

BoardRoom Press

A Bimonthly Journal of News, Resources, and Events for Today's Healthcare Boards



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Board Practices for Innovation

**Elevating Community Health
through Philanthropy**

SPECIAL SECTION

**Reducing Risks and Achieving Goals:
The Critical Role of the
Post-Acute Care Network Structure**

**Digital Health and Data
as a Strategic Asset for
High-Performing Organizations**

ADVISORS' CORNER

**Getting True Value
from Board and
Leadership Retreats**

Finding Space



Summer is one of those in-between times when we try to slow it down and enjoy the outdoors, go on vacation, spend more time with family, and try to get away from (or reduce at least!) the chaos of daily to-dos and our jobs. This year may be harder than most to avoid that chaos and truly get away. I read the daily headlines and wait anxiously to hear if there will be any changes made, good or bad, to our healthcare legislation. I try to dig through the speculation and filter out the most important facts. It can be hard to focus on anything else.

Our Advisors' Corner article in this issue is about getting the most out of board and leadership retreats. When I think "retreat" I think about introspection and reflection, about getting to what really matters. Now is a great time for all of us to think about perhaps an individual retreat of a sort—to get away from the political uncertainty and refocus on our organizations' missions and visions for the future. While things are uncomfortable now, there are also many exciting things happening and opportunities for boards of hospitals and health systems to make meaningful changes focusing on patients' needs. This issue of *BoardRoom Press* has articles on innovation, philanthropy, post-acute care, and digital health. The Advisors' Corner brings it all together by reminding us of effective ways to funnel information into meaningful action. We hope these articles provide helpful takeaways and generate strategic ideas as many of you prepare for the busy fall season of retreats, reassessing missions and visions, and finalizing end-of-year goals.

Kathryn C. Peisert, *Managing Editor*

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Board Practices for Innovation: Balancing Prudence and Risk

BY JIM FINKELSTEIN AND SHEILA REPETA, FUTURESENSE, LLC

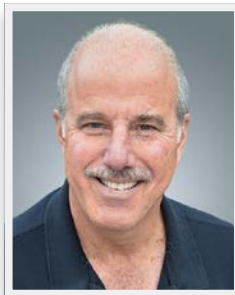
Innovation is a word that frequently instills fear into boards—innovation means new and new is synonymous with change and risk. Managing risk frequently tops the governance priority list, whereas discussions about innovation often go by the wayside. As healthcare organizations look to become sustainable and continue to grow in this highly volatile and complex environment, boards are confronted with new questions and challenges. To survive and thrive amongst these changes, healthcare governance needs to balance fiduciary responsibilities while increasing innovation.

Boards must not misconstrue innovation with randomized experimentation, which carries huge risk. There are, in fact, ways in which diligent governance can incorporate organizational advancement and improvements through board practices, organizational partnerships, and hospital executive leadership selection.

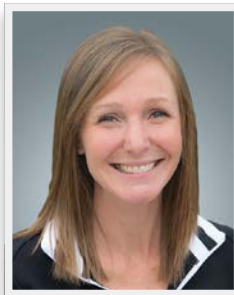
As boards seek to increase innovation, it is essential to look past the standard “professional qualifications” and find transformation-minded members who have demonstrated success in thinking outside the box to find risk-balanced opportunities, make highly bold decisions, and be willing to disrupt and pivot legacy business practices.

Board Practices

Historically, the composition of a strong hospital board included members with the primary skill sets of operational expertise and “number watching.” Diversity in board membership included someone with a finance background, a law background, and clinicians. Selection onto the board was based on experience and professional acumen. But as boards seek to increase innovation, it is essential to look past the standard “professional qualifications” and find transformation-minded members who have



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demonstrated success in thinking outside the box to find risk-balanced opportunities, make highly bold decisions, and be willing to disrupt and pivot legacy business practices.

The focus is not just about new member selection, but also continued development of an innovation mindset with current board members. As you assess your board’s innovation practices, ask if your board:

- Explores best or uniquely interesting practices from other organizations
- Participates in board education, development, and ideation opportunities that have a focus on innovation
- Takes time to learn about governance issues and challenges that have been overcome in other industries, and/or network with organizations in other industries, to integrate new opportunities and practices from outside healthcare

Lastly, current board members need to take an honest look in the mirror about their ability to not only think but execute innovatively. In annual self and aggregated board assessments, boards should ask open questions about their flexibility, openness, adaptivity, willingness to explore process improvements, and other competencies that indicate an innovative mindset.

Organizational Partnerships

The second area boards can look to improve innovation is through unique organizational partnerships. In her book, *Our Journey to Corporate Sanity*, Futurist Ayelet Baron explains that historically, leaders have sought safety and security at all cost, but businesses have taken this penchant for safety to such an extreme that it has come at the high cost of restriction.

Key Board Takeaways

As all healthcare boards seek to navigate the current volatile and uncertain environment, they are considering the changes they must make to survive and thrive. One such way is to integrate innovative practices, while also balancing risk and fiduciary responsibilities. For example:

- Improve board practices such as increasing diversity in experience, background, and vocation for board member selection, as well as provide intentional education and skill development on innovative practices.
- Incorporate innovation through finding unlikely partnerships.
- Widen the considerations for hospital executive leadership selection—select leaders who can demonstrate innovation through adaptability and metered creativity.

Her suggestion is to develop partnerships to help drive innovation and build economic viability.

Affiliations, acquisitions, alliances, mergers, and joint ventures are central talking points in critical conversations about hospital viability, growth, and sustainability. In a survey of senior financial executives in healthcare, Healthcare Financial Management Association (HFMA) reports 42 percent of hospitals have entered an affiliation or acquisition relationship in the last five years. Additionally, 34 percent of hospitals are considering an arrangement in the next 12 months. As healthcare delivery transforms in the U.S., hospitals need to partner with other organizations to be successful.¹ Historically some hospitals, such as academic medical centers, may be more familiar with this type of long-term partnership, but there is opportunity to expand further partnerships.

One such example is The Innovation Institute, which is owned by five non-profit health systems. Located in La Palma, California, it is a unique collaborative focused on creating a culture of innovation for these health systems. The Innovation Institute owns an incubator that is focused on solving problems on the front lines by working with physicians, nurses, healthcare workers, and the general public to mine ideas and develop new products that can be commercialized. Most community-based

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¹ HFMA Value Project Report: Acquisition and Affiliation Strategies, June 2014.

Elevating Community Health through Philanthropy

BY BETSY CHAPIN TAYLOR, FAHP, ACCORDANT PHILANTHROPY

Today's healthcare providers face a pressing expectation to elevate community health status and to pivot from a care delivery model focused on sick care to one of prevention and wellness. This has intensified the focus on expanding preventive care, addressing health disparities in at-risk populations, and creating community partnerships to address a continuum of needs. Emerging efforts also embrace non-traditional hospital priorities to address social determinants of health including the availability of healthy food, housing, access to recreation, and prevention of violence. Organizations are honing in on specific groups defined by geography, ethnicity, diagnosis, or insurance status as well. While many organizations anchor their specific ambitions in data from community health assessments and organizational strengths and priorities, the greatest barrier to implementing strategies for community health improvement is not *defining* needs to address, but rather *securing* resources to address them.

Today, more than 90 percent of hospitals and health systems agree "population health" is aligned with their organizational mission; however, only 19 percent say they have the financial resources needed to pursue it.¹ While healthcare organizations anticipate downstream financial benefits from community health efforts, the fact that the current healthcare reimbursement system provides minimal financial support for community health is a significant impediment to organizations pursuing this strategy. This means governing boards must grapple with identifying sources for capital and operating dollars to develop, build, expand, refine, and sustain solutions to elevate community health status. Therefore, many organizations are moving beyond dependency on operational revenue and reserves to leverage alternative funding including healthcare philanthropy: voluntary, charitable giving by individuals, businesses, and foundations.

The rationale for harnessing community giving is simple. Healthcare philanthropy offers an exceptional return on investment,

with a median return of \$4.29 for each dollar invested in fund development activities.² Further, savvy donor-investors are drawn to projects with a clear, identifiable, and measurable social impact. Donors also respond to proactive solutions with demonstrated downstream impact: because prevention can ultimately be the most powerful form of cure.

Examples of Leveraging Philanthropy

Charitable investment for community health activities is an opportunity for all types of organizations—from community hospitals to healthcare systems to academic medical centers—with the scale and ambition tailored to the capabilities, geographic footprint, resources, and vision of the facilitating organization. For example, consider how some organizations have leveraged philanthropy to power their plans:

- Cheshire Medical Center/Dartmouth-Hitchcock is a 169-bed hospital serving Keene, New Hampshire. The hospital has been recognized for its Healthy Monadnock initiative to increase access to healthy food, safe walking and biking, smoke-free workplaces and public spaces, and family resilience for 80,000 area residents. To expand efforts, the hospital launched a community-driven major gifts campaign, the Initiative for Community Wellness, which raised more than \$1.1 million. This allowed the addition of worksite wellness managers to collaborate with 80 area employers to facilitate employee access to physical activity, healthy eating, and policies that support families; two school coordinators to engage 22 schools to promote physical activity and healthy eating; and a partnership manager to facilitate alignment of more than 50 community partners. Cheshire Medical Center/Dartmouth-Hitchcock's President, CEO, and Chief Medical Officer, Don Caruso, M.D., M.P.H., said, "Donor investment in our population health initiative, Healthy Monadnock, has made an important impact on our ability

Key Board Takeaways

Governing boards have an opportunity to utilize community charitable giving as a valuable element of the funding strategy to advance population health, community benefit, and community partnership initiatives. Leaders wishing to pursue this opportunity should consider the following:

- Philanthropy is a viable revenue opportunity for all types of healthcare organizations.
- Relationship-based fund development has an exceptional return on investment.
- Seek to uncover synergy between organizational vision and donor interest.
- Prepare to articulate the specific impact of proposed solutions to donors in terms of population impacted, numbers affected, outcomes, etc.
- Collaborate with the foundation board to identify initiatives with donor appeal.

to expand the initiative to reach more community members where they work, learn, live, and play. Cheshire Medical Center needed 'more boots on the ground' to further the reach of Healthy Monadnock, and our recent major gifts campaign supports this expansion."

- Dignity Health is the fifth-largest health system in the nation with 39 hospitals across California, Arizona, and Nevada. Its vision is for sweeping change to address a major public health problem: human trafficking. The health system aims to implement a Human Trafficking Response Program within every Dignity Health facility to connect victims to community resources beyond health-related needs and to share best practices with healthcare facilities across the country. This long-term and multi-million-dollar initiative will require many funding and program partners. To date, Dignity Health Foundation has raised approximately \$1.1 million to leverage the significant investment Dignity Health made to support leadership staffing and paid training time for its clinical teams. Funding has also supported workshops for providers outside Dignity Health to ensure other hospitals are prepared to assist victims. Director of the Human Trafficking Response Program and human trafficking survivor Holly Gibbs said, "Our goal is to share our best practices with other systems, so one day human trafficking response programs like ours will be a standard offering at all

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1 Health Research and Educational Trust, *Approaches to Population Health in 2015: A National Survey of Hospitals*, Chicago, IL, August 2015.

2 Association for Healthcare Philanthropy, *2016 Report on Giving*, November 2016.

Reducing Risks and Achieving Goals: The Critical Role of the Post-Acute Care Network Structure

BY MARK DUBOW, M.S.P.H., M.B.A., AND BENJAMIN TUDOR, M.H.A., VERALON

It's normal for hospital and health system executives to focus on acute and ambulatory care services. But it's no longer enough.

In the last few years, Medicare, and private insurers that are following its lead, have created an environment that requires hospitals and systems to turn their attention to what happens after hospital discharge—post-acute care (PAC)—or face serious risks. Medicare's Accountable Care Organization (ACO) program, with its emphasis on providers accepting full responsibility for provision of all services and for the total cost of care; its penalties for hospital readmission within 30 days of discharge; and its bundled payment programs that aggregate payment for all services within 90 days of hospital admission, all put acute-care entities at an increasing degree of financial risk for PAC.

The attention on PAC has revealed significant variation in PAC length of stay and resource use for patients with similar conditions at hospital discharge. It has also uncovered the potential to achieve greater cost reductions in episodes of care in the PAC than in the acute-care phase of the episode, as well as opportunities to improve patient experience. This in turn implies that it is imperative for acute-care organizations to establish a PAC strategy and play a proactive role in PAC services, improving care transitions, care management, and quality of care in PAC facilities, in order to reduce their own financial and strategic risks.

Today, it is clear that the way to have this kind of impact is through the formation of networks of PAC entities, with increased integration of acute-care and PAC entities.

It is no wonder that, according to Premier's Economic Outlook Survey, 85 percent of C-suite leaders plan to expand their partnerships with local PAC providers over the next three years. It's also not that surprising that 95 percent of those same leaders expect problems in achieving that.¹

The foundation of a PAC strategy is the development of a network of providers that offer a continuum of post-acute care services with appropriate geographic

coverage, and that ensure high-quality care and patient experience and efficient use of resources. The continuum usually comprises a combination of short-term PAC entities (home health agency [HHA], inpatient rehabilitation facility [IRF], and increasingly, home- or facility-based hospice and palliative care services), and longer-term PAC entities, including one or more skilled nursing facilities (SNFs) and, less often, a long-term acute-care hospital (LTACH).

Continuing care retirement communities (CCRCs) are generally not considered PAC entities, but hospitals and systems are increasingly incorporating them in their PAC strategy and adding them to the care delivery and management continuum.

The foundation of a PAC strategy is the development of a network of providers that offer a continuum of post-acute care services with appropriate geographic coverage, and that ensure high-quality care and patient experience and efficient use of resources.



Key Board Takeaways

With increasing attention on post-acute care, board members should:

- Understand that a well-formulated PAC strategy is essential for hospitals/health systems active in bundled payment, accountable care, capitation, and reduction of readmission penalties.
- Ensure a PAC strategy is included in the organization's strategic plan.
- Expect management to form a PAC entity network through preferred provider relationships.
- Require PAC entity network formation to address all four forms of business risk (discussed in this article).
- Reinforce with management the need for one individual accountable for the PAC strategy, rigorous criteria for network member selection, and regular reports on PAC facility network performance.

PAC Strategies in the Market

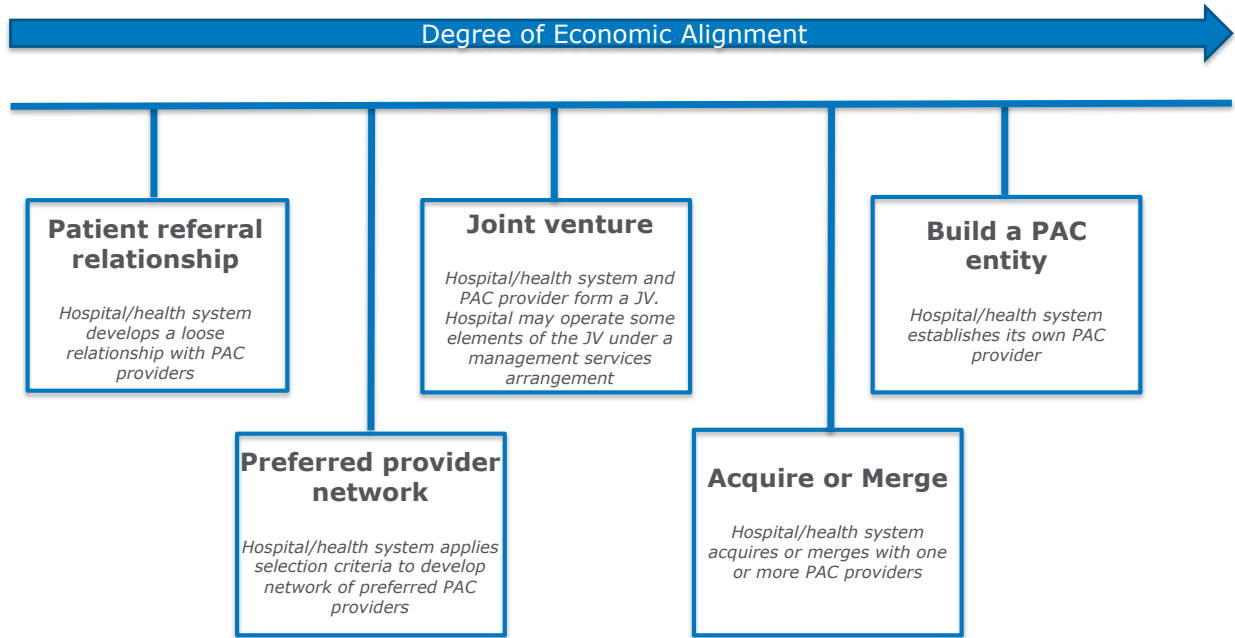
As hospitals and systems develop PAC networks, it is crucial that they do so in a way that is consistent with three factors: their strategic objectives, the operational and financial business risks they are seeking to mitigate, and the extent to which they are willing to invest scarce capital. The latter two issues are the principle focus of this article. The strategic objectives may include (but are not limited to):

- Differentiating on value delivered
- Establishing a continuum-wide care delivery network to support implementation of an ACO, prepare for population health management, and prepare to accept greater levels of financial risk
- Positioning the organization for inclusion in the "top tier" for those health plans using tiered provider networks
- Achieving growth

Historically, the approaches used by hospitals and systems to develop their networks of PAC entities have included (see **Exhibit 1** on the next page):

- "Building" one or more PAC facilities (or continuing to operate legacy facilities)
- Buying a PAC facility or a multi-site PAC organization
- Joint venturing with one or more PAC providers
- Merging with or acquiring another acute provider that operates PAC entities (this

¹ Premier, Inc., *Inpatient and Beyond: The Post-Acute Care Conundrum*, December 2016.

Exhibit 1: Methods for Developing Networks of PAC Entities

may be an “incidental” acquisition of a PAC entity)

- Establishing a preferred provider network

A review of published literature and an informal survey of nine regional health systems, conducted by the authors, indicate that *currently the most common approach to forming a PAC network is developing preferred provider networks*. Few hospitals or systems are building facilities, and selective acquisition of PAC facilities is often incidental to a merger with another acute-care organization. Under that circumstance, continued operation of those legacy facilities, whether directly or through joint venture, is common.

Many hospitals and systems have concluded that investing capital in PAC is not desirable. This reflects an understanding that PAC facilities tend to have low margins, and operating expenses and regulatory requirements are increasing while reimbursement is decreasing. At the same time, most healthcare organizations have a lengthy list of other high/higher-priority capital initiatives (e.g., IT, building a physician network, etc.).

This article is intended to help hospital and system leaders and their boards:

- Understand the motivation for developing a PAC network, with a preferred provider structure (or hybrid structure

where capital costs have been minimized).

- Become familiar with how selected health systems have shaped their PAC preferred provider networks with an eye to reducing specific business risks.
- Discuss steps taken during network implementation to contribute to risk mitigation.

The Business Case for a Post-Acute Care Network

A PAC network can mitigate four business risks faced by acute-care entities: risks entailed in having insufficient PAC capacity, risks of obstacles to effective care management, risks caused by inadequate quality of post-acute care, and risks associated with management of patient transition to and from PAC.

Risk of Insufficient PAC Capacity

The most significant reason for hospitals and health systems to develop a post-acute care network is that doing so will enable them to ensure there is a sufficient supply of post-acute care beds available that they can discharge patients to when they are ready, rather than having those patients continuing to occupy acute-care beds.

Even in markets that retain a fee-for-service orientation, delayed patient transfer has several negative implications. First, it reduces patient (and family) satisfaction,

in turn negatively impacting HCAHPS scores and the competitive position of the hospital. Second, the delayed discharge creates a capacity “bottleneck” that restricts other patient admissions, in general. Third, the extended length of stay of the patient not placed in a PAC entity is often excluded from reimbursement, resulting in financial losses for the hospital and a higher average cost per covered day. In markets where health plans have implemented tier provider networks, those organizations whose cost of care are high are frequently relegated to a lower tier. Patients would be subject to a higher out-of-pocket expense to use that hospital thus reducing its attractiveness and contributing to lost patient volume.

When the hospital or system is participating in a bundled payment or ACO shared savings program and is not able to transition a patient to PAC in a timely manner, there is a high likelihood that the cost of care will exceed the reimbursement with the resulting losses borne by the hospital and the physicians.

Implications: To mitigate capacity risk, the hospital/system needs to determine the number of facilities, beds, and HHAs needed, by patient acuity level, and how they should be distributed throughout the service area to ensure that there will be sufficient openings that patients can access conveniently and in a timely manner.

If the organization's regional service area is one in which there is a significant excess of post-acute care capacity at all levels, then access considerations alone could be addressed by a simple referral agreement. However, even if there is an annual average of 20 available beds among the SNFs in a given area, there will be days when there are no available beds or no beds for patients at a given level of acuity. The higher the area occupancy rate for SNFs, LTACHs, and IRFs of an acceptable quality, the more important it will be to ensure access to a defined capacity through a formal relationship. A preferred provider network can be designed to minimize capacity risk (see sidebar for more on assessing capacity risk).

Capacity Risk: Elements of Assessment

- Acute-care organization's historical trends in the volume (average and statistical distribution) of patient discharges to each type of PAC entity by type of patient condition, payer, and by location of patient home
- Acute-care organization's historical trends in the wait time to successful patient placement by patient condition, payer, and type of PAC entity
- Market capacity (occupancy—mean and distribution) for each entity, by type of PAC entity
- Willingness and ability of PAC providers to make their capacity available to hospital/system patients
- Ability of the acute-care organization to influence/control access to PAC facility capacity without formalized relationships

Risks to Care Management/Finances

Where the case managers, discharge planners, and physicians associated with an acute-care hospital are not able to have oversight on and meaningful influence over the care management at a PAC facility, three types of risk are incurred. First, the care process may be operationally inefficient and the recovery period may be extended, resulting in a high length of stay in the PAC facility and a higher than necessary cost of care. Second, the care process may fail to follow protocols, resulting in higher than necessary clinical resource use (diagnostic tests, therapeutic procedures, medications, clinical staff time, etc.). Third,

patients may be readmitted from the PAC entity to an acute-care hospital resulting in Medicare penalties for the originating hospital. Each of those elements contribute to unfavorable financial performance and reduced patient and family satisfaction. Both are particularly problematic in a value-based reimbursement environment in general and for bundled payments, ACOs, and capitation in particular.

Implications: To mitigate these forms of care management risks, the acute-care organization needs a well-structured role in guiding the care delivery process in the PAC entities. In conjunction with this, one of the criteria used in evaluating and selecting PAC entities for inclusion in the network should be their willingness to have hospital physicians and case managers collaborate in the care management process.

The following specific steps are among those often taken to further reduce care management risk: hospital/system-affiliated SNF specialty physicians ("SNF-ists") act as the medical directors of the PAC entity, the care protocols specific to an acute-care episode are extended to include post-acute care and applied in the PAC setting, and the electronic medical records for a patient are linked between the acute and PAC facilities. The latter may require the hospital or system to implement a local health information exchange as a "bridge" between the PAC electronic health record (EHR) and the hospital EHR, so that patient clinical data can be shared more easily.

Risks to Quality of Care

Points of patient transition from an acute-care provider to a PAC entity often give rise to incomplete "handoffs." As a result, it is not atypical for patients to incur medication conflicts and errors during this period. Historically, as the treatment process continues, a relatively high proportion of PAC patients incur infections, falls, and other quality-of-care deficits. In the absence of a structured approach to ensuring the quality of care provided by a PAC entity, there is an increased risk that these events will not be adequately controlled.

These occurrences are unsatisfactory for the patient and also contribute to longer lengths of stay, expanded use of care resources, and potential readmissions to the acute-care facility, which, individually and collectively, increase the overall cost of care. This would be particularly problematic in the case of patients whose



care is part of a bundled payment arrangement, for patients attributed to an ACO, or where reimbursement is capitated. To the extent that the hospital or system is seen as having been responsible for the choice of PAC entity, it could also be damaging to its reputation and brand.

Implications: To mitigate these risks, agreements between the PAC preferred provider network and the hospital/system are needed to ensure that the acute-care organization has the ability to meaningfully guide and contribute to enhancing the infrastructure supporting care quality. One commonly applied approach is for the nurses and other clinicians in the acute-care organization to provide training to and assist the PAC staff to expand their clinical skills. As noted in the preceding care management section, hospitals and systems will often provide the PAC entity with access to hospital-developed, evidence-based protocols. Among an array of potential additional steps to reduce quality risk are assistance in enhancing medication management and placement of a medical director with expertise in geriatric care at the PAC organization.

Other modes of mitigating the quality risk include establishing committees within the PAC entity to coordinate development of procedures to minimize falls, infections, and errors in medication dispensing. The hospital/system generally requires the PAC network members to provide monthly quality performance reports, reserve the right to require corrective action where necessary, and to remove consistently



under-performing PAC providers from the network.

Risks to Patient Transition Management

Without a strong working relationship, it is not uncommon for a patient initially discharged from one hospital/system to a SNF, IRF, LTACH, or HHA to be sent by the PAC entity to a competing care hospital/system when additional acute care is needed. This increases the likelihood that the original acute-care provider will lose the opportunity to serve that patient and his or her family at future points in time (lost future earnings). This is particularly troublesome in an ACO, which would essentially lose an attributable life and the associated income stream.

Without a PAC network in which the acute-care and PAC entities have jointly established procedures to guide and control transfer, there is also a higher risk of patient dissatisfaction with how their transfers are handled.

Implications: One approach that hospitals and systems often take to mitigate the risk of losing patients to competitors (“leakage risk”) is to proactively work with the PAC network members to establish guidelines specific to the management of patient readmissions. A second step taken by hospitals and systems is to arrange for the rotation of physicians at the PAC facility and video telehealth connectivity such that PAC facility clinical staff can seek remote observation of patients and consults with physicians to address patient care

needs and eliminate unnecessary acute-care readmissions.

Consistent in the literature and interviews referenced above is the perspective that the business risks and the mitigation steps described here can be achieved through the thoughtful formation of preferred provider networks. The build, buy, and joint venture approaches are generally not necessary, thus allowing hospitals and systems to conserve scarce capital.

The acute-care organization needs a well-structured role in guiding the care delivery process in the PAC entities. One of the criteria used in evaluating and selecting PAC entities for inclusion in the network should be their willingness to have hospital physicians and case managers collaborate in the care management process.

Additional Considerations in Shaping the PAC Network

When setting a PAC strategy and determining the optimal composition of a network of PAC providers there are at least three additional issues to be considered: circumstances in which ownership of a PAC entity makes sense, approaches a hospital/system should consider as a means of protecting itself in the event that a PAC network

member becomes financially unstable or non-viable, and effectively navigating situations in which medical staff members have pre-existing well-established relationships with selected PAC entities. While one or more full articles could be devoted to these issues, the information provided below is a helpful supplement to the preceding business case discussion.

Circumstances in Which Ownership of a PAC Entity Makes Sense

Ownership of one or more PAC entities can be an important aspect of network formation and management in three situations:

1. When at an earlier point in time the hospital/system had already developed or acquired one or more PAC entities (a “legacy” PAC entity) and that entity continues to perform well and fit the broader PAC strategy.
2. When a hospital/system is evaluating the potential to merge with or acquire another acute-care provider and the potential partner’s structure already includes one or more well-performing PAC entities, thereby “jumpstarting” the initial development of a PAC network or supporting expansion of an existing network.
3. When the hospital/system’s PAC strategy calls for inclusion of a particular level of post-acute care (e.g., SNF, IRF, LTACH, HHA) and no providers exist in the geographic area served.

In the third example, several options are possible. The hospital or system could unilaterally develop, own, and operate the



new PAC entity. Alternatively, the acute-care provider could approach this as a joint venture, potentially with a firm that has a long, successful track record in PAC organization management.

It is notable that in the interviews referenced, every system that had acquired or already possessed such capabilities said that if they were starting from scratch, they would have focused solely on a preferred provider network rather than investing to acquire or build PAC facilities.

Proactive Protection Against Financial Weakness of a PAC Network Member

If a preferred provider within the PAC network becomes financially unstable or non-viable, it may no longer be possible to discharge patients to it. This would reduce post-acute patient care capacity, triggering each of the negative ramifications described in an earlier portion of this article. Additionally, while the PAC entity is not owned by the hospital or system and thus the acute-care provider would not necessarily suffer a direct financial impact, the circumstance could taint its image in the market and the satisfaction of its patients. For these reasons, steps should be taken to proactively shield the hospital or system from the downside risk of a financially troubled PAC network member, including:

1. Each PAC network member should be required to report its financial performance to the hospital/system on a quarterly basis. Failure to meet pre-designated metrics should trigger warning “flags” as well as the implementation of corrective action plans. Those could entail retention of third-party PAC experts to resolve the problems.
2. The hospital/system should prepare and maintain contingency plans for removing troubled network members and replacing them with other entities to retain the needed patient care capacity.
3. When selecting participants for a preferred provider network, the hospital/system should diversify the network to include members with a variety of sizes, ownership, sponsorship, and other criteria. This will serve as a hedge against unexpected developments related to capacity, payment, and the evolution of care.

When Medical Staff Members Have Pre-existing Relationships with PAC Entities

Some physicians affiliated with the hospital or system are likely to have existing

economic relationships, ranging from ownership interests to paid medical directorship or coverage arrangements, with PAC organizations in the service area. If the proposed PAC network structure interferes with those economic relationships, it may create “political” risks for the hospital/system and the potential for active opposition to the network by affiliated physicians.

There is an array of potential solutions to this situation. A couple to consider include:

1. If the PAC facility involved is not critical to the network (because it is small, geographically remote, has a poor reputation, etc.) it may be possible to omit it from the network. That leaves the physician economic relationships as they are, but may not make those physicians happier if hospital discharges move away from the PAC entity with which they are affiliated.
2. The network approach can be refined to allow the hospital/system to work collaboratively with physicians that have an established working relationship with PAC organizations in the area—whether that means including those organizations in the network while preserving those economic relationships (where possible), or creating a joint venture in which those physicians can participate.

Tailoring Structure to Manage Risks and Achieve Objectives: Case Examples

The specific PAC network composition used by a hospital or system generally reflects its post-acute care patient needs, its unique PAC strategic objectives and approach to risk mitigation, as well as the nature of the inventory of PAC facilities in the market served. The examples that follow were chosen to highlight a variety of PAC network configurations that represent various combinations of the preceding factors and different regions of the U.S.

Scripps Health

Scripps Health is a health system based in San Diego, California. It has four campuses and treats more than 500,000 patients annually. The system wanted to develop a PAC network to support its strategies specific to bundled payment and ACO development, while at the same time ensuring access to sufficient PAC capacity, effective care management, and high quality.

System leadership did not consider the acquisition of PAC facilities to be the best use of its available capital. Scripps Health

therefore developed a network of preferred PAC providers, including 16 SNFs out of the 90 in its service area. It entered into a series of agreements with each SNF, including a master agreement and an EMR data-sharing agreement. Scripps integrated the health system’s geriatric physicians into a group and embedded a representative of the group in each SNF, enabling co-management. To facilitate monitoring of quality, a performance scorecard transparency agreement requires network members to report monthly performance on 30 quality indicators.

Dartmouth-Hitchcock Health

Dartmouth-Hitchcock is a non-profit academic health system serving New Hampshire and Vermont. The system includes the main academic medical center, an NCI-designated comprehensive cancer center, a children’s hospital, four affiliated acute-care hospitals, and a series of ambulatory care centers in portions of the region served.

Dartmouth-Hitchcock’s network of PAC entities includes two IRFs that were pre-existing components of hospitals that joined the system as affiliates, as well as SNF units that were pre-existing services of several of the member critical access hospitals. In addition, the health system works with many other SNFs in the region to support the geographic coverage needed. To ensure effective care management and quality, Dartmouth-Hitchcock physicians serve as medical directors in some of those SNFs.

Dartmouth-Hitchcock recently brought an HHA into its system to improve transitions to home care and to take the patient-centered medical home concept into the home of the patients served. It is hoped that this will better integrate inpatient and outpatient hospice and palliative care services.

Geisinger Health System

Geisinger Health System serves Pennsylvania and southern New Jersey with 12 hospital campuses, two research centers, and a health plan that serves more than 550,000 members.

The system developed a PAC network in order to assure adequate PAC capacity for its patients—a prime concern given the rural location of the medical center and many of the system’s community hospitals. Geisinger also wanted to provide high-quality PAC for its health plan members, minimizing losses at the system level.



Geisinger's PAC network includes a combination of owned facilities, a joint venture, and a preferred provider network. The owned entities include three hospice programs and three SNFs.² Their IRF is a joint venture with HealthSouth,³ which is the operating partner. Most of these owned facilities were acquired when the previously independent hospitals that operated them became part of the Geisinger system.

Geisinger maintains a preferred provider network with 15 SNFs. As a component of its ProvenHealth® medical home model, employed physicians and advanced practice clinicians participating in Geisinger's Skilled Nursing Facility Specialist program⁴ have a daily presence in each of the network's SNFs, providing a degree of control over clinical quality and system efficiency.

Saint Luke's Health System

Saint Luke's Health System includes 10 acute-care hospitals in the greater Kansas City region (Missouri and Kansas). In addition, the system employs over 450 physicians and operates 13 nurse practitioner-run convenient care centers, two "big box"

ambulatory care centers, and is developing seven micro-hospitals.

In developing its PAC network, Saint Luke's primary objective was to ensure the system's ability to manage patient care in support of its existing bundled payment arrangements, and in preparation for an environment expected to evolve toward population health management and toward providers taking financial risk. It also wanted to improve access to PAC beds for the patients served, while minimizing capital investment.

Saint Luke's used a formal process to develop its PAC network. It began by circulating RFPs to all of the SNFs in the region, receiving responses from 56 entities. It ultimately formed a preferred provider network with 22 SNFs. The system owns and operates its own HHA, and maintains a preferred provider relationship with four additional HHAs. The system has an affiliation agreement with one LTACH (not owned) and also sends patients to two other LTACHs with which it has no affiliation agreements. Among its hospitals there are three owned IRFs and a 12-bed hospice house, and home hospice services are provided.

Participants in the preferred provider networks entered into "evergreen" agreements with Saint Luke's with 90-day cancellation clauses. As a condition of participation, the network members must adopt the acute-care system's clinical protocols, agree to serve its patients, and report on and meet a specified array of

performance criteria to remain in the network. Participation in the network may be canceled if the PAC entities fall short on performance targets and fail to complete corrective action.

HonorHealth

HonorHealth owns and operates five general acute-care hospitals in Phoenix and Scottsdale, Arizona, as well as an ACO.

Unlike the systems discussed above, HonorHealth is located in a market with a large number of SNFs and HHAs as well as three LTACHs, and some of those entities have excess capacity. While HonorHealth initiated the conversation around forming a PAC network, the PAC entities were already very interested in seeking affiliations with area hospitals and systems. Because there is competition between PAC providers, HonorHealth is positioned to be selective in developing a PAC network that can address its concerns regarding control of care management and financial risk, patient care quality, and PAC patient leakage to other acute-care facilities in the event of rehospitalization.

HonorHealth created a PAC RFP to obtain data allowing assessment of the 96 SNFs in the region. Based on this, they have begun to select a preferred provider network with two tiers. The system is applying a similar process in forming a preferred provider network with HHAs as well as its owned home health agency. HonorHealth had already established an IRF some time ago, which is operated as a joint venture.

2 Definitive Healthcare, Geisinger Health System IDN Profile.

3 For more information on Geisinger HealthSouth Rehabilitation Hospital, see www.geisinger-healthsouth.com.

4 Janet Tomcavage, "Post-Acute Continuum—Lessons Learned from Geisinger's ProvenHealth® Navigator," February 3, 2012.

Prior to developing its network of PAC entities, HonorHealth had a number of pre-existing relationships with SNFs and HHAs. Notably, the ACO was utilizing a small network of SNFs and HHAs and had already embedded transition specialists who visit the SNFs. In addition, the hospitalist groups with which the system works each had relationships where member physicians were acting as medical directors in several of the SNFs. Success in establishing the preferred provider network requires that the SNFs are utilizing physicians who are aligned with HonorHealth to maintain continuity and execute on lowering readmissions and improving transitions of care.

Ochsner Health System

Ochsner Health System includes 12 owned hospitals and 17 managed/affiliated hospitals, all serving patients across Louisiana. Ochsner's network also includes 60 community health centers that deliver primary and specialty outpatient care, and approximately 2,500 affiliated physicians.

Ochsner serves America's second most unhealthy state.⁵ Despite the health challenges faced by its communities, Ochsner has accepted some level of financial risk (through full risk-based contracts and shared savings programs) for approximately one-third of its patient base. It developed a PAC network in order to support its focus on population health management and further its efforts to integrate healthcare providers across the continuum of care.

The health system's PAC network is composed of 17 SNFs in a preferred provider network, two fully owned acute rehabilitation facilities, and two joint ventures (an LTACH and an HHA) developed in partnership with the investor-owned LHC Group.

Ochsner has formal contractual relationships with the SNFs, outlining transfer protocols and establishing metrics to which affiliates are held accountable; hospitalists are provided with a directory of preferred providers. Ochsner is in the process of further developing its alignment with the preferred provider network; for example, a pilot program will provide the SNFs with access to the health system's electronic medical records for their patients. Although Ochsner does not provide medical directors to its SNF affiliates, an appointed medical director for community affairs meets with the SNFs on a bimonthly basis to

address any emerging concerns regarding transitions to and from Ochsner's acute-care facilities.

Ochsner is planning to build a new IRF in a joint venture with Select Medical Corporation, a national leader in inpatient rehabilitation, which will increase their inpatient rehabilitation beds and add pediatric rehabilitation beds. This is part of a major expansion of its Jefferson Campus in which many facilities are being upgraded.

Making PAC Relationships Work to Achieve Objectives

Selecting the participants in a narrow network of PAC entities can take time. Participants that are not owned (fully or partially) need to be brought into a productive relationship with the hospital/system. Participants should be expected to agree to provisions that will allow the hospital/system sufficient involvement in the clinical operation of the entity to meet its objectives, while respecting the independence of the PAC entity.

Provisions that will facilitate achievement of these objectives include, but are not limited to, agreement on:

- A master agreement with specific performance criteria, transparent monthly reporting, requirements for corrective action plans, and the potential to remove network members that are not able to resolve performance gaps
- Protocols for transition management, medication management, clinical care, etc., to which the partners will be held accountable
- An appropriately trained physician serving as the medical director in the PAC entity, with some decision-making authority
- Provisions for tracking patients across the continuum of care, from acute care to PAC and back if appropriate, so that care management can be extended accordingly. This includes integrating EMR technology throughout the network, or linking EMRs through a local health information exchange
- Developing a cohesive team across the entities

The Role of Senior Executives and the Board

Most hospitals and health systems will be developing a PAC preferred provider network. Senior executives should play a role in setting and approving the PAC strategy



and ensuring that a thorough implementation plan is developed—identifying action steps, the individual accountable for each step, start/completion dates, milestones, and progress tracking components. The executives must hold the sponsors/champions of PAC network formation accountable for rigorous analysis in selecting network participants and developing a risk mitigation plan for the network.

The board should be familiar with the issues set forth in this article and proactive in holding the executive team accountable for developing and maintaining a PAC network that effectively mitigates the risks. The board should hold the senior team to an objective assessment of its ability to address the questions and issues set forth in this article using its internal resources and expertise versus using appropriate third-party resources.

Senior executives need to provide the board with regular reports on the status of network development and performance. Most significantly, it is the board's responsibility to ensure that the PAC strategy is consistent with and supportive of the organization's overall vision and direction and that the PAC strategy strengthens its long-term financial viability. ●

The Governance Institute thanks Mark Dubow, M.S.P.H., M.B.A., Director, and Benjamin Tudor, M.H.A., Associate, at Veralon, for contributing this article. They can be reached at mdubow@veralon.com and btudor@veralon.com.

5 America's Health Rankings, 2016 Annual Report.

Digital Health and Data as a Strategic Asset for High-Performing Organizations

BY DANIEL J. MARINO, M.B.A., M.H.A., GE HEALTHCARE CAMDEN GROUP

Healthcare organizations are beginning to recognize that their strategic goals of reducing costs, improving quality, and creating value are contingent upon their ability to harness their data and translate it into actionable information to drive the most optimal results. Incorporating actionable information into a digital healthcare delivery model creates performance-driven outcomes that can help transform hospitals and health systems into high-performing, value-driven organizations.

Many healthcare organizations are making investments in their infrastructure to position themselves as cost-effective and nimble, yielding high-performance results. They are building digital health technologies and advanced analytic capabilities aimed at managing populations with a goal of delivering the most efficient care at a reduced cost. Simultaneously, they are finding new ways to engage, educate, and retain consumers and differentiate themselves as an innovative healthcare leader compared to their peers. Developing an effective, efficient digitally empowered care delivery system from which to identify and drive high performance under

value-based contracts remains of utmost importance. However, achieving digital health objectives along with building an analytics ecosystem continues to be a struggle.

To help guide the development of an effective digital health strategy, hospital and health system leaders should consider the following four key initiatives.

1. Transform Data into a Strategic Asset

Many organizations will admit that they are *data rich* and *information poor*, but they don't know where to start to correct the problem. They may have made the mistake of aggregating as much data as possible into a large data warehouse or "data lake" only to discover that they can't extract meaningful information from disorganized data. High-performing organizations have taken a "problem-backed" approach in organizing and harmonizing their data and building coordinated data marts or organized data structures allowing for the creation of richer reports leading to actionable information. This approach is described in more detail in this article.

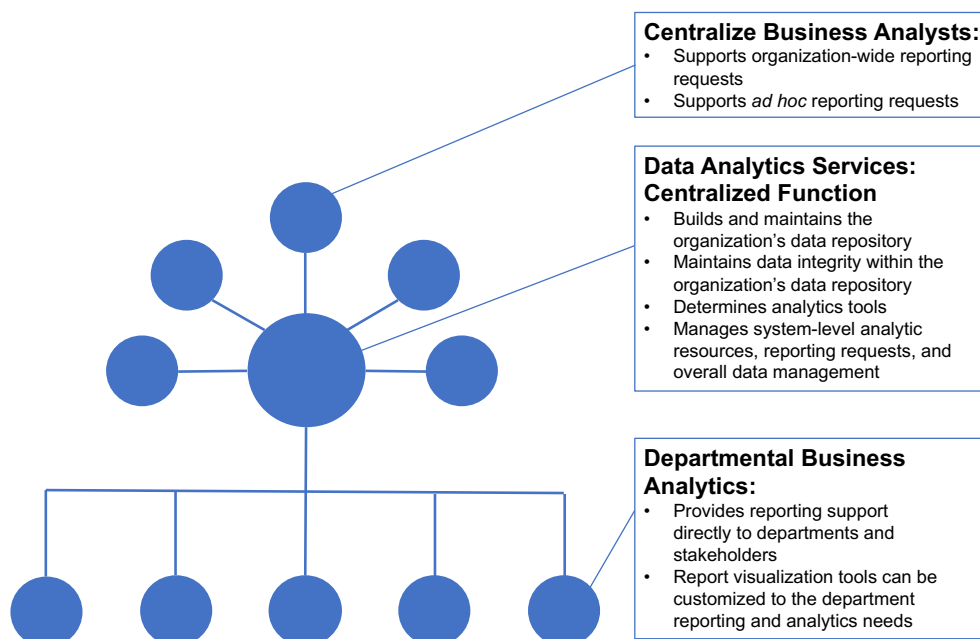
Key Board Takeaways

Many hospitals and health systems strive to be a high-performing organization yet lack the information insight and performance analytics to achieve these goals. Boards should emphasize the burning platform for healthcare leaders to create a digital health and analytic strategy, and position data as a strategic asset for the organization. Without the drive to build an action-oriented digital health strategy, hospitals and health systems will have difficulty innovating with new care delivery models and leveraging technology to create strategic positioning and value-based success for the organization.

2. Build a Data Analytics Organization

As hospitals and health systems grow and information needs evolve and become more critical, departments must create their own information repositories, which includes a limited database and visualization tool. It's not uncommon for healthcare organizations to have numerous centers of data repositories. This can create internal challenges between departments that focus on a lack of data integrity, data ownership, and tremendous unproductive time from staff either trying to validate

Exhibit 1: Model Analytics Department



their report or reproducing information that has already been created.

High-performing healthcare organizations that recognize their data as a strategic asset have created an analytics ecosystem utilizing a hybrid data management approach focused on data analytic services. These newly formed departments create a hybrid methodology around master data management. The data analytics services department centralizes data governance and data ingestion and builds an organization-wide data warehouse to support the information needs of the operational departments and the entire organization. While the data analytics services department creates data management structure for the organization, the individual departments create their own reports based on their individual needs or information requirements. The key is that all department-generated information draws from a single “source of truth” of data, which is managed, controlled, and maintained within data analytic services. (See **Exhibit 1** for a detailed look at a model analytics department.)

3. Focus on the Transactional Data to Drive Actionable Information

Historically, as healthcare organizations build information, they focus on data that has occurred in the past and create reports to evaluate progress or performance. Often, they will create trending reports to understand what has previously happened and try to modify future performance based on interpretation of past information. Organizations also create these retrospective-based key performance indicators to help monitor current and future performance.

Although this retrospective information approach is valuable, it does not allow operators to make real-time changes to their operational activities. Many high-performing hospitals and health systems organize data into two categories: retrospective and transactional. Transactional data—and the organization’s ability to harness and incorporate it into real-time (or close to real-time) information or technology—allows organizations to more quickly drive performance. One example of this is an organization’s ability to receive “real-time” information on a patient’s condition and incorporate it into their care management program. Healthcare organizations that have a value-based contract are focusing on identifying the most vulnerable, high-risk patients and identifying transactional data that will allow care managers to more quickly know if they present to the emergency department. The quicker care managers receive this information, the quicker they can intervene in the care. Understanding key transactional data will produce actionable information the hospital or health system can use to improve its overall productivity.

4. Incorporate Actionable Information into New Technical Capabilities

Lastly, as organizations identify transaction data and actionable information, they must incorporate this data into technologies and electronic solutions so that staff can capitalize on the information. For example, the identification of transactional data supporting certain disease conditions or quickly recognizing patients within different risk cohorts can allow clinical staff

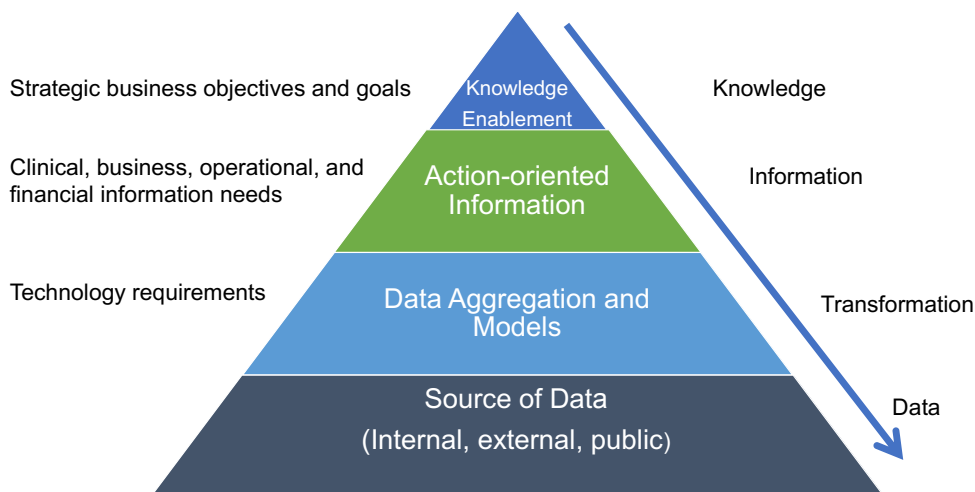
to receive an “alert” within their technology tool. High-performing organizations have created an information management framework that incorporates a “problem-backed” approach to improving performance. They begin with understanding the problem to solve, information that is required to quickly influence performance, data required to produce actionable information, and the appropriate technology to enable results. (See **Exhibit 2** for a sample problem-backed approach to digital health.)

Some progressive organizations are using actionable information and new technologies to support innovative care models. For instance, telehealth technology is incorporating smartphones and is supporting real-time ingestion of data to assist providers with clinical support. These new care delivery models are using digital health technologies combined with transactional data allowing providers to care for patients quicker than ever before and expand their clinical reach beyond their immediate geographic target market.

In summary, high-performing healthcare organizations are creating analytic and digital health technology strategies that focus on harnessing the great information that exists within their organization, and use this information to increase productivity, manage populations, and define new care models creating a differentiator within their direct market or region. The healthcare organization’s governance and leadership team have to align on the vision of creating data and information as a strategic asset for the organization. An aligned vision will include a financial, operation, and full organization commitment in building digital health technology strategies. These strategies are not easy and require a commitment from leadership to instill a new cultural paradigm based on using data and actionable information—a true “tool” toward building the innovative healthcare organization for tomorrow. If the strategy is built and activated using a pragmatic and prescribed approach, organizations will begin to realize the power of their own data, and leverage actionable information and digital health technology creating an invaluable strategic asset for their organization. ●

The Governance Institute thanks Daniel J. Marino, M.B.A., M.H.A., Executive Vice President, GE Healthcare Camden Group, for contributing this article. He can be reached at daniel.marino@ge.com.

Exhibit 2: Problem-Backed Approach to Digital Health



Board Practices for Innovation...

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hospitals do not have tech-transfer capabilities and miss out on the opportunity to advance innovative solutions, but through this partnership, The Innovation Institute is making waves.²

Hospital Executive Selection

Another area in which boards can exert innovative practices is through the selection of their executive team. With healthcare enshrouded in a cloud of legislative and financial uncertainty, selecting executive leaders who can demonstrate innovation through adaptability and metered creativity (the kind that minimizes risk) are critical competencies that should be considered in any executive hire and developed in any current executives.

Finding and/or developing these skills in executives who can not only plan for, but also execute against a strong business plan is no longer good enough. It is mission critical for executives to be able to plan for and execute against Plans A and B, while also being ready to pivot into Plan C with an adaptive and creative mindset. To ensure innovation across all facilities as a part of a healthcare system, boards can make a commitment to exploring how to define

these innovative competencies across all hospitals within the system.

Seth Lee, President and CEO of Summit Talent Group and an expert in the recruitment of healthcare executives, notes “Innovation is process improvement on steroids.” Finding executives with a long history of process improvement and divergent thinking will improve innovation operationally at hospitals and health systems. In addition, Seth suggests boards that are trying to become more innovative will recruit executives that have worked outside healthcare at some point, have had varying career experiences, have worked in multiple geographies, or have even been expatriates. All of these qualities will help build a more innovative leadership team.

Effective boards must be able to pivot and move to new frontiers, not just try and make small adjustments within the parameters of business as usual. Boards must consider how to improve their innovation mindset through their board practices, partnerships, and executive selection to ensure that there is a balance of prudence, but also a capacity for significant change. ●

The Governance Institute thanks Jim Finkelstein, President and CEO, and Sheila Repeta, Senior Consultant, of FutureSense, LLC for contributing this article. You can learn more about their company and work at www.futuresense.com or contact them at jim@futuresense.com and sheila@futuresense.com.



² For more information, visit The Innovation Institute's Web site at www.ii4change.com.

Elevating Community Health through Philanthropy

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hospitals and healthcare facilities across the country.”

- HealthEast, a four-hospital system serving greater St. Paul, Minnesota, convened a community-based collaborative to identify opportunities to improve community health and well-being. The collaborative selected two priorities for its initial work: access to healthy food and mental health and resilience within specific populations including the area's Latino, Hmong, and Karen communities. HealthEast Foundation provided \$700,000 in start-up funding for two, 18-month prototype programs: East Side Table, which seeks to develop food skills, increase

consumption of healthy food, and affect long-term health outcomes among communities experiencing the greatest health disparities, and the East Side Mental Health & Stress Resilience Partnership, which seeks to build stress-resilience and holistic well-being among targeted low-income community members. The collaborative has received additional funding from private foundations and has a commitment from HealthEast Foundation to be a featured funding priority in 2017.

A proactive approach to community health strategies will be essential in the emerging

value-based reimbursement landscape. As organizations position to implement robust solutions to address health disparities, to foster preventive care, and to mitigate social determinants of health governing boards must consider the vibrant opportunity to engage the greater community not only as advocates but also as financial investors in creating a healthier, shared future. ●

The Governance Institute thanks Betsy Chapin Taylor, FAHP, President of Accordant Philanthropy, for contributing this article. She can be reached at betsy@accordantphilanthropy.com.

Getting True Value from Board and Leadership Retreats

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- **Set the stage for the board's work in the year ahead.** The most effective boards organize their work through a rolling annual calendar that organizes the events core to the life of their organization—budget approval, year-end review, CEO evaluation, board member appointment, etc. The annual retreat needs to be an anchor point of this cycle, an opportunity for readjusting priorities, affirming plans, and resetting goals. In this way the board's work leading up to the retreat elucidates issues that warrant major time and attention; the board's work following the retreat is shaped by the discussions, conclusions, and action steps that have coalesced during the retreat. Attention to this rhythm of ongoing organizational life inoculates the retreat—whether it is semi-annual, annual, or biannual—from the frequent error of existing as a stand-alone event, unmoored from other activity and thereby doomed, ultimately, to being window dressing.

The question of venue is also something to consider. Many hospitals and health systems keep retreats local and focus on cost control. Others spend lavishly, feeling that this is an occasion to reward volunteer directors and express appreciation to hardworking leaders. With respect to the question of “where to have the retreat,” moderation is once again, a virtue. If it is useful, remove people from distraction and create an atmosphere underlining the fact

that the event is special. On the other hand, in these days of falling reimbursement and tight budgets, something so indulgent that it may raise eyebrows if reported in the local press would be unwise.

Suggestions for Health Systems and Subsidiaries

While there is no unitary governance model for American health systems, every system does have a corporate or system board with ultimate fiduciary responsibility for the enterprise. This system board needs a retreat ritual defined precisely by the guidelines of this article.

Two questions remain for health systems and subsidiaries:

1. Should there also be retreats that gather together the governing bodies of all a health system's member institutions? Unless member (or affiliate) governance structures have been eliminated, an inclusive retreat of all governing bodies is indeed critical. It allows for the creation of a shared knowledge base and the cultivation of a shared identity and sense of purpose. It fosters alignment around goals that are larger than any component organization, and builds a sense of trust and inclusion that can serve to inoculate against misunderstanding or feelings of marginalization when decisions are made that apparently disadvantage a particular operating entity.



2. Should individual hospitals that belong to a health system have their own retreats? Individual hospital retreats become less critical if meaningful system retreats take place. Nonetheless, they allow affiliate boards to become more deeply engaged, can serve to galvanize local leaders to help fit system strategies with local realities, and can set the stage usefully for local philanthropic work. It is important, however, that individual hospital retreats not obscure the reality of the system's ascendant fiduciary responsibility, and that such retreats do not drift in the direction of celebrating the “good old days” before affiliation, and its attendant sacrifice of full autonomy.

Conclusion

Board retreats are a fact of life across the healthcare landscape. Some of them are profoundly meaningful; some simply “check the box” and are deemed a success if attendees are not bored to death. Hospital and health system leaders need to see regular retreats as fabulous opportunities to make discontinuous moves in progressive directions. That mindset, supported by attention to the success factors listed above, will result in an event worth every hour of attendees' time, and every dollar spent. ●

The Governance Institute thanks Eric D. Lister, M.D., Managing Director, Ki Associates, and Governance Institute Advisor, for contributing this article. He can be reached at elister@kiassoc.com.



Getting True Value from Board and Leadership Retreats

BY ERIC D. LISTER, M.D., KI ASSOCIATES

For most hospitals and health systems, a board retreat is a standard occurrence. The majority of senior executives are involved, and the invitation list is often broadened to include physician leaders. While the retreat ritual is common, the impact derived from the retreat itself varies widely. Experience suggests, however, that rigorous planning and careful attention to established success factors can ensure a profoundly meaningful experience. Interestingly, while retreat *topics* will inevitably vary across hospital size and type, the *success factors* for a retreat will not.

Factors Contributing to a Successful Board Retreat

There are many factors that can help ensure a board retreat is valuable and productive. Below are a few best practices based on experience:

- **Craft a meaningful agenda.** Your retreat should not simply be an extra-long board meeting, nor should it serve as an opportunity to drown the board in detail. It needs to be seen as a pivotal opportunity for a deep discussion of one or two topics fundamental to the success of your enterprise. Interaction is paramount, and discussion needs to be focused on carefully crafted governance-level questions so that, by the end of the day, management has been enriched by a clear sense of the board's collective wisdom,

and has been given direction as to how it should move forward.

- **Allow for deep discussion of one or more critical strategic issues.** The retreat topic or topics (no more than two) need to be selected—by the CEO and board officers—based upon a) the major strategic initiatives under consideration by the organization, b) complex and fundamental operational issues that are essential to success (quality and safety, service line reorganization, etc.), or c) major shifts in the marketplace that may necessitate the reinvention of your business model.
- **Engage one or more outside experts.** A retreat is a wonderful opportunity to broaden the board's perspective and frame of reference relative to the issues at hand. Outside experts can be very useful here, but "canned presentations" are not likely to add sufficient value. Much more likely to be useful are experts who have consulted within your own institution, or who spend time on-site getting to know your institution in preparation for the retreat. If such an expert has the skills to facilitate discussion and action planning relative to the presentation topic, that is even better.
- **Integrate the material presented with the theme of the retreat.** One common error in retreat planning involves the recruitment of an outside speaker based

Key Board Takeaways

Board retreats create invaluable opportunities for deep engagement, reflection, and affirmation of your mission. For this potential to be realized attention must be paid to six key success factors:

1. Craft a meaningful agenda.
2. Allow for deep discussion of one or more critical strategic issues.
3. Engage one or more outside experts.
4. Integrate the material presented with the theme of the retreat.
5. Include actionable self-reflection.
6. Set the stage for the board's work in the year ahead.

Finally, choose a celebratory, but not exorbitant venue.

upon his or her presentation skills or cachet. While this can be entertaining and useful in a vague, future-oriented way, it is rarely deeply meaningful. We recommend identifying an expert who can speak with experience and knowledge to the specific issues you have identified as thematic to the retreat, so that the speaker's remarks provide a rich platform for the discussion that follows, allowing all attendees a shared body of knowledge that can inform their engagement with retreat themes. Breakout groups following prepared remarks is a vehicle for involving the entire assemblage, and expert facilitation allows the synthesis of key priorities, as well as a follow-up action agenda when breakout groups come together to share their perspectives.

- **Include actionable self-reflection.** Retreats, as events with time for deep discussion, are the preferred settings for reviewing and digesting board self-assessments, external feedback about board performance, or major surveys germane to the life of the organization (culture of safety survey, engagement surveys, patient satisfaction surveys, etc.). For this to be a meaningful experience, the data to be presented should be reviewed and curated by the appropriate board committee, and presented in a way that leads to actionable discussion. These discussions, to be truly valuable, must be facilitated in a way that results in clear plans around how the board conducts its own business, and/or explicit goal-setting for management.

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