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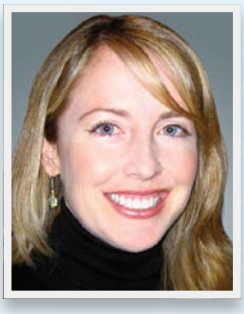

When putting together the articles for this issue, I was struck by a quote from Marian Jennings' book on strategy for uncertain times, written 15 years ago (see page 5). It articulates the large-scale and difficult change being experienced in the healthcare industry at the time. Several other articles in this issue deal with our current challenges regarding change and uncertainty. In my years of editing publications for The Governance Institute, I recall the discussion about change proliferating since Sarbanes-Oxley, though it likely began even earlier. The discussions to which I was privy then were centered around increased legal scrutiny—the "new" healthcare board couldn't just be a rubber stamp group spending most of its time on the golf course. It was then we knew that the "real work" needed to begin.

That was around 2002, and here we are in 2015 continuing to talk about change, transformation, reform, uncertainty, fast change, slow change, disruptive change, and needing to *prepare* for change. I live in a place where the slow food movement and "locavore" values are mainstream, so I often see the bumper sticker on cars that states, "Let's stop the glorification of busy." I think its time we apply this to healthcare and declare that we will stop the glorification of change. We should no longer be preparing for change—we should be in the middle of it and recognizing that change is just business as usual. Whatever change we are currently experiencing will be a precursor to the next change five years (more or less) down the line. Let's settle on the vision, strategies, and goals, and face this change head on, and be accountable to our progress. Let's look at what else is coming and say that we are ready for it. Let's finally say we can handle the grey areas because it's not likely to be black and white in healthcare anytime soon.

Kathryn C. Peisert *Managing Editor*

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9685 Via Excelencia • Suite 100
San Diego, CA 92126
Toll Free (877) 712-8778 • **Fax** (858) 909-0813
GovernanceInstitute.com

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Developing an Effective Board to Manage Change

BY KEVIN J. MILLER, FACHE, RHIA, MILLER HOSPITAL CONSULTING & INTERIM MANAGEMENT

Today's healthcare environment is a turbulent sea with no calm in sight. As the Affordable Care Act reshapes the healthcare system, each hospital needs to weigh the value and risks of new models such as accountable care organizations, bundled payments, and patient-centered medical homes.

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We face increased scrutiny by payers and regulators, and need to implement technical improvements that require significant funds, while at the same time hospital payments decrease.

Our organizations must transform themselves in order to successfully navigate these choppy seas, and as a first step, the board must transform itself. Boards are the decision makers, the captains of their ships, but today many are not prepared to sail their organizations out of the storm.

Kevin J. Miller, FACHE, RHIA
President
Miller Hospital Consulting & Interim Management

The change management process typically includes three phases:

- Preparing for change: assessment and strategy development
- Managing change: making and implementing detailed change management plans
- Analyzing change: gathering data, recognizing successes, and taking additional steps to strengthen weak areas

Let's look at four important steps that will help boards determine their strategic direction, prepare for change, and create organizational transformation.[1]

Four Steps to Guide the Change Management Process

1. Have Candid Discussions about What Transformation Means for the Organization

In the change management process, the first step is to prepare for change. That requires an honest, direct discussion of significant changes needed to support the organization's vision.

Too often, the board spends time listening to formal reports on actions that have already been taken. To be most effective, the board could schedule a "deep dive" on an important subject for each meeting, so that it takes time to think carefully and prepare for the major decisions every hospital and health system will face in the uncertain future. This requires a thorough assessment and discussion of the organization's culture, its challenges and opportunities, and its readiness to change.

During the decision-making process, the board and the executive team need to engage fully, speak up, question each other, and take time to explore the potential advantages and weaknesses of differing viewpoints. Boards sometimes agree upon a vision for the future, without always understanding or supporting the changes needed to make a significant transformation. Boards should steel themselves for the resistance to change exhibited by some staff, medical staff, community members, and others, since some degree of resistance is an inevitable aspect of change. For the process of change to be a success, the board must have one unified voice and support the organization's leaders once significant change begins.

2. Strengthen Board and Organizational Capabilities to Manage Change

Beyond the change management process, boards should consider several changes in their own operations:

- Mandatory board education in order to understand the healthcare industry and healthcare transformation.
- Competency-focused evaluations of each individual board member by their peers, as well as an evaluation of the board as a whole, and of the board's meeting process and effectiveness.
- Competency-based criteria in board member selection. What capabilities do board members need in order to prepare the hospital to respond to changing needs? Consider seeking board members with expertise in finance, information technology, quality improvement, marketing, healthcare regulations, public relations, fundraising, and/or labor relations.

3. Focus on Accountability for Outcomes

This means holding the organization's leaders accountable for meeting the goals set in the strategic plan. An effective board will also hold itself accountable for developing and meeting strategic objectives.

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Key Board Takeaways

Healthcare organizations and their boards must transform themselves to succeed in the current environment. Below are four important steps boards can take as they work to prepare for, manage, and analyze change:

1. Have candid discussions about what transformation means for the organization.
2. Strengthen board and organizational capabilities to manage change.
3. Focus on accountability for outcomes.
4. Encourage collaboration among providers to build care systems of the future.

As boards are managing the change process, they should be sure to be active sponsors of needed changes and always explain the reasons for these changes. It is also critical to develop both an organizational and a board transformation plan with specific goals and timelines for achieving those goals.

1 These comments were sparked by a list of 11 key steps in Lee Ann Jarousse, "Transforming Governance: Leading in an Era of Reform," *H&HN Magazine,* March 2014 (available at www.hhnmag.com/Magazine/2014/Mar/gatefold-transforming-governance).

Partnering with Physicians: A Journey from "I" to "We" to "Us"

BY JOSEPH S. BUJAK, M.D., FACP

Healthcare organizations require physician engagement in order to be economically viable. Physicians are seeking economic security. The interdependence is undeniable, the need to cooperate is obvious, and failure to do so is toxic. Yet, the relationship is most often tenuous, distrusting, and fragmented. Why?

This article looks at the reasons this relationship can be complicated and ways for physicians and hospitals to move past these barriers and build a strong partnership.

Breaking Down Barriers to Partnership

Most healthcare leaders are primarily businesspersons who speak the language of business and apply business metrics to define success. Clinicians speak the language of clinical medicine and define success using clinical metrics. Each can evaluate the same data set and arrive at totally different conclusions. To each the conclusion is obvious. For the other not to agree must mean that they either cannot see it or choose not to see it. They are either incompetent or self-serving, and in either case not trustworthy.

There is also an ethical divide. Physicians have an ethical responsibility to serve as the individual patient's advocate while administrators must be the patients' advocate. Each of these perspectives has an equally valid but totally separate set of ethics. No one can simultaneously serve both.

The dominant trend in today's market is to employ physicians. The term "employment," while technically correct, has a negative impact on the relationship. True engagement, or better yet commitment, requires an attitude of *partnership*. Too often administrators view independently minded physicians as adversaries to be leveraged in compliance with the organization's business plan.

Administrators oftentimes see physicians as fungible, seeking to employ them as a defensive strategy lest they be employed by a competing healthcare organization. To be fair, there is a political and economic cost to selective hiring. There is pushback from those physicians not included in the hiring strategy, and not enough included physicians to serve the large number of covered lives necessary to avoid becoming a commodity or to avoid an actuarial disaster.

In pursuit of a relationship, the negotiation invariably centers on tangibles like how much money and how little responsibility. When doing the deal is paramount, when it is all about the money, commitment and loyalty are defined by the next better offer. When there is no "big idea," the default is to self-interest.

There is no vision that transcends the business plan. In *Drive*, Daniel Pink states that autonomy, mastery, and purpose are the three primary motivators of those who perform heuristic work.[1] High-functioning teams are aligned to a shared purpose and bound together by a commitment to an agreed upon set of core values.[2] While pay is commonly thought of as highly important, the Hay Group lists money as number 10 in a list of the top 10 factors that contribute to retention in the workplace. In *Built to Last*, the authors conclude that in organizations that have sustained a presence in the Fortune 500 for more than 50 years, the business plan only served as a vehicle for the expression of the core ideology of the workforce.[3] The core ideology was defined as the sum of the organization's vision and values. It is all about the intangibles. Yet, too often there is no vision, and the value hierarchy—the expectations and accountabilities that provide the moral compass for decision making going forward—is rarely identified much less discussed.

What does the organization stand for and how does anyone know if joining is a good fit? In *Small Unit Leadership*, D.M. Malone discusses the importance of skill, will, and teamwork.[4] In his view, skill is an essential requirement for trust.

1 Daniel Pink, *Drive: The Surprising Truth About What Motivates Us*, Penguin Group, 2011.
2 Dave Logan, John King, and Halee Fischer-Wright, *Tribal Leadership: Leveraging Natural Groups to Build a Thriving Organization*, HarperCollins Publishers, 2008.
3 Jim Collins and Jerry Porras, *Built to Last: Successful Habits of Visionary Companies*, HarperCollins Publishers, 1994.
4 Dandridge Malone, *Small Unit Leadership: A Commonsense Approach*, Presidio Press, 1983.

Key Board Takeaways

Partnering with physicians is essential to the success of healthcare organizations. All enduring relationships are built on a foundation of shared and transcendent purpose and a commitment to the behavioral manifestations of an agreed upon set of core values.

Too often, attempts to create this relationship focus solely on "doing the deal." In the absence of a unifying shared purpose, the default is to economic self-interest. The business plan must serve the organizational purpose. Profit should not be directly pursued, but rather ensue from a primary commitment to purpose. That is the only way to access discretionary effort and affect commitment to an identified set of behavioral expectations.

When partnering with physicians, boards should:

- Safeguard organizational purpose.
- Focus primarily on the intangible aspects of relationship building.
- Recruit and retain individuals who see their self-interest served by alignment with group interest.

Individuals want to know that they can rely on the competence of those on whom they depend. Will is the alignment of self-interest with group interest—that which is most important to the individual is most important to the organization. Teamwork results when the individual acknowledges that he or she can get more of what they care most about by working together with others than by continuing to work independently. For the Marines, it is "The Few, The Proud," not any willing provider.

Physicians are no better prepared to forge a successful partnership. They lack a collective identity, making all decisions in the form of a town hall democracy—one person, one vote, and majority rules. Among physicians, where individual autonomy remains the transcendent value, the presumption to leadership is viewed as illegitimate. Generational differences often prevent older and younger physicians from

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Moving beyond the Basics of Strategic Planning: The Board's Role

BY MARIAN C. JENNINGS, M. JENNINGS CONSULTING

"Strategy is a word that gets used in so many ways with so many meanings that it can end up being meaningless."[1] This quotation by Harvard Business School professor and well-known author Michael Porter was not meant to imply that strategy itself is meaningless. Instead, it underscores his point that strategy should focus on what can make an organization unique rather than head-on competition with others.

What does this mean in a period of upheaval in healthcare? What does this require of hospital and health system boards?

While we think of today's healthcare environment as uniquely turbulent, the following paragraph introduces *Health Care Strategy for Uncertain Times*, a book I edited and co-wrote 15 years ago:

> The healthcare industry is in the midst of a fundamental, often painful restructuring. Major healthcare systems and hospitals that long have enjoyed success and dominance no longer assume that their future is ensured. Community hospitals worry about their ability to remain independent while continuing to pursue their mission of service to all those in need. Rural hospitals, often serving an older and sicker population, worry about their ability to survive as a needed community resource. Physicians no longer hold the social or economic status that they enjoyed as recently as a decade ago. All the players—providers, physicians, and insurers alike—stand on the threshold of biotechnology and information technology advances that will transform what is meant by health, healthcare, healthcare delivery, and healthcare financing.[2]

Sound familiar? Today, of course, we use somewhat different terms to describe our painful industry restructuring: transformation, disruption, population health management, virtual or e-health, accountable care organizations, health reform, consumerism, and value not volume.

No matter what we call them, continued disruption and uncertainties about how the future will unfold are here to stay. Some feel that since this turbulent environment requires so much flexibility, agility, and quick responsiveness (all true), long-term strategic planning is no longer valuable. But being agile and speedy without a clear sense of direction is simply random motion, not progress. History shows us that those organizations in 2000 that embraced a future reality very different from what then was in place and effectively implemented a focused, disciplined long-term strategy are now winners. Indeed, they were flexible, agile, and responsive in "how" they moved forward, but they were disciplined in keeping their eyes on where they wanted to be in 10 years or more.

Some feel that since this turbulent environment requires so much flexibility, agility, and quick responsiveness, long-term strategic planning is no longer valuable. But being agile and speedy without a clear sense of direction is simply random motion, not progress.

"Skating to where the puck is going to be," is admittedly an overused Wayne Gretzky quotation. Yet while it may sound trite, that is effectively what your healthcare organization's strategy needs to do. Your organization cannot expect to be successful by "skating to where the puck is now"—for example, focusing on today's quality measures yet not preparing for how quality will be judged by payers and consumers in the future. Or worse yet, believing "consumers don't know what quality is." Similarly, your organization cannot endlessly replay its mistakes trying to figure out how you could have succeeded.

Establishing strategic direction for the hospital or health system and providing oversight related to implementation of that direction are core responsibilities of the board. Of course, the board works in partnership with management to craft the direction. Given overall not-for-profit healthcare performance, one must conclude that most "plans" have not led to

Key Board Takeaways

Establishing strategic direction and providing oversight of plan implementation are core governance responsibilities. Boards should consider what they are doing in today's dynamic environment to ensure that they are collaborating effectively with management to drive a vital and transformational planning process. This includes asking questions such as:

- What can the board do to avoid common pitfalls that result in strategic planning being a rote or even ceremonial process?
- What changes need to be made to the governance structure to enhance the planning and oversight processes?
- What policies and procedures should the board utilize to raise the bar for how it sets and implements strategies to benefit the organization and, more importantly, the communities and patients it serves?

1 Michael Porter, "Why Do Good Managers Set Bad Strategies," Wharton School of the University of Pennsylvania, SEI Center Distinguished Lecture Series, November 1, 2006 (available at http://knowledge.wharton.upenn.edu/article/michael-porter-asks-and-answers-why-do-good-managers-set-bad-strategies/).

2 Marian C. Jennings, *Health Care Strategy for Uncertain Times,* San Francisco: Jossey-Bass/John Wiley & Sons, Inc., 2000.

stronger, higher-performing hospitals or systems. Many are not winning in today's environment and are not well prepared for tomorrow.

Why? The following are the most common failings of strategy setting in hospitals and health systems, with a recommended course of action for the board to avoid these pitfalls:

- **The plan lacks clarity regarding the organization's desired positioning in five years**. Instead, many plans have general statements of desired positioning ("provide exceptional quality, service, and safety" or "improve the health of our community" or "become a leader in population health management"), without defining what these mean in measureable, practical terms. Other plans reflect a belief that future uncertainties require that we plan for only a year or two—hardly sufficient time to see an innovative strategy be implemented successfully. The board must demand that the strategic direction be articulated clearly and concisely, avoid jargon, and include a short list of strategic 10-year and five-year measures of success (strategic or "destination" metrics).
- **Executive compensation is not tied directly to the plan**. What you measure is what you get. Many executive compensation plans primarily reward performance against today's operational metrics rather than incorporating meaningful measures of both short- and long-term performance. A recent study of governance in the private sector by McKinsey & Company indicates that this short-term focus is not unique to not-for-profit healthcare governance. The study recommends that directors of corporate boards spend less time focusing on short-term performance and instead "spend more time discussing disruptive innovations that could lead to new goods, services, markets, and business models."[3] Similarly, the hospital or system board must focus more of its time on long-term positioning. The board must insist on executive performance measures that assess both today's performance and progress toward desired future strategic outcomes.

- **The plan is too operational, not strategic.** Strategy formulation can challenge the culture and comfort zones of leaders, physicians, and staff. The desire to build consensus can result in "lowest common denominator" strategies or avoidance of issues that may generate conflict. This in turn can lead to the plan being simply a compilation of initiatives that will address today's performance issues but will not adequately prepare the organization for tomorrow.
- **Budget shortfalls crowd out strategic thinking.** With the impact of multiple pressures on current financial performance, strategic planning often gets pushed aside as pressures to make budget take precedence, and anything that does not contribute directly to this objective gets cast aside. The board can and should play a unique, important role in redirecting discussions to focus on long-term success and ask, "What must we do now to avoid this same situation every year?"

- **The plan is developed by those wearing "rose-colored glasses."** Plans often fail to adequately address organizational weaknesses, market threats, or, most commonly, potential major challenges or disruptions. While directors are naturally inclined to be supportive of their hospitals or systems, good planning requires a grasp of reality rather than a bias toward optimism. In particular, directors must avoid being lulled into a sense that "these industry disruptions would never happen in our market."
- **The plan does not challenge the status quo or collective thinking.** We need more directors who are willing to make observations similar to that of one insightful board chair during his system's recent planning retreat, "Keep in mind: 'consumerism' may be new in healthcare, but it is well known to American business… and the bottom line is that consumers value low cost more than higher quality. Our overall American business experience with active consumerism should be a cautionary tale for our health system." This statement was made

3 Dominic Barton and Mark Wiseman, "Where Boards Fall Short," *Harvard Business Review,* January/February 2015.

following much discussion by clinicians and others that consumers should be willing to pay more for services delivered by the hospital than at a freestanding center, since (although we cannot prove it) "we believe the hospital offers higher quality care." The chair's real-world insights brought the discussions down to earth.

- **The plan takes nothing off the table.** The easy part of planning is to identify strategies and initiatives. Understandably, each part of the organization wants to make certain its priorities are included in the strategic plan document. The hard part of planning is saying "not now" or "no" to initiatives that, while potentially valuable, are not the best use of scarce resources. One valuable element of a good plan is a list of "the things we will not do." Board members should ask for such an inventory of eliminated initiatives or projects.
- **The plan is not integrated with a long-term strategic financial plan.** Ultimately, strategic planning is about resource allocation to position the organization for future success. Without a long-term financial plan, there can be no clear sense of which initiatives represent the best and highest use of scarce resources, which should be the highest priorities and why, and/or the preferred sequencing for initiatives or investments.

What Needs to Happen?

As one CEO nicely summarized:

> In this era of unprecedented change in the healthcare system, the work of our boards to bring about and support this monumental transformation is critical. Leading strategically, supporting disruptive innovation, and driving boldness in our efforts to improve the health of individuals and communities are what make governance effective in transformed health systems. Just like every aspect of our organizations' operations, what has worked well for us in the past likely will not be sufficient for tomorrow's success. The same is true for governance.[4]

The purpose of this article is not to provide directors with a prescriptive strategic plan for their organizations. Instead, it is to identify how the board can adapt its own governance structure and governance policies to strengthen the effectiveness of its strategic planning and provide better oversight of plan implementation.

> With the impact of multiple pressures on current financial performance, strategic planning often gets pushed aside as pressures to make budget take precedence. The board can and should play a unique, important role in redirecting discussions to focus on long-term success and ask, "What must we do now to avoid this same situation every year?"

Structuring Governance to Enhance Strategic Planning and Oversight

For our purposes, by "governance structure" we mean bylaws that legally outline roles and responsibilities, the board's "job description," board committees and their charters, and—for organizations that function with multiple levels of governance—the governance matrix that specifies board responsibilities and authorities at each level.

We do not advocate maintaining a standing strategic planning committee but prefer that setting strategy and monitoring performance be the work of the board as a whole. However, should your organization prefer to utilize a planning committee, you should:

- Consider reconstituting your finance committee as a strategy and finance committee. The work of these two committees must be inextricably linked. This is especially the case given changes in payment models such as value-based payments as well as new delivery models such as accountable care organizations. Positioning the organization to deliver value—as defined by consumers/payers, not providers—is both a strategic and financial imperative.
- Alternatively, establish a time-limited *ad hoc* strategic planning committee to serve a specific purpose.
- Regardless of what form your committee takes, the board should ensure that its charge—and its charter—are clear.[5]

Should your board decide not to use a planning committee, the board's role in setting and monitoring strategic direction must be clearly articulated and, as outlined in the next section, sufficient time be devoted to fulfilling this core governance fiduciary role. Additionally, directors should be recruited and developed to ensure that the board has the requisite competencies of strategic thinking and experience to successfully navigate an organization during a period of rapid industry change.

Using Governance Policies to Enhance Strategic Planning and Oversight

Governance policies and processes are critical to ensuring that your hospital or health system develops and successfully implements an effective strategy (see sidebar below). Each of the key elements below is a critical contributor to success; all need to be in place for optimal performance.

Changes to Board Policies and Procedures to Enhance Effectiveness of Strategy Development and Oversight

- ✔ Foster generative discussion.
- ✔ Lead change from the top.
- ✔ Set higher expectations related to the process and plan content.
- ✔ Embed the plan into the work of the board and its annual board calendar.
- ✔ Use "bifocal" governance dashboard metrics.[6]
- ✔ Develop a competency-based board.
- ✔ Strengthen board orientation, education, and development.
- ✔ Hold management accountable.

4 James H. Hinton, "Why We Should Support Our Hospital Boards During Times of Change," *H&HN Magazine,* November 2014.

5 The Governance Institute outlines what board-delegated powers should be granted to strategic planning committees for both freestanding hospitals and health systems, and also provides sample committee charters in *Board Committees* (Elements of Governance), The Governance Institute, 2012, pp. 14–15, 31–32.

6 *Governance Practices in an Era of Health Care Transformation,* AHA Center for Healthcare Governance, 2012.

Foster Generative Discussions

Generative discussions are those that ask questions about fundamentals: existential questions about the core purpose of the organization, what makes the organization relevant, how the organization will become distinctive, what the organization values, and how it will add value. Generative thinking is about deciding on what to decide, probing assumptions about the organization, and identifying the underlying values that should drive strategy and tactics.[7]

Hospital and system boards should incorporate generative discussions into all decision making, not reserve it for the annual board planning retreat or the planning process.

In developing or updating the strategic plan, directors should start not with a review of the current mission and vision, for instance, but rather with a series of broad-based questions to foster creative thinking and dialogue:

- Why does our organization exist? If we did not exist, why would someone establish us—or would we be needed at all?
- What do we expect to be the greatest changes in our market—and when?
- What do we want to become in five years? In 10 years?
- In what ways would we be distinctive?
- How would we add value—and to whom would these benefits accrue?
- What will it take to achieve that "desired future state"? Is it realistically achievable with focus and hard work?
- How much change is implied by our desired future state?
- Would we be willing to radically redeploy our resources to achieve our desired future state?
- What will be required of us as a board? Of our leadership team? Of our physicians and other clinical colleagues? Of our staff?

Such discussions can be uncomfortable at first. They require that board members be willing to explore questions that have no correct answers. They require that directors be willing to consider futures drastically different from today and become more comfortable with ambiguity. However, in times of major disruptions, it is imperative that boards become more actively engaged in strategy formulation and oversight as their hospitals and systems seek to navigate uncharted waters.

These generative discussions lay the groundwork for revitalizing your planning processes and developing more useful plan content.

Lead Change from the Top

Planning must be led from the top of the organization. Transformation may demand radical changes in business models, decisions to eliminate or downsize business lines, importation of new leadership and/or staff competencies, or changes in the power hierarchy. Such changes are identified only rarely in a bottoms-up approach.

Importantly, leading from the top does not mean executing from the top. The board should set strategic direction but allow management latitude in how to achieve it. The board must restrain from micromanaging the strategies, initiatives, and tactics used by management.

Beware consensus. Consensus can force out innovation or yield "lowest common denominator" strategies. Consensus building also can function like the game of telephone: by the time a final decision has been made, so many parties have had input that the final decision bears little resemblance to the original strategic intent. While decisions should be reached in an informed, open, and transparent process with dialogue that is respectful of all perspectives, directors are cautioned against believing consensus means "we all agree." Doing so can unwittingly allow the party least willing to change to dictate the pace of change—an enormous strategic disadvantage in times of rapid change.

Execution lives or dies with the managers in the middle. Research shows that "consensus" or involvement in decision making is less important to effective execution than are ensuring effective communication from above to middle managers, ensuring that critical information about real-time events flows freely across organizational boundaries, and clarifying so-called "decision rights" (that is, a clear articulation of the decisions and actions for which one is responsible).[8]

Set Higher Expectations Related to the Process and Plan Content

In some organizations, planning has become a rote or even ceremonial process. Others have turned to using a one-year plan, basically hoping that incremental change will improve their long-term viability.

We believe that the process of developing a viable long-term strategy should be lively, using generative discussions to ensure all issues are on the table. Practically speaking, the board can facilitate a more robust process and a better resulting plan by ensuring:

- There is clarity around roles and responsibilities for plan development.
- The plan is based on objective information and market research; specifically, it includes expert opinions on emerging market trends/disruptions.
- The plan includes clearly articulated assumptions about future market conditions, along with implications for your hospital or system.
- The board or planning committee routinely incorporates scenario planning

7 Bill Ryan, "Governance as Leadership: Key Concepts," presented at PricewaterhouseCoopers, October 2008 (see www.pwc.com/ca/en/directorconnect/strengthening-nonprofit-boards.jhtml).

8 Gary Neilson, Karla Martin, and Elizabeth Powers, "The Secrets to Successful Strategy Execution," *Harvard Business Review,* June 2008.

or "what if" analyses in plan development to ensure leaders have considered the impact of potentially dramatic market changes—especially those that would challenge continued success or require substantive changes.[9]

- The plan is as clear about what "we will not do" as what the organization will do.
- The plan includes a clearly articulated "desired future state" that looks out at least five—but preferably 10—years. This desired future state should include four to six related "destination" metrics that would answer the question, "How would the board know we have achieved our desired strategic positioning?" These metrics must be both meaningful and measurable. For example, if your intent is to be a high-performing health system that improves the health of the community, exactly how would you propose to measure that? (See sidebar "Sample 2020 Destination Metrics for a Regional Health System.")
- The plan focuses on strategies and tactics for the next three fiscal years consistent with the longer-term desired future state.
- The plan includes strategic metrics for each of the three years consistent with the longer-term destination metrics. The board will utilize these annual strategic metrics to monitor implementation progress.
- There is a strategic financial plan that outlines the required capital along with expected incremental revenues and expenses associated with plan implementation.
- The board and management agree on the major risks associated with plan implementation, and management has identified practical approaches to mitigate these risks.
- There is regular frequency of and rigor in monitoring and evaluating the strategic plan.
- The board conducts its annual planning retreat in the first quarter of the fiscal year to review current market changes and emerging disruptions/trends and to identify needed changes to plan content. This timing is critical to ensure changes to the plan can then be incorporated into the capital and operating budgets for the upcoming fiscal year.

Sample 2020 Destination Metrics for a Regional Health System

- System has received AHA's Foster McGaw Award for hospital/systems that distinguish themselves through efforts to improve the health and well-being of everyone in their communities.
- System named among Truven's Top 50 Health Systems at least twice in five years.
- System has maintained at least an A+ bond rating.
- System's community (hospital referral region) has improved from third quartile to second quartile on "Overall Health System Performance" in state's Scorecard on Local Health System Performance.
- System has doubled external research funding.
- System has at least 200,000 "attributed" lives for which it is responsible for both clinical and financial performance—and is making money on these contracts.

Even if the board uses a committee or *ad hoc* group to develop the proposed plan, the whole board must spend the time required to thoroughly understand the plan context and content. Typically, the organization would conduct a major reassessment of the plan every three years, with updates in the interim years. When in the reassessment portion of the cycle, board members should engage in generative discussions to explore underlying assumptions as well as the types/degrees of transformation the plan requires for the organization; ask "why are we doing this?"; understand the magnitude of change required by the organization and how that will be managed; and learn about the alternatives considered.

The board should not be asked to complete an initial review and approve the plan at one meeting. Instead, the board should be engaged in generative discussion of the initially proposed plan, expecting that a final proposed plan will be brought to the board for approval at the next meeting.

Embed the Plan into the Work of the Board and Its Annual Board Calendar

Keep the plan front and center for the board at all times to ensure that strategy drives board policy formulation, decision making, and oversight. Use a consent agenda to accomplish routine board business to allow time for directors to understand and discuss areas of greater long-term importance. Consider holding fewer but longer board meetings to refocus them from a format of presentations with little conversation to meetings that allow for generative discussion, thoughtful decision making, and more effective execution of all governance responsibilities. Specifically:

- Develop an annual board calendar in which each meeting is organized around one of the goals in the plan. In this way, the board obtains an in-depth understanding of each focus area and has an opportunity for generative discussions around what is occurring in the market, how effectively the plan is being implemented, proposed priorities for the upcoming year, and the challenges and opportunities related to the goal.
- Ensure that major decisions of the board are made in the context of how the

9 Marian Jennings, "Scenario Planning: More Useful Now than Ever," E-Briefings, The Governance Institute, November 2005.

decision will further the long-term strategic positioning of the organization. For example, management should identify why each decision is essential to long-term success, along with how it furthers specific goal(s), strategies, or strategic metrics.
- During the annual capital and operating budgets approval process, ensure that the board understands how these tie directly to the core strategy.

Use "Bifocal" Governance Dashboard Metrics

Many boards use a balanced scorecard that incorporates key performance indicators related to, for example, quality, safety, and the patient experience; financial performance; employee engagement; turnover rates; and success in physician recruitment. This approach is valuable to directors in effectively overseeing current performance and moving the organization to higher performance levels.

However, unintentionally, these indicators of current performance may overly focus the board on "skating to where the puck is now" and reinforce the status quo. While necessary, they are not sufficient. Just as a driver needs to see both his dashboard and look further down the road, directors need to track both current performance and key indicators of future success.

In addition to broad strategic destination metrics, the board should review performance against clearly defined metrics related to each goal on a quarterly, semiannual, or annual basis based upon the nature of the metric.

Below are some thoughts around what these more strategic, longer-term dashboard metrics might look like:
- Assuming a continued rise of consumerism, the board should anticipate how future healthcare decisions are likely to be made—with much greater emphasis on convenience and low cost—and begin tracking how the accessibility and cost-effectiveness of its care compare to that of regional competitors.
- If a system wants to perform at the level of a Truven Top 50 system, it should track not only the usual balanced scorecard metrics, but also begin to compare itself against likely future benchmarks of top performers. ("Skating to where the puck will be.")
- Envisioning a future where more payment will be based upon delivering "value," in addition to monitoring specific quality or other metrics, the board should monitor what portion of potential incentive dollars the hospital or health system achieves for delivering "value" and estimate how it is likely to fare in the future on such incentives.
- Preparing for a future in which individuals will relate to networks of providers, the board should track what portion of "attributed lives" in the region relate to its system and affiliates.
- Anticipating a future with greater transparency of hospital quality data, the board should monitor its performance against quality data of local competitors not simply track its own improvements.

Develop a Competency-Based Board

Numerous studies and blue ribbon panels have come to the same conclusion: hospital and health system boards should use a competency-based approach, not only to recruit new board members but also to assess, educate, and develop existing members—ultimately creating a board with the right blend of knowledge and expertise, experience, personal attributes, and diversity for the hospital or health system of the future.[10,11]

What are the specific competencies the board should look for to be more effective in strategy formulation and oversight? Several come to mind to complement the more traditional competences found on boards:
- Knowledge and expertise ("hard skills")
  - » Expertise in change management/ innovation and transformation
  - » Knowledge of customer service process improvement
  - » Expertise in public policy or community health planning
  - » Knowledge of reliability science for improving quality and patient safety

10 Don Seymour and Larry Stepnick, *Governing the 21st Century Health System: Creating the Right Structures, Policies, and Processes to Meet Current and Future Challenges and Opportunities* (white paper), The Governance Institute, Fall 2013.

11 Marian Jennings, "Competency-Based Board Recruitment: How to Get the Right People on the Board," Governance Notes, The Governance Institute, February 2015.

- Professional and personal experience
  - » Experience in managing complexity or governing in a complex organization
  - » Experience in successfully navigating an organization during a period of rapid change
- Personal attributes
  - » Strategic thinking
  - » Ability to hold self and others accountable for achieving goals
  - » Curiosity and an interest in continuous learning

Importantly, in addition to possessing these competencies, board members must demonstrate them in the boardroom and other board-related responsibilities. They must be well-prepared, active participants in board dialogue and in their committee service.

The board must provide management the latitude to be agile, flexible, and responsive to market changes in its approaches, while ensuring that steady progress is being made toward achieving the desired long-term positioning.

Strengthen Board Orientation, Education, and Development

The magnitude of change related to industry restructuring—and the associated demands on boards of hospitals and health systems—require substantially strengthened board orientation, education, and development. These activities should include:

- Content related to understanding the healthcare industry and industry trends, restructuring, and disruptions.
- The roles and responsibilities of not-for-profit healthcare boards.
- The roles of the board within a multi-level governance structure (if relevant). This is particularly important since, all too frequently, board members of hospitals that are part of a larger health system are unclear about their roles and responsibilities.

Orientation must be designed as an intensive ongoing activity throughout the first year of a director's initial term, rather than a one-time event.

The board governance committee should develop a focused annual education and development plan to ensure that directors have the knowledge and skills to support strategy formulation and oversight. This includes not only a knowledge of the industry and emerging trends both nationally and regionally, but a solid understanding of the changing roles and responsibilities of hospital and health system boards in this era of transformation. The board should be surveyed annually to identify its greatest needs for education and development to fulfill their strategic planning and oversight roles, to inform a solid annual board development plan.

There are benefits to educational sessions in which all board members are in attendance, since these give rise to opportunities for generative discussions. These include forums such as annual board retreats or attendance at national or state conferences. Additionally, as described earlier, at each board meeting, the board as a whole can do a deep dive into specific issues and trends.

Increasingly, Web-based courses, Webinars, and other virtual forums are available, focused on board development for hospital and health system directors. These can be used in individually tailored education and development plans or for the board as a whole.

For hospital board members of larger health systems, the regional or national health system may have its own board education and development programs you can access. Understanding the responsibilities and authorities of subsidiary boards is essential to effectively carry out the responsibilities delegated by the parent organization.

Hold Management Accountable

As part of its oversight responsibilities, the board should regularly monitor progress in achieving key elements of the strategic plan and, where performance is lagging, expect management to prepare and initiate thoughtful, realistic corrective plans of action to get back on track.

The board must provide management the latitude to be agile, flexible, and responsive to market changes in its approaches, while ensuring that steady progress is being made toward achieving the desired long-term positioning.

Sometimes referred to as "tight-loose-tight," the recommended approach is for the board to be:

- "Tight" in its definitions of expected future outcomes related to desired future strategic positioning. These are the longer-term metrics that should be incorporated into the bifocal governance dashboard. To be effective, there must be clearly defined, objective, and measurable five- or 10-year destination metrics along with a set of goal-related metrics with annual targets for at least the next three years.
- "Loose" in allowing management the flexibility needed to implement long-term strategy in a dynamic market. The board should not micromanage how management moves forward; rather it should focus on monitoring the outcomes that are being achieved.
- "Tight" in increasing the frequency and rigor of monitoring performance toward strategic ends using the longer-term metrics on the governance dashboard. The board must focus itself on strategic outcomes—not recitations of the initiatives or processes underway to move forward or, worse, the reasons why an outcome was not achieved. If the outcome/metric is no longer meaningful, the board should delete or modify it. If it is still meaningful, the board should expect management to formulate a plan to get back on track.

Closing Thoughts

While the transformation of the U.S. healthcare system demands a more rigorous approach to strategic planning, most of the tenets of traditional strategic planning still apply, albeit with renewed senses of urgency and internal coordination. To be successful in tomorrow's environment, the board must go beyond "rubber-stamping" the organization's plan and drive a more vital, transformational, and iterative strategic planning process. With a firm foundation in "how to move beyond the basics" of healthcare strategic planning, boards can reclaim the meaning of "strategy" for their organizations and enable their organizations' long-term success.

The Governance Institute thanks Marian C. Jennings, President of M. Jennings Consulting, for contributing this article. She can be reached at mjennings@mjenningsconsulting.com.

Coming to a Board Meeting Near You: The Expanding Controversy over Physician Maintenance of Certification

BY TODD SAGIN, M.D., J.D., SAGIN HEALTHCARE CONSULTING, LLC

Most hospital board members will not be aware of a controversy that has been roiling the national physician community for several years concerning specialty board certification. The issue is whether medical staff members should be required to maintain specialty board certification to be eligible for the appointment or reappointment of hospital privileges.

In the near future, this contentious issue could be elevated by your medical staff organization to become a matter for board involvement. Hospital governing bodies should be prepared to address the matter and manage potential political fallout on relationships with their physician community.

The Maintenance of Certification Debate

In recent decades, a majority of hospitals and health systems have made specialty board certification a criterion for medical staff membership and/or privileges. This has occurred without much controversy because it has been common for medical staffs to "grandfather" non-boarded members who were on staff at the time this criterion was adopted.

The best recognized organization that promulgates standards for board certification has been the American Board of Medical Specialties (ABMS), which formally recognizes 24 medical specialty boards that comprise the ABMS membership. More than 75 years ago, the ABMS and its predecessor organization began to develop and advocate for a national set of standards for the education of medical specialists. While originally board certification was offered as a lifetime status, starting in the 1970s, several of the ABMS member boards began to make their board certification designations time-limited. Many medical staffs wrestled with whether to require board "recertification" to maintain hospital privileges and the results have been mixed. Over the past two decades, hundreds of medical staffs have amended their bylaws to require that board certification be continuous, while others have found this to be too onerous an imposition on physicians who were already well established in practice.

In the last few years, the matter of continued board certification has heated up considerably. This is the result of an ABMS initiative that began nearly 15 years ago to have all of its member boards adopt an approach called Maintenance of Certification (MOC). The ABMS argues that these new requirements are based on evidence-based guidelines, national standards, and best practices in combination with customized continuing education that demonstrates mastery of specialty subject matter. Advocates of MOC argue it benefits physicians because it drives focused learning based on individual practice needs, may decrease malpractice premiums, can reduce duplicate demands for evidence of competence from credentialing bodies, and can be used to market the quality of a physician's care.

However, the approach has vocal detractors who see MOC as burdensome requirements imposed on physicians to meet the growth demands of sponsoring specialty boards. Opponents of MOC are dismissive of its scientific basis and argue that it fails to conform to the actual practice realities and clinical demands that individual physicians face day to day. Recent pushback from practicing physicians comes from several distinct groups: doctors who fail to qualify for or achieve board certification from ABMS specialty boards; doctors in the latter years of practice who do not wish to undertake the burdens required of MOC with retirement in their near future; practitioners who object to the expenses relating to participation in MOC; and physicians excluded from medical staffs and managed care organizations that require MOC for membership and/or privileges. This pushback from physicians has escalated markedly as a large number of baby boomer practitioners enter their last years of active practice and as a result of a decision in January 2014 by the American Board of Internal Medicine (ABIM) to no longer

Key Board Takeaways

Maintenance of physician specialty board certification has become a controversial issue among doctors. Some physicians or medical staffs may come to the hospital board requesting changes in current board certification requirements under the medical staff bylaws. Boards should prepare for emotional discussion on this matter by becoming knowledgeable about the pros and cons of physician maintenance of certification (MOC). They should also consider the following questions:

- Should medical staff members be required to be specialty board certified in order to be granted initial membership and/or privileges?
- Should medical staff members be required to maintain specialty board certification as a criterion for reappointment of membership and/or privileges?
- What board specialty societies should the hospital accept as certifying organizations? Only the American Board of Medical Specialties (ABMS) and American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS)? Any self-proclaimed specialty board or collection of such boards?
- Should the board allow long-standing medical staff members to opt out of maintenance of certification?
- How will these decisions impact the hospital's reputation, quality, competitiveness, eligibility for narrow network participation, and malpractice rates?
- How will these decisions impact working relations with the hospital's physician community?

exempt internists who became board certified before 1990 from MOC.[1]

Specialty societies that comprise the ABMS have been responding to this criticism and several are making modifications in their MOC programs. The American Board of Internal Medicine has been a particular target of MOC protestors, and it has made significant changes in recent months to make its requirements less burdensome and more relevant to variations in clinical practice.

Be Prepared for MOC Discussions

In the next few years, it is likely that vocal MOC opponents will be taking their opposition to medical staff forums to continue their fight. Many medical staffs that currently require continuous board certification will entertain proposals to remove the requirement. Supporters of a continued MOC requirement will argue that the rapid pace of change in medical science and practice necessitates a method to ensure physicians are staying currently competent. Given widespread concern about the quality of medical care in hospitals, they believe that a medical staff whose members are board certified on a continuous basis protects patients and enhances the caliber of care.

This fight may come before the hospital board if the medical staff votes for bylaw amendments that change current credentialing criteria. Proposed changes may be aimed at eliminating MOC or board certification requirements or at altering the board certification organizations that will be considered acceptable for credentialing purposes. At present, most medical staffs recognize the member specialty boards of ABMS or those of the American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS). However, there are many other self-designated specialty boards in the marketplace that cater to the self-serving needs of particular cliques of physicians. Some have been formed to promote the marketing of practitioners who wish to grow their business (e.g., specialty boards that support doctors doing cosmetic procedures). Others have been formed to create a home for those unable or unwilling to achieve board certification through an ABMS or AOABOS member. A few of these organizations have made an effort to bring some rigor to their certification requirements. Others have requirements that amount to little more than paying a fee.

Board members should be careful to avoid being swayed by the emotional outbursts and passion a few physicians bring to this issue. If the board certification controversy surfaces before the board, it would be wise to establish a working committee to fully explore the matter. There is considerable literature to review that looks at the value of board certification. Beyond a desire to have competent physicians, a hospital should also consider other germane factors. Having board certified physicians is often viewed by third parties as an indicator of a hospital's quality. Having physicians required to participate in MOC can be a marketplace differentiator where competition is stiff. Many third-party payers prefer to work with hospitals and health systems where physicians are board certified and it may be a requirement for physicians who wish to be included in their managed care networks. This may also be true if a hospital wishes to be designated a Center of Excellence by a payer or employer or included in a narrow network option. If the hospital is self-insured it should look at the data on board certification and malpractice incidence.

Once a board has studied the issue, it should engage with thoughtful medical staff leaders in crafting a best approach. Some organizations might find it helpful to bring in a facilitator to ensure the discussions are constructive, well-informed, and respectful. The maintenance of good hospital–physician relations is essential to the success of both, but they are often a fragile affair. This controversy may not yet be on your board agenda, but forewarned is forearmed and the MOC battle is not likely to recede any time soon.

The Governance Institute thanks Todd Sagin, M.D., J.D., Governance Institute Advisor and a consultant who works with hospitals and medical staffs on a wide range of issues and controversies. He can be reached at tsagin@SaginHealthcare.com or found on the Web at www.SaginHealthcare.com.

1 The controversy broke into public view in a recent article: Kurt Eichenwald, "The Ugly Civil War in American Medicine," *Newsweek*, March 2015 (available at www.newsweek.com/2015/03/27/ugly-civil-war-american-medicine-312662.html).

Developing an Effective Board to Manage Change

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4. Encourage Collaboration among Providers to Build Care Systems of the Future

At present, healthcare competition leads to duplicate services that waste limited resources and fail to support the long-term health of our communities. The most successful organizations will be those that embrace collaboration as opposed to competition whenever possible.

The most effective boards will create annual collaboration goals for their CEO and other leaders. This might take the form of a hospital-hosted monthly or quarterly meeting of all long-term care facility leaders in the community in order to improve communication, efficiencies, and outcomes. It might mean working collaboratively with the county's public health department to develop a community health assessment and plan. It might mean partnering with a federally qualified health clinic to assist appropriate low-income patients in accessing that clinic's services in lieu of relying on the emergency room for routine care. These collaborations are examples of win-win initiatives for all participants.

Key Points in Organizational Transformation

Early in my career I had the good fortune to work with Tom Koenig, who was an exceptional healthcare leader, boss, mentor, and friend. He taught me some valuable lessons about the process of managing change:

- It's essential to have the highest-level executives and board members as active sponsors of needed changes. That means being out among the staff, doing executive rounds, and talking with and listening to all of the people who are affected by these changes.
- You must explain the reasons for needed changes; you must connect the dots for people. In a turnaround situation, you may need to lay off 10 percent of the workforce, and no one is happy about that. However, once people understand this is needed in the interests of long-term organizational survival and job security, then their viewpoint shifts.

At three points in my professional career, I was brought in to lead the turnaround of a hospital or health system that was in trouble. Each of these organizations was in financial crisis; they were losing millions of dollars each year. You have to put efficient business practices into context; you have to explain that financial solvency is essential so that we can continue to offer high-quality healthcare to the community. In my first job, I worked for a Catholic nun, the hospital's CEO, and she always used to say, "Margin equals mission." That is a fairly simple statement, but it emphasizes that you must have a positive bottom line in order to fulfill your greater mission of serving people. In healthcare today, we must, unapologetically, function as efficient businesses.

During this process of change, the board often can communicate key messages to the medical staff and throughout the organization and those messages will be heard most effectively because they come from the board. In the last two hospitals where I served as CEO, I was chosen because the organization was in crisis. In each case, the board chair came with me to my first meeting with the management team and said, "The board has asked Kevin to transform this organization to help you bring us back from the brink of failure. It's going to be tough, and we expect you to support his initiatives." This explicit support from the board was worth its weight in gold.

The board chair came with me to my first meeting with the management team and said, "The board has asked Kevin to transform this organization to help you bring us back from the brink of failure. It's going to be tough, and we expect you to support his initiatives." This explicit support from the board was worth its weight in gold.

In each of these organizations, in addition to the financial turnaround, the organizational culture needed to be transformed. In my experience, achieving financial success and improving clinical quality is easier than trying to transform the culture, which is generally a years-long process. Often, when an organization faces financial losses, people start to shift blame and point fingers in various directions. That atmosphere obviously becomes destructive for everyone involved.

Each organization is unique. There is no standard recipe for creating a positive teamwork culture that relies on and expects continuous improvement. I found one important step in cultural transformation is creating, communicating, and celebrating early successes. At one hospital we set up a geriatric psych unit, which had not existed before. It was a profitable service for the hospital, and was extremely popular in the community, especially since it offered local nursing homes professional support in dealing with their most challenging patients.

Another hospital had not been accredited by The Joint Commission during the past 11 years, so when I came on board the directors set accreditation as an early goal. The hospital executive team thought it would be difficult to achieve that quickly, but to their surprise the hospital did achieve Joint Commission accreditation within 15 months.

These early successes are so valuable because negativity and discouragement build upon themselves. When you are able to point to successful changes, that creates a new narrative. As you celebrate successes, as you share the vision for the organization and show how everyone connects to that vision...well, most people want to be part of a winning team.

How does a board make essential changes in its own patterns to support a hospital that does function as a winning team? The first step is to develop both an organizational transformation plan and a board transformation plan with specific goals and timelines for achieving those goals. Importantly, realign board meeting agendas to minimize verbal reports. Instead, schedule time for active discussions of transformational changes that are necessary for the organization, and what those changes will look like. Focus on an efficient timeline for change—don't drag it out unnecessarily. The time is now!

The Governance Institute thanks Kevin J. Miller, FACHE, RHIA, President, Miller Hospital Consulting & Interim Management, for contributing this article. He can be reached through his Web site at www.millerhospitalconsulting.com or at KJMiller77@aol.com.

Partnering with Physicians...

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talking together to identify areas of agreement as to how better to proceed forward. Shift work and ever more narrowed subspecialty practices complicate the orchestration of care.

Integrating physicians into the management of organization work is complicated by significant cultural difference. Physicians work to the principle of distributive justice wherein the end justifies the means. They are great violators of policy and procedure in service of what they believe their patient needs now. Working together with others is actualized by writing orders. By contrast, those who work in healthcare organizations work to the principle of procedural justice. All who might be impacted by any proposed changes must vet initiatives. When this expectation isn't met, passive aggressive behavior results. Until this difference is resolved, dyad management initiatives will meet with frustration.

Two additional barriers deserve mention. First, healthcare organizations all budget departmentally precluding the ability to creatively redesign throughput and facilitate the orchestration of care across time and domains. Secondly, mergers and acquisitions are resulting in ever-larger healthcare systems. Those in system offices too often seek to franchise their component organizations in pursuit of standardization thereby denying the unique characteristics of those units and frustrating those trying to optimize local performance.

Shared Purpose and Values Lead to Integration

In conclusion, to truly integrate physicians into the healthcare enterprise, it is imperative to focus on the intangibles. It's all about shared purpose and shared values. There needs to be an alignment of self-interest with organizational interest at the level of the "big idea." It's not just what you do that matters, but rather why you do it. People don't commit to a vision because it is achievable, but rather because it is irresistible. The business plan must serve the organizational purpose. Money should not be directly pursued, rather ensue from a primary commitment to purpose.

Indeed, in the absence of a great dream, pettiness prevails. It is only the transcendent dream that can move physicians from autonomous "I" to collective "we" to a truly integrated "us" in partnership with the healthcare organization.

The Governance Institute thanks Joseph S. Bujak, M.D., FACP, healthcare speaker, facilitator, and consultant, and Governance Institute faculty, for contributing this article. He can be reached at jbujak@attglobal.net.

A Strategy Checkup...

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a 10 percent revenue decrease from selected health plans? Price pressure will come with health plan consolidation and transparency, as well as from the federal push toward value-based reimbursement for 50 percent of Medicare payments by 2018. What revenue contingency strategies should be accelerated in your 2016 priorities?

8. Risk Mitigation Analysis

All strategies have varied degrees of associated risks. Some organizations ignore them; others have formal methods to identify, assess, and mitigate them. However, risks are not fixed variables. They can be prospectively mitigated to increase the chance of success. Are you including a risk mitigation analysis for selected high-priority strategies? This activity can help you decide between choices with the same potential return as you consider priorities for the coming year.

9. Philanthropy, Again

With downward pressures on revenues, philanthropy remains more important than ever. Capturing the philanthropic dollar from a new generation of potential donors is more competitive and complex than in the past. Prior generations of donors contributed for legacy and out of a sense of duty. Boomers consider donations as making "investments" toward the social good and want to see specific measurable results for a "return" on their investment. Is your purpose, vision, brand, and message sufficient to attract this new breed of potential donors and to generate higher levels of philanthropy? As healthcare advisor Leland Kaiser often observed, "Big ideas attract big donations." What big ideas do you have in your future?

10. Competency-Guided Governance

The strategic questions laid out here demonstrate the sophistication needed to navigate the challenging healthcare landscape and make decisions that determine if an organization will be sustainable and thrive. Do you have the right board composition for this climate? What worked before may no longer be sufficient in the future. It is essential to determine what board member competencies are required (individually and collectively) to effectively govern the organization through these complexities. Additional competencies may include experience in high-tech, security (IT breaches), population health, predictive analytics, social media, culture alignment and change management, innovation, and others. An annual competency/capability needs profile of your board can help guide future recruitment efforts to create a board that is more diverse, engaged, competent, and confident in fulfilling its fiduciary duties and core responsibilities. What are the recruitment capabilities that should be considered in 2016 and beyond for your board of directors?

A pre-2016 strategy checkup by the board using some or all of these questions will put your organization ahead of the curve in weathering the evolving healthcare environment that persists. Managing the turbulence successfully will be the challenge of the next decade for all.

The Governance Institute thanks Guy M. Masters, M.P.A., Senior Vice President, The Camden Group, and Governance Institute Advisor, for contributing this article. Panos Lykidis, Vice President, The Camden Group, was also a contributor to this article. They can be reached at gmasters@thecamdengroup.com and plykidis@thecamdengroup.com.

A Strategy Checkup: Setting Your Hospital Up for Success in 2016

BY GUY M. MASTERS, M.P.A., THE CAMDEN GROUP

What strategic issues has your board really wrestled with this year? Have board meeting discussions focused on strategic concerns a large percentage of the time or are they consumed with financial and operating reports?

The following 10 areas are strategic "checkup" subjects that the board should consider to calibrate and transition to next year's priorities. We recommend that you pick the top three or four items that relate to your market and healthcare organization, and discuss their potential impact on strategic focus and competitive positioning for 2016 and beyond.

1. Pre-2016 Strategy Tune-up

Some of your high-priority strategies have most likely worked, and perhaps some have not. Has the board taken time to discuss and understand why some fell short of expectations or failed? Are the results due to timing, market factors, availability of resources, staff attention, or execution? Unless you examine the contributing variables, you will not improve your success rate and will continue to diminish the value generated. Do you need to eliminate some strategies and reinvigorate others? Take time now to ask and answer the questions: Do we have the right strategic plan? Is it being implemented effectively? If not, do we have the right leadership team?

2. Physician Enterprise Results

Many organizations are losing record amounts of money on their employed physicians when measured as a standalone enterprise. Have you identified the cost/benefit value of your employed physicians for 2015? What standards and metrics are you using to measure the results? Do you have a target for desired performance in 2016? Are you using physician co-management models to standardize clinical processes and improve performance in key service lines such as orthopedics, cardiac, oncology, women's health, and other areas? Recalibrating and tying the performance of your physician enterprise to organizational targets should be an ongoing process.

3. Service Line/Department Business Process Efficiency Analysis

There have always been periods where organizations focus on "trimming the fat" and becoming lean. Those efforts can be followed by periods of no growth, as the remaining staff struggle to perform the basic duties of the organization. Are your clinical departments and service lines operating efficiently and optimally? A rigorous assessment of your administrative support and clinical departments can stimulate growth and improve efficiencies by reducing waste, eliminating duplication, and streamlining operational processes. This process can be critical to reducing costs and improving quality to enable success in risk and value-based payment models, including bundled payment and shared savings arrangements.

4. Pre- and Post-Acute Continuum Services

Over time, non-acute and outpatient services have become as important as inpatient for many healthcare organizations. Is your hospital/health system well positioned in the delivery of coordinated pre- and post-acute care service delivery modalities? Increased focus on bundled payment arrangements, the Medicare Shared Savings Program, reducing inpatient readmission rates, and risk-sharing models all require the ability to provide efficient, cost-effective, quality care seamlessly across the entire continuum of non-acute as well as inpatient services. Do you have the care team capabilities to do so now? What strategies will be essential to implement in this area in 2016?

5. Care Model Redesign

You have likely revised your care protocols to achieve best practices across the organization. Are your care models positioning the organization to succeed in value-based payer relationships? Are they responsive to new entrants into your market that are patient- and technology-friendly? Are your incentive models reinforcing the desired care model and clinical team performance? Your care redesign efforts should be enhancing your ability to attract, engage, and retain patients. Are they resulting in behavior change from your providers with measurable results?

6. Narrow Network Strategy

Your organization's payer mix no longer changes based only on consumer choice or socioeconomic status of the service area population. Are you creating narrow physician networks to competitively position your organization while strategically displacing one or more of your top competitors? The opportunity cost of not being on the right side of this equation is compounded by the significant advantage you may be inadvertently providing to competitors. Is your strategy effectively positioning your hospital/health system as a must-have provider in available preferred/narrow networks in 2016?

7. Revenue Impact Assessment

Changes to worry about used to be related to losing a payer contract or seeing an important medical group align with a competitor. In today's environment, the changes are happening in waves, and the impacts can be exponential. Can your organization survive

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Key Board Takeaways

Calibrate 2016 priorities now by conducting a "checkup" of essential focus areas based on your healthcare organization's market and competitive situation:

- Can you identify the specific "whys" of your current success (or shortfalls)?
- Which strategies should be reinvigorated or eliminated?
- Will you experience price pressure from health plan consolidations?
- Do you have the right strategic plan? (How do you know?)
- Is your strategic plan being implemented effectively?
- What new competencies should you consider in board candidates (e.g., hi-tech, data security, predictive analytics, risk contracting/management, social media)?