover, even if there are people in the community who can serve, it is often preferable to have some objective board members from outside the community who can make crucial care delivery decisions without concerns about community repercussions.

For example, employing physicians is an important part of many community health system strategies. Yet, as the percentage of employed physicians increases, finding objective physician participation on boards becomes more difficult. One way to address this issue is to find physicians from outside the market who can participate in the governance process. Otherwise, the board is left to excuse local physician board members during any discussion that may present a conflict of interest to them. Inviting physicians onto a board only to excuse them during crucial conversations is not optimal governance. Yet, the perspective that would be offered during the conversation is valuable. The answer is often found in a skill set offered by a person outside the market.

Other examples include the potential of finding someone who has a detailed understanding of healthcare payment strategies, mergers and acquisitions, or other skill sets either not present in most local communities or compromised because of local conflicts of interest.

For these and many other reasons, serving on a non-profit board is simply becoming more than can be expected of local community servants, and boards are increasingly forced to find specific talent to help them better meet the needs of the populations they serve. As a result, many non-profit boards across the country are paying members for their board service. According to The Governance Institute's biennial survey, compensating the board chair is slightly on the rise for non-profit hospitals and health systems, moving from about 10 percent in 2009 to 12 percent in 2017. In 2013, approximately 15 percent of respondents reported compensating other board members, up from 10

Key Board Takeaways

The complexity of today's healthcare industry requires expertise on non-profit hospital and health system boards. To acquire such expertise, boards should consider paying for the service of board members, and in return expecting performance to include:

1. Appropriate preparation for all meetings and physical attendance at board meetings
2. Mandatory annual education sessions at national conferences
3. Annual self-evaluation, to include benchmarking to industry standards and addressing areas of underperformance
4. Supporting development of the hospital or health system's direction and vision through the strategic planning process

percent in 2009.[1] Although in 2017 that number decreased to 11 percent.

However, for those organizations that are deciding to pay, there are return expectations as well. The following are performance criteria, which are generally expected of all board members, and for which boards may need to be willing to pay:

1. Attendance: Effective boards require their members to physically attend board and committee meetings. Calling in by phone is simply not a sufficient governance process. Though it may seem like an obvious requirement, it is common today for board members who may winter in other areas or simply be unavailable to call into board meetings and believe that they have met their obligation. However, individual preparation for board meetings and physical attendance at them is crucial to success, and central to member expectations.
2. Education: Board members should receive annual training at a professional conference, in addition to their board meeting assignments and education sessions. Such education is critical to understanding and adapting to the myriad forces pressing for change in the industry.
3. Evaluation: To develop future action plans, every board should go through an annual self-evaluation process, to include benchmarking their results to industry standards and identifying specific areas where they are under-performing. Each board should also have a meaningful discussion as to whether to take a similar approach with individual board member evaluations.
4. Strategic planning: The mission, vision, and values of any organization are the responsibility of the board to approve. They, along with the strategic plan, need to be an active output of an involved board. Each board member should fully understand and support the direction and vision.

In an industry that requires professional output from non-profit organizations, it is only reasonable to suggest that we have professional board members involved in the process.

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

The Governance Institute thanks Rulon Stacey, Ph.D., FACHE, Managing Director at Navigant, Immediate Past Chair of the Board of Overseers of the Malcolm Baldrige National Quality Award, and Chair of the International Hospital Federation CEO Circle, for contributing this article. He can be reached at rulon.stacey@navigant.com.