# BoardRoom Press

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

THE GOVERNANCE INSTITUTE ■ VOLUME 26, NUMBER 4 ■ AUGUST 2015
GovernanceInstitute.com

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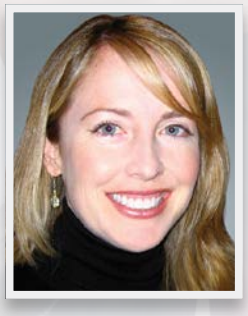

Since our last issue was printed, the Supreme Court issued its ruling on *King v. Burwell.* The ruling removed any concerns about Americans losing subsidies from state exchanges that are run by the federal government, representing a step forward and one more uncertain detail for healthcare leaders to check off the list.

As we continue down our value-based path, sound leadership, vision, strategy, and execution will continue to be the cornerstones of successful healthcare delivery. With continuing pressure to reduce costs and lower reimbursements, philanthropy becomes a critical strategic goal. Value-based payment models continue our focus on expanding board oversight across the care continuum and developing a more concrete vision of community health. Finally, our ability to execute these essential strategic goals lies in aligning governance structure with strategy.

Kathryn Peisert

**Kathryn C. Peisert** *Managing Editor*

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# Elevating Hospital Foundation Board Governance

*BY STEVEN W. CHURCHILL, ASSOCIATION FOR HEALTHCARE PHILANTHROPY*

Healthcare organizations are elevating fund development on the strategic agenda as charitable giving becomes a core revenue source. Now, leading organizations are rethinking foundation board involvement to ensure it is designed to leverage board leadership and to optimize the financial opportunity philanthropy represents. While effective governance is a core element of success for any non-profit organization, the leadership role for non-profit healthcare foundations has many unique features. In the healthcare foundation, great governance still demands a proactive and engaged approach to advancing the organization's mission—but with a keen commitment to fund development. This article explores seven considerations for optimizing foundation board work through engagement, clear and meaningful roles and responsibilities, and effective governance practices.

**Steven W. Churchill**
*President and CEO*
**Association for Healthcare Philanthropy**

## Seven Considerations for Refining Foundation Board Engagement

**Foster Role Clarity**
Hospital and health system boards and separately incorporated foundation boards technically have the same governance obligations in terms of oversight, policy setting, strategy, and fiscal stewardship. However, healthcare foundations are unusual non-profits by virtue of supporting another non-profit with its own board. Thus, foundation boards often deploy governance differently. There is value in the foundation board and hospital/health system board working together to determine what priorities will be allocated to one board or the other and what will be shared to ensure agile collaboration that addresses core issues and opportunities. Role clarity will become increasingly important as governing boards continue to re-engage in development.

**Eliminate Confusion About the Primary Role of the Foundation Board**
The foundation board is not another hospital operating board. Foundations are formed by healthcare organizations to cultivate financial support to strengthen and sustain the healthcare mission. Simply, raising money is the healthcare foundation's reason for being. While healthcare governing boards focus *inside* the healthcare organization to juggle complex issues like finance, strategy, risk, and compliance, foundation boards prioritize looking *outside* to connect the organization to a wide variety of external stakeholders with the key objective to advance charitable giving. Having clarity that the foundation exists for the primary purpose of raising money and clearly communicating that fact to foundation board members can provide the focus to excel at this noble task and can overcome a pervasive misconception that thwarts the success and performance of many foundation boards.

**Nobody Wants Window Dressing**
No successful board member wants to feel their presence is simply to check off a box that says the foundation has a board. Yet, development executives often confide that they feel foundation board engagement is lacking and board support is a distraction from more valuable activities. High-performing foundation boards create value and benefits that exceed what the organization invests in the board. Organizations must effectively foster board engagement through careful membership selection, clear expectations of membership, individual board member engagement plans, and systems to drive accountability. When boards don't deliver meaningful value, the foundation executive is often complicit in the failure and is essential for enabling change.

**Embrace Development as a High-Value Board Role**
Many healthcare organizations are apologetic about asking board members to participate in the cultivation and solicitation of charitable gifts, but they shouldn't be—fund development plays a key role in the organization's success. The book *Governance as Leadership* distinguishes between work that requires "no" board, "any" board, or "this" board.[1] Work requiring "no" board could be done by management, and work requiring "any" board could be done by any responsible individuals. However, work requiring *"this"* board not only takes diligent and well-intentioned people but also demands those who care deeply about the mission and will champion its success. Under this standard, philanthropy and advocacy rise to the top of the list as high-impact board work.

**Individual Initiative Trumps Collective Action**
While most board governance work is accomplished through collective action, the most impactful roles on a foundation board are individual. It's important to enable success by tailoring individual board member

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### Key Board Takeaways

Hospitals and health systems are rethinking foundation board involvement as charitable giving becomes more important to their financial success. While working to elevate foundation board governance, healthcare organizations should consider the following:

- Be clear about the role of the hospital board and the foundation board, and how they will work together to address core philanthropy issues and opportunities.
- Eliminate confusion about the primary role of the foundation board—to advance charitable giving.
- Foster board engagement through careful membership selection, clear expectations, individual engagement plans, and systems to drive accountability.
- Embrace development as a high-value board role.
- Tailor individual board member involvement—individual initiative trumps collective action on the foundation board.
- Recognize the link between strategy and stewardship.
- Ensure meetings reflect priorities and are not dominated by report giving and rubber-stamping.

1 Richard Chait, William Ryan, and Barbara Taylor, *Governance as Leadership: Reframing the Work of Nonprofit Boards*, October 2004.

# The Next Phase of the ACA: The Cadillac Tax and Value-Based Purchasing

*BY ANJANA D. PATEL AND ADAM C. SOLANDER, EPSTEIN BECKER & GREEN, P.C.*

In the next several years, changes ushered in through the Affordable Care Act (ACA) will dramatically impact the way employers provide and pay for health benefits to their employees.

Starting in 2018 with the rollout of an excise tax on healthcare costs above specified annual amounts or the so-called "Cadillac Tax," employers will be forced to embrace innovative value-based purchasing initiatives with respect to the health benefits they provide for their employees. This article describes the impact of these changes on employers and how this shift represents a huge market opportunity for hospitals and health systems to provide novel ways to work more closely with employers.

## The Cadillac Tax

The Cadillac Tax subjects employer-sponsored group health plans to a 40 percent non-deductible excise tax on the dollar amount of coverage that exceeds certain specified thresholds. The 2018 thresholds for individual coverage are $10,200 and $27,500 for family coverage. Thereafter, these thresholds are indexed to increases in inflation.

The purpose of the tax is to curb the rising cost of healthcare by discouraging employers from purchasing overly rich employee benefit packages. At first look, the tax seems reasonably designed to achieve this goal because the triggering thresholds are more generous than the current cost of most employer-provided benefit plans. However, this impression is deceptive because the thresholds are tied to increases in the Consumer Price Index for All Urban Consumers (CPI-U) and the cost of healthcare has traditionally risen much faster than the CPI-U. In general, the cost of employer-provided coverage doubles about every 10 years.

The penalty is not insignificant. For example, if an employer offered individual coverage costs $12,000 per employee in 2018, the annual liability per employee would be $720. Furthermore, the Cadillac Tax is not tax deductible. Thus, for employers, it becomes difficult to pay a penalty that will grow in amount every year because of the indexing, but that provides no additional benefit to employees or any tax relief to employers.

## The Employer Response

In addition to the Cadillac Tax, the ACA imposed a number of changes to the benefits employer-provided plans must offer employees. Generally, the ACA has forced most employers to provide a richer benefit to more employees. These changes have largely been the result of the employer mandate and the various market reforms that must be reflected in employer-provided coverage, such as statutorily defined essential benefits.

Incorporating these changes has been significant and employers have been largely focused on compliance. Thus, the evaluation of plans for Cadillac Tax purposes has, in many cases, been delayed. Compounding the problem, many of the ACA's mandates took effect either immediately or in the first few years following passage of the act. Thus, employers were forced to make changes quickly without fully understanding how a particular change would affect plan cost in the long term.

The most common employer responses with respect to the Cadillac Tax seem to focus on cutting the richness of the benefits package, moving to high-deductible models, implementing telehealth, and focusing on improving the effectiveness of employer-provided wellness programs. While the employer response takes into account population health considerations through investing in wellness programs and new care delivery mechanisms, recent government guidance could hamper an employer's ability to use these pathways to bend the cost curve in the future.

Recently, the Internal Revenue Service clarified that the Cadillac Tax applies to any coverage offered by a group health plan that is excludable from the employee's gross income (or would be excludable if it were paid for by the employer). Given this broad definition, many of the value-based purchasing initiatives employers are using to control costs, such as on-site clinics, telehealth, disease management, and wellness programs, are likely included in the employer's spend for purposes of calculating the tax. Thus, unless employers can show a positive return on investment resulting from implementing these initiatives, it is unlikely they will be able to rely on them to keep from incurring the Cadillac Tax.

### Key Board Takeaways

The phase-in of the ACA's "Cadillac Tax" in 2018 will significantly impact hospitals and health systems, both as large workforce employers and as providers. Healthcare boards should take time to consider the effect of this tax and the opportunities it will bring for their organization:

- All employers, including hospitals, will need to be smarter to contend with the impact of a non-tax-deductible penalty aimed at discouraging employers from purchasing overly rich benefit packages.
- Hospitals have a unique opportunity to creatively pursue economically feasible population health management strategies that will benefit their own bottom line, as well as marketing these strategies to other large workforce employers.

Hospitals and health systems that act now to pursue these strategies are likely to have a significant competitive edge over other providers.

## Providers Are the Solution

The continued provision of benefits in a post-Cadillac Tax world certainly presents challenges for employers. Hospitals and health systems have a potential dual role in this, both as employers themselves and as providers. There is a tremendous opportunity for employers, including hospitals, to work with healthcare providers and embrace true healthcare reform. By working with providers, employers will be able to provide a more effective benefit package that makes employees healthier and, in turn, saves the employer money.

In any group health plan there are a number of disease conditions that result in a disproportionate percentage of the employer's healthcare spending. While some of these cost drivers are common to all employers such as chronic care

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# Improving Community Health through Multi-Sector Partnerships

*BY REX P. KILLIAN, J.D., KILLIAN & ASSOCIATES, LLC,*
*AND LAWRENCE PRYBIL, PH.D., LFACHE, UNIVERSITY OF KENTUCKY*

A common goal in the mission statements and strategic plans of many non-profit, tax-exempt hospitals and health systems in the United States is to improve the health status of the communities they serve.

Yet, until recently, the board's role in this area has been unclear and there was a dearth of evidence to demonstrate how hospitals and health systems were fulfilling this responsibility. A recent study involving hospital–public health collaborations to improve community health provides guidance to hospital and health system boards.

While hospitals and health systems were faithfully fulfilling the Internal Revenue Service (IRS) "community benefit" requirements, it was difficult to show how their community benefit programs and activities had made a positive improvement on the health status of the community.

Further, there has been lack of clear understanding on several key terms and concepts in this area, including how to differentiate "health" and "healthcare" in this new dialogue; how "community health status" or "population health" was being defined; how the "community" was defined in an era of rapid health system consolidation; what forms of collaboration had proved successful in improving the health status of a community; what metrics are relevant in measuring improvement; and how health improvement activities can be organized and operated in a sustainable financial model.

The ACA upped the ante in this area in two significant ways:

- All tax-exempt hospitals are required to conduct community health needs assessments (CHNAs) at least every three years, with input from persons who represent the broad interests of the community; develop an implementation strategy to address priority needs; and make them widely available to the public.
- The National Strategy for Quality Improvement in Health Care,[1] required by the ACA, developed by the Secretary of HHS, and published in March 2011, established three aims for quality improvement, one of which is to improve the health of the population (i.e., population health).[2]

These developments have placed a new emphasis and regulatory scrutiny on community health needs and what measures should be taken to improve the health of the population. Faced with these issues, board members are called to provide strong governance leadership. Several action items should be considered by senior leadership and boards of hospitals and health systems:

- Clarify the board's responsibilities in the area of community health and how the board monitors fulfillment of its responsibilities.
- Develop annual board goals to address community health improvement.
- Provide clear differentiation between the hospital's traditional obligation to provide "community benefit" and the newer requirements regarding "community/population health."

1 *2011 Report to Congress: National Strategy for Quality Improvement in Health Care,* U.S. Department of Health and Human Services (available at www.ahrq.gov/workingforquality/reports/annual-reports/nqs2011annlrpt.htm).

2 The National Strategy for Quality Improvement in Health Care established three aims (and six priorities) for quality improvement: 1) better care: improve the overall quality of care by making healthcare more patient-centered, reliable, accessible, and safe; 2) healthy people/healthy communities: improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants for health in addition to delivering higher-quality care; and 3) affordable care: reduce the cost of quality care for individuals, families, employers, and government (also known as the Triple Aim).

## Key Board Takeaways

In many hospitals and health systems, the board's role and responsibility in the area of improving community health is unclear and there is little evidence as to how improvement is being measured and monitored. With increased emphasis and scrutiny on community health needs, board members are called to provide strong governance leadership. A recent study on improving community health through hospital–public health collaboration provides board members with several key takeaways:

- Clarify the board's responsibilities regarding community benefit and community health improvement.
- Establish a standing board committee to provide oversight and monitor performance.
- Collaborate with key stakeholders in the community, including public health, health plans, employers, and competing hospitals.
- Link community health initiatives to the community health needs assessment.
- Evaluate performance with specific objectives, targets, and metrics.
- Develop objective value propositions that demonstrate benefits to the community.
- Develop long-term sustainable funding strategies.

- Undertake board education on the regulatory requirements and expectations in this area.
- Evaluate the collective competencies of the board to make certain that it has the right people in the boardroom to address this new challenge.
- In identifying and prioritizing the health needs of the community, consider collaborating with other partners, including competing hospitals, in a community-wide effort.
- Provide strategic input on the priority health needs of the community, what initiatives should be implemented, and a realistic timeline and milestones to monitor improvement.
- Strategize on sustainable funding sources.
- Provide insight on, and approval of, the metrics to be used to monitor and measure community health improvement.
- Promote transparency and communication with the community and key stakeholders.

ACA-driven developments have placed a new emphasis and regulatory scrutiny on community health needs and what measures should be taken to improve the health of the population.

## Improving Community Health through Hospital–Public Health Collaboration

Confronted with these emerging issues, a study was recently conducted by the Commonwealth Center for Governance Studies with the purpose of identifying and examining successful partnerships involving hospitals, public health departments, and other population health stakeholders. The purpose was to ascertain key lessons learned from their collective experience and offer recommendations based on the data and analyses. With funding from Grant Thornton LLP, Hospira, Inc., and the Robert Wood Johnson Foundation, the study's key findings, lessons learned, and recommendations were published in November 2014. The data, key findings, emerging patterns, and recommendations cited herein

are based on that report.[3] The observations and insights reflect the views of the authors based on their extensive work and experience with hospital and health system boards.

After developing a set of core characteristics of successful partnerships involving hospitals, public health departments, and other parties,[4] the researchers invited and received nominations of 157 partnerships located in 44 states.[5] The partnerships were screened against the core characteristics and subsequently reduced from 157 to 12 exemplary and diverse partnerships. The 12 partnerships represented 11 states and varied in geography from coast to coast, rural and urban, state-wide or local community, and in scope from a broad focus ("to be the healthiest community in the nation by 2020," Healthy Monadnock 2020) to a narrow focus ("reducing the infant mortality rates in three inner-city neighborhoods," Detroit Regional Infant Mortality Reduction partnership). (See sidebar "Partnerships Involved in the Study" for a full list of participants.) The research team conducted two-day site visits and completed interviews of key partnership representatives, board members, and senior leadership.

3 L. Prybil, D. Scutchfield, R. Killian et al., *Improving Community Health through Hospital–Public Health Collaboration: Insights and Lessons Learned from Successful Partnerships,* Commonwealth Center for Governance Studies, Inc., November 2014 (available at www.uky.edu/publichealth/hospital/collaboration).
4 *Ibid.,* pp. 48–49.
5 *Ibid.,* pp. 51–62.

## Partnerships Involved in the Study

The study on improving community health through hospital–public health collaboration included 12 diverse partnerships from across the U.S.:

- National Community Health Initiatives, Kaiser Foundation Hospitals and Health Plan, Oakland, California
- California Healthier Living Coalition, Sacramento, California
- St. Johns County Health Leadership Council, St. Augustine, Florida
- Quad City Health Initiative, Quad Cities, Iowa-Illinois
- Fit NOLA Partnership, New Orleans, Louisiana
- HOMEtowns Partnership, MaineHealth, Portland, Maine
- Healthy Montgomery, Rockville, Maryland
- Detroit Regional Infant Mortality Reduction Task Force, Detroit, Michigan
- Hearts Beat Back: The Heart of New Ulm Project, New Ulm, Minnesota
- Healthy Monadnock 2020, Keene, New Hampshire
- Healthy Cabarrus, Kannapolis, North Carolina
- Transforming the Health of South Seattle and South King County, Seattle, Washington

## Emerging Patterns

Each of the 12 partnerships that participated in the study is unique in several respects. While all were dedicated to improving the health of the communities they serve, their origin, mission, goals, and their strategies for addressing health needs varied considerably. Yet, certain patterns appeared consistently in all 12 partnerships.

**A Focus on Population Health**

Increasing focus at the local, state, and national levels on "population health" and improving the health of the communities was at the core of these partnerships. There is a fundamental change occurring in the United States driven by the awareness that inadequate attention and resources have been allocated to prevention of illness and injuries, early diagnosis and treatment, and promotion of wellness. Further, hospitals are now being held accountable for healthcare outcomes through various programs including accountable care organizations (ACOs), value-based purchasing (VBP), pay-for-performance, bundled payments, and never events. These transformational changes require community health considerations, not just individual patient concerns or a focus only on patients in the hospital. It also needs a community orientation with new partnerships and relationships with others and the pulling together of several community resources to develop that shared and collective capacity.

**Mission Statements**

All of the partnerships' mission statements focus on improving the health of the community they serve, but the nature and scope of the respective missions of the 12 partnerships varied significantly ranging from a narrow to a very expansive scope. One of the problems noted in several partnerships was that it was difficult to fulfill the mission where it was not evident that the hospital, public health department, and other partners had a clear and common understanding of what "community health" or "population health" means, the geographic scope of the community served, how health status should be measured, and/or the evidence-based targets for improvement.

**Partner Engagement**

The active engagement of many partners in the establishment and ongoing operations is essential to the partnership's sustainability and success. The principal partners in the 12 partnerships universally included a public health agency or agencies and one or more hospitals or health systems. A welcome pattern found in several of the partnerships was that competing hospitals in the community collaborated together in addressing the need to improve the health of the communities they served. On the other hand, while the improvement of community health should be of equal

concern and focus to local businesses and health plans, the common pattern of the partnerships studied showed very few local businesses or health plans as partners.

> There is a fundamental change occurring in the United States driven by the awareness that inadequate attention and resources have been allocated to prevention of illness and injuries, early diagnosis and treatment, and promotion of wellness. Further, hospitals are now being held accountable for healthcare outcomes. These transformational changes require community health considerations, not just individual patient concerns or a focus only on patients in the hospital.

**Difficulty Measuring Progress on Objectives and Metrics**

Many partnerships continue to be challenged in developing objectives and metrics and demonstrating their linkages with the overall measures of population health on which they have chosen to focus. Most of the partnerships studied are challenged to set, articulate, and prioritize goals, objectives, and metrics that clearly reflect the mission, and to measure and monitor progress in a way that demonstrates improvement and maintains the momentum of the partners. This can be problematic for hospital boards and leaders who are accustomed to evaluating financial, strategic, and quality performance through the routine use of metrics, goals, and scorecards.

**Starting with a Loose Affiliation Model**

A large majority of the partnerships studied are organized in a loose affiliation or coalition model. While a majority of the partnerships were formed in a loose organizational model with a policy-setting body, none were organized in a corporate model, nor have evolved into a more structured organizational model. Several of the interviewees made it clear that going to a formal structure in the beginning would most likely not have been well-received in the community. Yet, a substantial proportion (one-third) of leaders interviewed believe their organizational model needs to evolve to a more structured form.

**Financial Sustainability Challenges**

Financial sustainability remains a significant challenge in most partnerships. With few exceptions, the partnerships studied were created without long-term sources of financial support. They tend to be lightly funded and therefore must constantly seek external grant support. The leanest partnership operated with total financial support of just over $60,000 for its most recent fiscal year, while the most highly capitalized partnership received an average of $4.6 million per year in financial support over its 10-year history. In addition to anchor institutions such as hospitals, health systems, and public health departments, other long-term sources of financial support could include health plans that understand the need and benefit of focusing more resources on population health, and local employers that see the value proposition to the community, their employees, and local government.

## Recommendations

The research team concluded that partnerships involving hospitals and/or health systems, public health departments, and other key stakeholders in the community have an important social role and can serve as effective vehicles for collective action focused on population health improvement. Based on empirical findings and our judgment, the study team developed 11 recommendations,[6] the following 10 of which should be of special interest to hospital and health system board members and senior leaders.

**1. Partners**

*Partnerships should include hospitals and public health departments as core partners and, over time, these core partners should reach out and engage a broad range of other parties from the private and public sectors.* Other potential partners include school

6 Prybil, Scutchfield, Killian, 2014, pp. 39–44.

systems, health plans, local government, business organizations, and community interest groups. It has become clear that hospitals and public health departments are logical and essential partners in efforts to improve the health of the communities they serve. Hospitals that compete in other ways can find common ground to collaborate in this important work. For example, in the Quad City Health Initiative, Genesis Health System and UnityPoint Health-Trinity are anchor institutions that provide financial support, serve on the board of the partnership, and are committed to its goals and objectives, yet they compete aggressively in the same region on healthcare services. Collaborating with local hospitals and health system can have many benefits, such as helping to align community health initiatives, making efficient use of resources, leveraging the expertise of partners, sharing health data, and avoiding duplication of efforts. In support of this conclusion, the final CHNA regulations promulgated by the IRS effective December 29, 2014, strongly emphasize the value of collaboration and encourage and facilitate collaboration with other hospitals and organizations for the common good of the community.

**2. Trust-Based Relationships**
*Whenever possible, partnerships should be built on a foundation of pre-existing, trust-based relationships among the founding partners.* Indicators of a strong culture among partners include a tradition of participating in collaborative arrangements, mutual respect and trust, and being open and transparent with one another. It is not necessary or feasible for independent organizations or competing hospitals that establish or join a new partnership to have identical values or cultures, but without substantial congruence, problems are likely to occur. For long-term success, all partnerships require sustained attention to building and maintaining relationships among principal partners based on honesty, mutual respect, and trust.

While there is growing attention to "population health" in all sectors, there is not broad understanding—even among health professionals—regarding definitions, priorities, or the metrics that should be used in assessing community health and measuring progress in improving it.

**3. Mission and Goals**
*Partnerships should adopt a statement of mission and goals that focuses on clearly defined, high-priority needs and will inspire community-wide interest, engagement, and support.* The mission and goals need to be defined both strategically and pragmatically and balance many factors including prioritization of community needs, existing programs and services, current and potential sources of funding, and the pros and cons of using a collaborative partnership as a vehicle vis-à-vis other organizational models. The statement should also carefully define the scope and nature of the mission and goals in a realistic framework that will translate into a tangible plan of action. A partnership with a mission that is unrealistically broad and complex is likely to experience difficulty in demonstrating sufficient progress to generate sustainable funding and maintain community interest.

**4. Anchor Institutions**
*Partnerships need to have one or more "anchor institutions."* While many partnerships were established by a small number of organizations that share common interests, it is clear that the long-term survival and success of these partnerships is enhanced when one or more principal partners step forward to serve as an "anchor institution." Partnerships without an anchor institution to provide a solid, dependable foundation of economic and non-economic support are inherently fragile and constantly dependent upon obtaining new sources of financial support to sustain core operations.

**5. Organizational Structure**
*Partnerships should have a designated body with a clearly defined charter that is empowered to set policy and provide strategic leadership. Though structure is important, collaborative parties do not need a formal corporate structure to achieve the goals and objectives of the participants.* While a majority of the partnerships studied are organized in a loose affiliation or coalition model, it remains prudent for the principal partners to create a mechanism for shaping the partnership's operating policies, providing strategic leadership, and making budgetary and resource allocation decisions. These bodies can take on various names such as a board, steering committee, or leadership council. Whatever term is employed, it is important to clearly define the role and accountability of the body and this can be done in a written charter or other organizational document.

**6. Population Health Terms, Concepts, and Principles**
*Partnership leaders should build a clear, mutual understanding of "population health" concepts, definitions, and principles among the partners, participants, and community at large.* While there is growing attention to "population health" in all sectors, there is not broad understanding—even among health professionals—regarding definitions, priorities, or the metrics that should be used in assessing community health

and measuring progress in improving it.[7] Partnership leaders should intentionally devote efforts to build a solid base of common understanding regarding important population health concepts, definitions, and principles.

**7. Evaluating Performance**

*To enable objective, evidence-based evaluation of a partnership's progress in improving the health of the community, leadership must specify the community health measures to be addressed, the specific objectives and targets they intend to achieve, and the metrics and tools they will use to track and monitor progress.* Selecting the objectives and targets they want to achieve and the appropriate metrics to monitor progress are among the most important and challenging duties of the leadership team. Unless these selections are based on the best science currently available, it is difficult, if not impossible, to evaluate the success of the partnership's programs and strategies. One example of the methods employed to develop measures is found in the Healthy Montgomery[8] partnership where population health is seen as a shared responsibility of healthcare providers, governmental public health agencies, and many other community institutions. To manage this shared responsibility, two sets of measures were developed: 1) a community health profile that summarizes a community's overall health status for which all parties share responsibility, and 2) a set of measures that focus on performance of agreed-on program activities.[9]

> Making demonstrable improvement on key measures of community health is difficult and requires a long-term commitment of efforts and resources. This reality needs to be communicated and understood by the key stakeholders.

**8. Value Proposition**

*Partnerships should develop and disseminate "impact statements" that present an evidence-based picture of the effects the partnership's efforts are having in relation to the direct and indirect costs it is incurring.* The intent of the impact statements is to provide partners, funders, key stakeholders, and the community at large with an objective "value proposition" that demonstrates the benefits to the community in relation to its operating and capital costs. Making demonstrable improvement on key measures of community health is difficult and requires a long-term commitment of efforts and resources. This reality needs to be communicated and understood by the key stakeholders. Much of this work is in the early stages, and it became clear in the study that it is extremely difficult to "bend the curve" on key community health indicators. As discussed more thoroughly in the report, the health of a community or population group is determined by a complex array of factors, many of which are outside the control of the hospital, health system, or public health agency.

**9. Sustainable Funding**

*Partnerships focused on community health improvement need to develop a deliberate strategy for broadening and diversifying sources of funding support.* A major challenge for most of the partnerships in the study was securing sufficient and sustainable funding. Partnerships with anchor institutions (hospitals, health systems, and public health departments) have a stronger and more durable foundation; e.g., Kaiser Foundation Hospitals and Health Plan is the home base for Kaiser's system-wide Community Health Initiatives program; MaineHealth, a Portland-based non-profit health system, is the principal sponsor for HOMEtowns Partnership; and the St. Johns County Health Leadership Council in Florida and Healthy Montgomery partnership in Maryland (and other partnerships) are closely aligned with strong local health

7 U.S. Centers for Disease Control and Prevention, *Community Health Assessment for Population Health Improvement: Resource of Most Frequently Recommended Health Outcomes and Determinants,* Atlanta, GA: Office of Surveillance, Epidemiology, and Laboratory Services, 2013; Institute of Medicine, *Vital Signs: Core Metrics for Health and Health Care Progress,* Washington, D.C.: The National Academies Press, 2015.

8 The product of a community health needs assessment, Healthy Montgomery in Rockville, MD, includes all five area hospitals, safety net clinics, minority health initiatives, and social services agencies in a formal consortium of interested parties dedicated to health improvement; see Prybil, Scutchfield, Killian, 2014, pp. 76–77.

9 See Healthy Montgomery Core Measures, *Ibid.,* pp. 78–79; Michael A. Stoto and Colleen Ryan Smith, *Community Health Needs Assessments—Aligning the Interests of Public Health and the Health Care Delivery System to Improve Population Health,* Institute of Medicine, April 2015 (available at http://bit.ly/1RzAkHO).

departments. Subsequent to completion of our study, Blue Shield of California has begun providing financial and other forms of support for the California Healthier Living Coalition, one of the partnerships in the study. Both local employers and health plans that provide coverage for population groups served by successful partnerships focused on community health improvement will benefit from the partnership's efforts. We believe it is time for successful partnerships to "make the case" both to major employers and health plans. Well-documented, evidence-based impact statements, including the value proposition and/or the ROI, are likely to be essential in securing their interest, understanding, and support.

**10. Standing Board-Level Committee**
*Governing boards of hospitals, health systems, and local health departments should establish standing community benefit committees to provide oversight of their responsibility to improve the health of the community.* Hospital and health system boards that have oversight responsibility for improving the health of the community should establish a standing committee of the board and charge it with the responsibility for the organization's role, priorities, and performance in the realm of population health improvement, including their strategies for promoting collaboration with other community organizations. The existence of a standing board committee composed of persons with special interest and expertise in population health will focus board attention on important issues and galvanize ongoing action and evaluation of progress.

## Conclusion

Several years ago, we were attending a board retreat of a large non-profit health system when during a review of the health system's mission statement ("to improve the health of the communities we serve"), one of the board members asked the question, "What business are we in, 'health' or 'healthcare'?" It was clear in the ensuing discussion that our core business was "healthcare"—treating illness and disease whereas "health" entailed preventing persons from getting sick or ill. The whole discussion stimulated us and has caused us to question what a hospital means when its mission statement refers to improving the health of the community. We think what it means to most hospitals is that they will provide low-cost and high-quality healthcare to the patients they serve. Through their community benefit requirements, they will provide uncompensated care as well as other programs that will benefit the community such as research, education, increased access, new patient care services, etc.

Now, the business of "health" is the new frontier. While hospitals and health systems need to maintain and sustain the core business of healthcare, who better to take a leadership role in the effort to improve the health of the communities than healthcare providers and public health agencies. And while no single hospital or health system can be accountable for the overall health of the community, who better to set and help direct the culture of health tone than hospital and health system leadership and boards.

*The Governance Institute thanks Rex P. Killian, J.D., President of Killian & Associates, LLC, and Lawrence Prybil, Ph.D., LFACHE, Norton Professor in Healthcare Leadership and Associate Dean, College of Public Health, at the University of Kentucky, for contributing this article. They can be reached at rkillian@killianadvisory.com and lpr224@uky.edu.*

# Linking Governance Structure to Strategy

*BY PAMELA R. KNECHT,* ***ACCORD*** *LIMITED*

In today's complex healthcare environment, highly effective boards are partnering with senior management to revisit their organization's overall strategic direction. As part of this process, they are requesting intense education on healthcare industry trends and they are discussing the potential implications of those trends for their organization's future success.

In addition, these boards and management teams are conducting retreats that include in-depth conversations about their various strategic options so they can make clear decisions about the appropriate course for the future. The best boards also ensure that management develops measurable strategic plans so they can more easily hold management accountable for achieving the plan.

All of these governance practices are critical for healthcare boards to ensure that they are helping to steer their organizations toward achievement of their mission. However, many boards fall into the trap of thinking that once they have approved the written strategic plan, their work in this area is done.

## The Link between Strategy and Governance Structure

It is true that the board should delegate implementation of the strategies to management. But, boards that are following governance "best practices" know that their strategy work has not been completed until they have determined how, if at all,

they need to change their own governance structure to support achievement of the organization's strategic plan.

For the purposes of this discussion, governance "structures" will include the following:

- Corporate legal entities and board size, composition, and authority
- Committee structures
- Board competencies and independence

## Restructuring Corporate Legal Entities and Their Boards

It may seem that only large, multi-hospital systems need to revisit their corporate legal entity chart in light of their new strategy. But, many single-hospital strategic plans now include the development of "care systems" that incorporate all the components of care across the continuum as a foundation for population health management within their communities.

These care systems usually have multiple corporations including a parent and some subsidiaries such as a hospital, an employed physician group, a skilled nursing facility, a foundation, and for-profit ventures (e.g., durable medical equipment). Each of these separate legal entities must have a board, but the size, composition, and authority of each board can differ.

Some systems (large and small) have decided that the best way to provide consistent, high-quality care to their communities is to use a centralized strategy and an operating company business model. These systems eliminate almost all of their legal corporate entities and associated boards. They tend to retain one board—the parent board—that is composed of "external community" members and has ultimate authority for governance throughout the system. Any other corporations that need to remain in existence for regulatory, legal, or reimbursement reasons will be populated with "internal management" members and will most likely have very limited authority.

Other care systems have decided that a more decentralized strategy is appropriate, so they have instituted either a holding company model or a modified operating company model. In a modified operating company model, some subsidiary corporations and boards exist for distinct "business lines" such as a health plan or senior services. In the holding company model within a larger system, there may also be separate boards that oversee all of the care within a geographic region.

### Key Board Takeaways

A healthcare organization's governance structure should support achievement of its strategic plan. Boards can help ensure that governance structure and strategy are properly aligned by asking the following questions about their governance structures:

- Do we need to revisit the number and type of corporate legal entities in our "system" in light of our strategy?
- Have we provided sufficient clarity regarding the role, responsibility, and authority of each board (and committee)?
- Is the size and composition of each board (and committee) appropriate?
- Should we modify our committee structure to provide more focus on areas included in our strategy?
- Does our board as a whole include all of the competencies, skills, and perspectives needed to develop and oversee implementation of the strategy?
- Are our boards and committees sufficiently "independent" to provide objective oversight of our organization?

In both of the decentralized models, the parent boards and most of their subsidiary boards have "external community" members. However, these subsidiary boards are often smaller and their authority level is usually narrowed to their area of focus (e.g., fundraising or credentialing/privileging).

## Revisiting Committee Structures

A board's committee structure may also change with its strategy. For instance, a hospital or system board may add a community relations and benefit committee if its strategy emphasizes the need to understand and address all of the community's healthcare needs. This committee can oversee management's development of the ACA-required community health needs assessment and actions designed to address the identified needs.

Many hospitals and systems are implementing physician alignment and employment strategies. As a result, they have decided to broaden the scope of their executive compensation committee to include oversight of physician compensation as well.

Some hospital and system boards have added a population health management committee to further their strategy of building the full continuum of care and participating in payment systems that include sharing of risks and rewards.

## Ensuring Sufficient Competencies and Independence

One of the most important ways to link governance structure and strategy is to ensure that the board has all of the competencies, skills, and perspectives needed to develop sound strategies and to oversee implementation of the selected strategies. To do this well, boards today often need members who are experienced executives within the healthcare industry. And, boards that have approved a clinical integration strategy value members who have successfully developed a network of clinicians who work in an integrated fashion across all the sites of care.

There are many other competencies that are needed by boards whose strategies include integrating care across the continuum and/or population health management. For instance, boards are adding experts in public health and risk management.

However, a challenge arises as boards attempt to add executive and clinical expertise. Regulators and legislators are concerned that not-for-profit boards are composed of a sufficient percentage of "independent" members. Since local healthcare executives and active medical staff members are generally not considered "independent" by the IRS, many boards are choosing to add members from outside their local geography to secure these and other areas of expertise from non-conflicted individuals.

The delivery of healthcare in this country is undergoing significant transformation. Therefore, forward-thinking boards and their management teams must partner to develop appropriate strategic responses.[1] However, being involved in strategy development (and monitoring) is not enough. Organizational effectiveness experts have known for decades that strategic plans are more likely to be implemented if the corporate, governance, and management structures are aligned with the strategy. Therefore, the very best boards are taking a hard look at all of their governance structures and then implementing any needed changes. In this way, they are hardwiring their own governance into the vision and mission of the organizations they are charged with overseeing.

*The Governance Institute thanks Pamela R. Knecht, President and CEO, **ACCORD** LIMITED, for contributing this article. She can be reached at pknecht@accordlimited.com or (312) 988-7000.*

1 For more information on engaging in strategy, see Pamela Knecht, *Engaging the Board in Strategic Planning: Rationale, Tools, and Techniques* (white paper), The Governance Institute, Summer 2007.

## Elevating Hospital Foundation Board Governance

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involvement. In *Redefining Healthcare Philanthropy*, Betsy Chapin Taylor, President of Accordant Philanthropy, writes: "Board members deserve to participate in value-added activities aligned with their individual strengths, talents, comfort zone, interests, and constraints. Simply, there doesn't need to be a one-size-fits-all, lockstep approach to board roles in fund development…Given the broad spectrum of meaningful development activities, board members should be able to choose amongst various roles to create their own engagement plan."[2] Achieving an individualized approach often unlocks board involvement, since those who had feared or dreaded a role in direct solicitation can now advance equally important tasks like identifying prospects with likely interest and ability to give, making introductions, sharing the organization's vision, or thanking those who have made a contribution.

**Recognize the Link between Strategy and Stewardship**

Most foundation board leaders would tell you *stewardship* is a key part of their role. However, good stewardship is more than just safeguarding dollars in hand. Boards also practice responsible stewardship by ensuring the organization pursues an appropriate strategy and programmatic mix to use staff time and operational budgets well. Too often, foundation boards advocate for chasing fund development strategies that are comfortable and familiar rather than insisting upon prioritizing what is most effective. For example, many boards often elevate the importance of special events to the detriment of more partnership-rich and resource-intense opportunities like major gifts.

**Meetings Must Reflect Priorities**

Many organizations allow board meetings to be dominated by low-value report giving and rubber-stamping. This detracts focus from the most important work to accomplish: leveraging the gravitas and earned trust of board members to initiate and foster relationships between those in their networks and the healthcare mission. To use board meeting time more effectively, foundation boards should dispense with routine business by using a consent agenda to consider unremarkable items in a single board action. This makes way for time to share information and stories about strategic funding priorities, to explore donor engagement opportunities, and to hold catalytic conversations to spur progress. Still, don't forget that most of the magic—in the form of peer-to-peer engagement—happens outside the boardroom.

It is time to reposition foundation board governance to achieve a new level of impact. There needs to be clarity about the foundation's role and the highest and best use of board leadership in advancing it. Board roles must leverage each individual leader's valuable, personal networks to gain access, build trust, and amplify the message of the organization. Boards should also insist upon strategies to maximize ROI that are consistent with current best practices in the field. By strengthening the engagement and deployment of foundation board leaders, healthcare foundations can leverage board member's individual strengths to maximize charitable support to advance the healthcare mission.

*The Governance Institute thanks Steven W. Churchill, President and CEO of the Association for Healthcare Philanthropy, for contributing this article. He can be reached at steve@ahp.org.*

2 Betsy Chapin Taylor, *Redefining Healthcare Philanthropy,* Association for Healthcare Philanthropy, May 2014.

## The Next Phase of the ACA…

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management, most employers have a handful of disease conditions that are unique to their population or industry. For example, in the manufacturing industry back pain, pain management, and certain orthopedic conditions are more prevalent than in other industries.

With increasing frequency, employers are directly contracting with providers to manage their plan cost drivers. For example, some employers are creating "narrow networks" of hospitals and physicians that can provide high-quality, low-cost care. Others have established centers for excellence and bundled payment arrangements with providers for certain clinical conditions that provide certainty with regard to cost of care. Another example has been the significant cost savings associated with chronic care management through the use of care coordinators. Given the effectiveness of these relationships, many employers are looking not only to increase the use of these types of arrangements to include a larger number of disease conditions in the future, but also turning to the provider community to develop increasing sophistication in these programs to more effectively and actively manage population health.

### Conclusion

As stated above, the most common employer response to the Cadillac Tax has been to reduce the richness of the benefit plan offered to employees. This approach, however, is akin to rearranging deck chairs on the Titanic because benefit buy-downs will only delay the impact of the tax and will do nothing to actually reduce the cost of providing care to employees. The developing trend in recent months of employers and healthcare providers collaborating to analyze employee populations, develop protocols for effective care management, and provide certainty as to pricing is more productive in the long run. By engaging in these initiatives and creatively pioneering new ones, hospitals and health systems have, both as employers themselves and as healthcare providers, a great opportunity to gain strategic advantage in successfully overcoming this next challenge presented by the ACA.

*The Governance Institute thanks Anjana D. Patel and Adam C. Solander, Members of Epstein Becker & Green, P.C., for contributing this article. They can be reached at ADPatel@ebglaw.com and ASolander@ebglaw.com.*

## Six Business Imperatives…

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and quickly an organization moves toward full risk models.

Hospitals and health systems can participate in a variety of value-based or risk contracts, ranging from fee-for-service with incentives (e.g., gain sharing and pay-for-performance) to partial or full risk models (e.g., global payment, partial capitation, or full capitation). Fully integrated health systems will be able to use all types of contracting arrangements that tie payment to performance and outcomes, while small providers will be more limited in the types of arrangements they can secure.

Contracting for PHM will require consideration of the risks and opportunities related to the health/risk characteristics of the populations served by specific insurance products, design of HMO, PPO, and employer-directed plans, contract terms and conditions, narrow and tiered networks requirements, and partnership opportunities related to specific networks, products, and plans.

Hospitals that do not pursue PHM contracting with purchasers soon may find themselves excluded from key networks in their region or may be relegated to the role of a discounted vendor of acute care services.

### Network Optimization

Effective and sustainable PHM requires the design and continuance of a high-performance delivery network. This network must cover the care continuum under an optimized contracting strategy, and apply effective approaches to engaging stakeholders, including patients, families, employers, and others. Sophisticated organizations will be developing an optimized network; other organizations will look to participate in an optimized network provided by another entity. To optimize networks, leaders consider:

- **Essentiality and adequacy:** The breadth and depth of care desired by the purchaser, and the ability to handle the projected volume of patients across the defined care settings
- **Service distribution right-sizing:** The elimination of duplication by reconfiguring the network to be highly efficient, deliver consistent quality across all sites, and manage patients in the least-intensive setting possible while still providing the necessary level of care
- **Network growth strategy:** The ability to grow the attributed or accessible managed populations to support organizational infrastructure and associated costs

Consumer engagement ensures both the clinical and business success of managing a population's health within a network. Effective consumer engagement enables an organization to help shape healthy behaviors, achieve the right level of utilization, and steer individuals to the best site of care.

### Operational Efficiency

As an organization's sphere of influence widens in a value-based environment, its cost/efficiency focus shifts from the traditional view, involving inpatient and physician-centric entities, to a population health view, involving a broader scope of the care continuum.

Broad strategic thinking about the care patients receive after they leave the hospital's four walls is required of leadership to ensure the right care in the right place, at lower costs and better quality.

### Enabling Infrastructure

Managing population health involves major clinical and organizational transformation made possible by investment in areas including:

- Management and governance structures that include a high level of physician involvement and cover contracting, risk assessment, clinical, and operational decision making
- A delivery network of sufficient size and scope
- IT systems that are able to support clinical care management processes, common electronic health record systems, clinical and predictive analytics, and business functions
- Care management and coordination tools and protocols tied to an enterprise-wide decision support and reporting function
- Contracting and risk assessment and management capabilities
- Patient engagement programs to build loyalty and "stickiness"

PHM will require leaders to rethink their infrastructure needs and invest and organize in a way that supports the organization's role and key initiatives in PHM going forward.

### Clinical Management

Three clinical imperatives apply to all hospitals and health systems, however large or small a role they play in PHM:

- **Identify, stratify, and prioritize the patient population along the health-risk continuum:** Organizations identify the geography they serve and the contracting arrangements for the patient populations within this geography. They then prioritize their PHM efforts for efficiency and effectiveness across patient health-risk categories.
- **Develop and implement interventions to improve health, access, and outcomes, and to reduce costs:** Hospitals understand the impact of technology and care settings, and recognize the importance of consumer engagement, new provider types, collaborative practice, and evidence-based medicine. They then design and implement prevention initiatives based on population health risk categories, spanning wellness, care transitions, disease management, care coordination, care navigation, and end of life, as appropriate.
- **Evaluate and refine the approaches and interventions:** Hospitals and health systems understand the big-picture objectives of performance improvement and the on-the-ground challenges of selecting and implementing appropriate measures of PHM progress. They select their targets and start moving toward the end goals of effective and efficient PHM.

The degree and pace at which organizations pursue the six business imperatives described here will depend on a variety of internal and external forces. These include organizational readiness with new competencies required for value-based care, overall stage of market evolution, vertical collaboration across health plans and provider organizations, and existing risk contracts and relationships. But population health management is the way U.S. care delivery is going, so all healthcare boards and management teams must work to develop the knowledge and skills to move their organizations in the right direction.

*The Governance Institute thanks Mark E. Grube, Managing Director, Kaufman, Hall & Associates, LLC, and Governance Institute Advisor, for contributing this article.* *He can be reached at mgrube@kaufmanhall.com.*

# Six Business Imperatives Expand Board Oversight

*BY MARK E. GRUBE, KAUFMAN, HALL & ASSOCIATES, LLC*

Healthcare's transition to a population health model presents hospitals and health systems with significant business opportunities and challenges. Increasingly, organizations will be responsible for providing defined care to a specific population while managing the population's total cost of care.

The value-driven approach to care delivery and financing focused on population health management (PHM) alters the established business fundamentals. To succeed, healthcare directors and executives must rethink the scope of their enterprise, including where, to whom, and how their organizations provide services, and which services are most appropriate given the unique needs of the populations they serve.

Significant additional board knowledge and oversight will be needed to arrive at a sustainable "solution set" for managing population health. Some organizations are changing board composition to include physicians and members with expertise in quality improvement, risk management, cost reduction, and other key PHM areas; other organizations need to move more rapidly to gain needed experience.[1]

Addressed here are six business imperatives that should be front and center on all board radar screens in developing and implementing their PHM strategy. These imperatives are interrelated and interdisciplinary, crossing strategic, financial, clinical, operational, and capital management domains.

## Key Board Takeaways

Below are six business imperatives boards should focus on as they develop and implement their population health management strategy, as well as questions to consider related to each:

1. Physician and clinical alignment:
   - » How do we ensure alignment with employed and independent physicians?
   - » What incentives are available for physicians? Do contractual arrangements clearly delineate the criteria for incentives? How do we address physicians not performing up to defined standards?
   - » How is leakage of patients to non-network physicians prevented? Do physicians clearly understand how attribution works?
2. Contracting strategy:
   - » What's our plan for gaining experience in managing risk through contracting arrangements?
   - » What's our strategy to ensure inclusion in key networks forming in our community?
3. Network optimization:
   - » What role will our organization play in a care delivery network? How are we determining the best combination and location of services and programs?
   - » How are we learning about consumer preferences and purchasing behavior?
4. Operational efficiency:
   - » How are we working with physician practices, post-acute, home care, and other providers to ensure efficiency and deliver value?
   - » What can we do to transform our cost structure to a much lower level?
5. Enabling infrastructure:
   - » Which means are we considering—building, buying, partnering—to gain needed infrastructure quickly?
   - » What process are we using to make capital investment decisions that support the organization's role in PHM? What return do we expect from these investments?
6. Clinical management:
   - » How do/will we prioritize PHM efforts across patient health-risk categories?
   - » What interventions will we develop and implement? How do/will we evaluate the success of these interventions and ensure improvement on an ongoing basis?

## Physician and Clinical Alignment

Improved economic and clinical alignment between hospitals and physicians will be essential to:

- Change the way patient care is delivered.
- Enhance patient, family, and provider satisfaction and engagement.
- Improve each element of the value equation (i.e., quality, access, patient experience, and operating/capital efficiency).
- Succeed under value- and/or risk-based arrangements.

Developing a solid hospital–physician alignment plan involves recognizing that one strategy will not be appropriate for all physicians, and that hospitals should offer physicians multiple options.

Finding the right incentives to motivate physicians is vital. Incentives should cover dimensions including financial, access, competition and recognition (e.g., quality ranking scores), and patient care (e.g., improved health outcomes). The most important principle is to develop uniform, readily quantifiable, consensus-driven incentive standards and metrics that have a consistent application across clinicians, locations, and specialties.

As health systems start building their physician networks, they typically have more relaxed (or lower threshold) performance criteria. As their experience grows, they tighten the criteria and are able to be more selective with physician participation. Physicians not performing up to defined standards often opt out or are *not* allowed to continue to participate in the network's value-based contracts.

For success with PHM contracting arrangements, a hospital or health system must have an integrated network of primary care physicians and must ensure accurate attribution of the targeted population segment(s) to this network. *Attribution* in PHM programs is the assignment of an individual to a specific primary care provider, typically based on past medical claims.

## Contracting Strategy

Contracting is fundamental to PHM programs as it is the vehicle to delineate what payers or other purchasers and providers will be accountable for. Organizational and market nuances dictate the types of contracting arrangements pursued for targeted population segments, and how far

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1 Kathryn C. Peisert, *Governing the Value Journey: A Profile of Structure, Culture, and Practices of Boards in Transition,* 2013 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute.