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Creating a Successful, Integrated Physician Culture

The Roles of Quality, Safety, and Technology as Financial Risks Are Shifted to Hospitals

SPECIAL SECTION

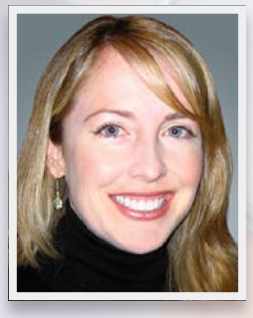
Considering Independence

Leading Operational Change at the Board Level

ADVISORS' CORNER

The Consumer-Centric Imperative for Healthcare Providers

The Year Ahead in Healthcare



As this is our first issue of 2016, it is a good time to consider key hospital and health system goals for the new year. Can we make a fresh start this year and accelerate our accomplishments?

This year more organizations will be accepting downside risk, whether through bundled payments or the next generation ACO model. The number of Americans with insurance continues to grow. Integrating physicians through sustainable models and developing effective physician leaders will be a continued need as organizations move forward with population health management. This year we will see the end of meaningful use and a major push towards interoperability, so technology will continue to play a significant role. Fulfilling consumer needs and expectations will also be a strategic driver. The articles in this issue cover each of these governance opportunities and provide key board takeaways to enable healthcare leaders and board members to grab the reins and kick off 2016 as a year of accelerated accomplishments.

Kathryn C Peisert

Kathryn C. Peisert *Managing Editor*

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Contents

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LEADERSHIP CONFERENCE
The Fairmont Princess Scottsdale
Scottsdale, Arizona
April 17–20, 2016

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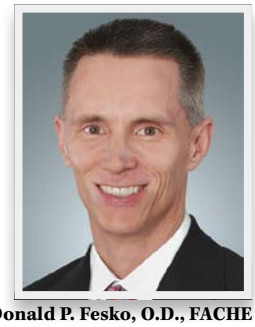
Creating a Successful, Integrated Physician Culture

BY DONALD P. FESKO, O.D., FACHE, COMMUNITY HOSPITAL



Donald P. Fesko, O.D., FACHE
CEO, **Community Hospital**

I believe the core of a successful, integrated physician culture is trust between the leaders of the organization and its physicians sustained through timely communication.

How we, as leaders and administrators of a healthcare organization, communicate with physicians is critical. When presented with a question or issue, it is important to give a straight yes or no answer along with reasons supporting your decision. Leaving a physician request open-ended causes frustration. It is more effective to give clear, concise responses in a timely manner on projects physicians bring forward. Physicians do not always like hearing "no," however, physicians learn to respect and understand it when you also explain the reasons for giving that answer, such as why you are unable to fund a project that they have requested.

An important question we considered in building our integrated physician culture was: How do we foster enthusiasm for our culture? We believe physicians' loyalty to the organization achieves the desired interest and excitement. When physicians are engaged, they know they have a voice within the organization and are active owners, not renters.

Our physician-led advisory committee has proven effective in cultivating loyalty and enthusiasm among our physicians by allowing them to provide guidance to the organization's board on important issues such as quality of care. The committee, which meets monthly, also works with senior management to develop workflows to help the organization streamline wasteful processes.

Appointing some of our key physicians to be on the committee, especially our house-based anesthesiologists and emergency physicians, empowers them. These physicians are granted some governance and management oversight to assist with process improvement projects. They not only oversee initiatives in traditional areas, such as surgery or anesthesia, but also the perioperative process in which they are responsible for the preadmission testing of surgical patients.

Having this level of physician involvement is a great benefit to our organization because physicians have wonderful ideas grounded in practice. Moreover, having a physician co-lead a clinical area or a service line provides important credibility with other clinicians. When you find physicians with the skill and ability to lead others, engaging them in a leadership position and allowing them to work directly with the organization's administration really helps support a successful, integrated physician culture.

Physician Report Cards

A key aspect of our work with physicians has been the institution of physician report cards. These report cards were developed jointly with the physicians last summer, and compare an individual physician's clinical outcomes to those of his or her peers. Through these report cards we have learned that physicians are highly competitive professionals who want to be leaders among their peers, not outliers.

As such, physicians have become more aware that a weak clinical report card translates into poor financial performance for the hospital. If a report card reveals underperformance, the revenue of the hospital decreases, which means it cannot purchase the most advanced technology, does not have as much money to put into staff education, and there is a potential that services may be reduced—all resulting in an environment that is not ideal for physicians to practice medicine.

Building the report cards took time, as additional information technology resources were required to allow for real-time meaningful data, but it was well worth the investment. Now, instead of outdated clinical information that was often irrelevant to physicians and therefore the administration's ability to make informed decisions, we have real-time accurate data available to physicians and administration that allows for meaningful strategic planning.

Working with the advisory committee to develop the physician report cards significantly helped to shape the relationship between the administration and physicians. They are more comfortable coming forward with quality improvement suggestions and, now that they know the data is accurate, are more inclined to ask what they can do to improve their report card and clinical outcomes instead of blaming the data for their poor clinical performance. Our administration's integration with the committee was chiefly responsible for the creation and implementation of the physician report card project and its general acceptance by our physicians.

Population Health and Physician Integration

Population health is tightly interwoven with a clinically integrated physician culture. Two years ago, we created a separate physician corporation under our organizational umbrella and put it in charge of population health management for the entire organization. As hospitals and healthcare systems step up to be the drivers and leaders of this focus shift, the integration of physicians from our local markets into leadership roles related to managing the health of the population will continue to be an important factor in our success.

However, this is but one small part of the larger process needed to build a robust population health management system. Leaders at our organization recognized early on that we will need to continuously build our system, piece by piece, over the

continued on page 11

Key Board Takeaways

Throughout the last seven years, Community Hospital has worked to achieve a successful, integrated physician culture. Leadership has built strong, trusting relationships with physicians through engagement and open communication. Some of the changes they have made that led to this culture include:

- Putting together a physician-led advisory committee that provides guidance to the board and administration on important issues such as quality of care
- Working jointly with physicians to develop and institute physician report cards
- Creating a separate physician corporation that is in charge of population health management for the entire organization
- Growing the hospital's network of employed physicians, and strategically developing employment contracts that build confidence and trust between the organization and medical staff

The Roles of Quality, Safety, and Technology as Financial Risks Are Shifted to Hospitals

BY WILLIAM C. MOHLENBROCK, M.D., FACS, VERRAS HEALTHCARE INTERNATIONAL

The entire American healthcare system and hospital boards in particular are again at a crossroads. Both were irrevocably transformed in 1965 by the introduction of Medicare and the *Darling* legal decision. Medicare began the shift from private to public funding and *Darling* shifted responsibilities for hospitals' quality of care from physicians to "hospital governing boards."[1] Now, 2016 launches a massive expansion of board responsibilities to include taking full financial risks for Medicare's Comprehensive Care for Joint Replacement (CJR) patients. This latest iteration represents a new healthcare financing model that imposes tremendous economic risks on CJR designated hospitals. But, great risks are accompanied by great opportunities for those who are prepared. CMS will reward hospitals and their medical staffs for delivering high-quality, cost-efficient outcomes, the net saving of which can then be legally shared with physicians.

Quality, Costs, and the CJR Episode

Beginning April 1, 2016, over 800 hospital boards in 67 U.S. regions will experience the full weight of their quality and fiduciary responsibilities. This date begins a preparatory year before CMS mandates the transfer of all financial risks to these hospitals for total hips and knees, including all costs incurred during patients' 90-day post-discharge period. Moreover, CJR heightens the focus on two of the most fundamental, inpatient cost components for which boards are also responsible: quality of care and patient safety. The nexus of medical quality and costs are profound. Over time, high quality is invariably cost-efficient in all industries, but especially in healthcare. This is because one complication or safety infraction doubles or triples a patient's hospital costs. Additionally, high-quality, cost-efficient outcomes define value, which fulfills the highest aspirations of both patients and payers.

All hospitals should use this preparatory year in the likely event the CJR bundle will soon be mandated for all U.S. regions. Under these pressures, collaboration between hospital administrators, boards, and physicians will be paramount. Each hospital should objectively and dispassionately assess its current levels of clinical quality and cost efficiencies, then make whatever course corrections are necessary to ensure net savings are generated. Lower extremity, total joint patients are often the hospitals' largest revenue source and for which negative cash flow could result in extreme financial hardships. Fortunately, CJR providers have a year's preparation to achieve these savings. Also, administrations will need to provide an objective means to equitably distribute the net savings among the hospital and physicians to avoid disputes over money. Clinical quality, patient safety, and cost efficiencies are disciplines in which modern information technology plays a critical role as hospital management and clinicians respond to the challenges posed by bundle payments.

Key Board Takeaways

Medicare's CJR will create significant financial risks for hospital boards and administrations in selected regional areas of the U.S. But, these risks can be offset by reimbursement opportunities for those who are prepared. This is due to the fact that CMS will reward hospitals and their medical staffs for delivering high-quality, cost-efficient outcomes, the net saving of which can then be legally shared with physicians. Three objectives the board should have for CJR and future bundles include:

- Provide physicians with clinical data to reliably produce bundled payment net savings.
- Objectively define clinical quality improvements on which to distribute net savings.
- Transparently share net savings among hospital and physicians, based on quality outcomes.

The Board's Three Objectives for CJR and Future Bundles

1. Provide information technologies for physicians to achieve net savings. The first hospital imperative is to ensure clinical and operational net savings are achieved for CJR patients, including inpatient, physician, and readmission costs. Without a positive cash balance there will be no dollars to offset the hospital's financial risks or to share with doctors. Inpatient expenses are usually over 50 percent of total CJR costs, so clinical and operational efficiencies are critical. Physicians admit, discharge, and direct 75 percent to 85 percent of all inpatient costs; therefore, a net savings at the physician level is key to financial success.

The most effective way to achieve a positive cash flow is for hospital information systems to demonstrate each physician's best-documented use of diagnostic and treatment resources (i.e., labs, pharmaceuticals, etc.). When doctors have their individual risk-adjusted, patient-specific data, they are able to collaborate among themselves and with hospital personnel to construct the most efficient two-level order sets for treating future patients. One order set is for less acutely ill patients and the other for severely ill patients within each diagnostic group, such as pneumonia or total hips.

2. Provide objective and transparent means to distribute net savings among the hospital and physicians. Since hospitals are at risk, they will receive any year-end net savings that are created by efficient patient care. Typically physicians believe their ordering patterns are responsible for generating the majority of these savings. In order to ensure the success of bundle payment episodes, doctors must trust the hospital administrators to accurately reward them with their fair share of net savings, based not only on financial, but also on clinical outcomes. This provider collaboration is a key component of the CJR risk-sharing model that incentivizes doctors to exert extra efforts in order to generate savings for the hospital, for themselves, and ultimately for CMS. Interestingly, net savings can be shared during 2016, a year before the start of hospital risk sharing.

3. Furnish oversight for selecting post-acute providers to manage CJR's 90-day, post-discharge phase. Board oversight for the post-acute selection process is important to current CJR designated hospitals and eventually to all hospitals. Deciding on which nursing homes, home health agencies, and physical therapists for contracting is generally not the expertise of hospital

continued on page 10

1 Darling v. Charleston Community Memorial Hospital, 211 N.E.2d 253 (1965).

Considering Independence: What Does It Take?

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

There has been so much discussion of provider consolidation in the healthcare industry that the very existence of independent hospitals may seem surprising. In fact, large numbers of hospitals remain either independent or loosely affiliated. Nonetheless, the momentum toward consolidation is forcing all of those hospitals to think carefully about whether they can sustain independence, and, if not, what model of affiliation might be optimal.

Affiliation at any level—from the "lightest" (integration of assorted clinical programs) to the "heaviest" (a full-asset merger)—should not be thought of in and of itself as either a failure or a goal. *The fundamental issue with which boards of currently independent hospitals need to wrestle is this: How do we, sustainably, fulfill our mission in a rapidly changing and highly stressful environment?* These are the critical issues: mission fulfillment and sustainability. From this perspective, strategies and policies represent the essential roadmap, regardless of whether any particular hospital is independent or allied with a larger system. The independence/affiliation/merger decision must *derive from* careful consideration as to what alignment and strategy will support sustainable mission fulfillment.

For some institutions, independence is an absolutely viable path to sustainable mission fulfillment. Even when system membership looks as though it can offer advantages, there are simultaneously sacrifices to be considered and weighed. Inevitably, the advantages of "scale" come with the complexities of size, constrained local autonomy, the outmigration to system executives and boards of many decision-making prerogatives, the need to consider system implications of local action, and the need to involve larger and more heterogeneous groups of stakeholders.

This special section will first look at why hospitals join larger systems, as a way of identifying the purported advantages that come with system membership. This will help identify the ingredients for successful independence, as independent hospitals will have to decide that they either do not need the particular advantage in question, or that they can obtain such an advantage without full affiliation.

This article will also provide examples of hospitals that have successfully remained independent, and describe the types of affiliation that can bring some of the benefits of size and scale without full sacrifice of autonomy. Finally, it will explore several aspects of the path to system membership, for those hospitals that feel required to make that move.

Why Independent Hospitals Seek System Membership

There are a number of arguments that, alone or in combination, drive hospitals to sacrifice autonomy and join larger systems of care delivery. The vague but inevitable discussion of a "need for *scale*" can almost always be reduced to one or more of the specific advantages (or purported advantages) listed below.

Prominent among these arguments are the following:

- The desire to tap into more sophisticated infrastructure (IT, shared services, HR, legal, etc.)
- Cost reduction via accretive savings
- Access to corporate expertise and sophistication
- Access to capital
- Access to improved contract rates for service
- Brand enhancement
- Ease of recruiting and retaining talent
- The opportunity to build new or more robust clinical programs (either specialty or population medicine)
- Protection from competitors in the near or neighboring marketplace
- Access to provider-owned insurance vehicles (that exist within a potential acquirer)

Of course, not every consolidating system is able to successfully deliver the desired (or in fact promised) advantages. A number of factors come into play including the strengths, resources, and competencies of the system, its rate of growth, its process of assimilating new acquisitions, challenges in its core markets, and organizational stressors (legal, regulatory, economic, or cultural).

Nonetheless, if we imagine a successful system with a track record that justifies the claims that it can deliver the list cited above to incoming totally owned affiliates, affiliation may seem attractive. But it also may be that a particular independent

Key Board Takeaways

Decisions related to affiliation should not be made in a vacuum, but rather in the context of a "zero-based" discussion about how the commitment to mission can be both fulfilled and sustained. Prominent reasons for affiliation include:

- Infrastructure needs
- Cost reduction via accretive savings
- Access to corporate expertise
- Access to capital
- Access to improved contract rates
- Brand enhancement
- Ease of recruiting and retaining talent
- The desire for more robust clinical programs
- Protection from competitors
- Access to provider-owned insurance vehicles

Healthy independent hospitals all find ways to either meet these needs without affiliation or forgo the help that affiliation would offer. A thoughtful self-assessment should serve as a prerequisite for any serious consideration of affiliation.

Should you decide that affiliation might be in your future, consider two critical cautionary notes:

- Negotiate from a position of maximal strength.
- When talking with potential partners, look past their promises to see how they have managed previous acquisitions.

hospital doesn't need the items on this list or can find ways of accruing these benefits without sacrificing independence.

We need to go carefully down the list, exploring what it takes to be sustainable without the ostensible benefits of affiliation, or how—short of full affiliation—similar advantages can accrue. This review will serve to construct for us a vivid profile of a hospital likely to succeed as a stand-alone entity.

An Independence Self-Assessment

The desire to tap into more sophisticated infrastructure (bricks and mortar, IT, shared services, HR, legal, etc.):

- We don't need this: Organizations that have been able to stay current in terms of infrastructure by virtue of reinvesting capital from operations or philanthropy, wise choices in vendors and systems over time, etc. can breathe a sigh of relief (so long as they have credible plans to keep up with the inevitable costs of reinvesting in IT).
- We can get it another way: An exceptionally strong balance sheet or exceptionally robust philanthropic support can allow investment in necessary infrastructure. Corporate partnerships occasionally support infrastructure as well.

Cost reduction via accretive savings:

- We don't need this: Organizations that have sustainable advantageous payer relationships, strong operating margins, and low cost structures need not worry about accretive savings (which are often more illusory than real).
- We can get it another way: Shared services agreements that allow independence offer another path to accretive savings, as do group purchasing arrangements.

Access to corporate expertise and sophistication:

- We don't need this: Larger hospitals that have attracted and retained sophisticated leadership teams have much less to gain in this area. Ongoing leadership development and succession planning are critical to sustaining these strengths.
- We can get it another way: Well-networked executives can often call upon a range of peer and trade association resources. Consultants can help as well, particularly if used judiciously so that costs remain manageable.

Access to capital:

- We don't need this: Hospitals with relatively new physical plants, up-to-date IT, and/or little debt have significantly less to worry about here.
- We can get it another way: Hospitals with exceptionally strong local philanthropic support have much less need for access to capital markets.

Access to improved contract rates for service:

- We don't need this: Hospitals with small levels of commercially insured patients may have financial difficulties, but they are not likely to benefit by "contracting power." Also, to the extent that consolidation-induced rate increases are in fact anticipated, anti-trust scrutiny can be expected as well, conceivably resulting in agreements with regulators that reduce access to higher rates.
- We can get it another way: Innovative programing, risk arrangements, and direct-to-employer contracting are all ways that some hospitals make up for disappointing contract rates. In fairness, however, it requires some size and sophistication, or participation in a consortium, to take advantage of these pathways.

> The fundamental issue with which boards of currently independent hospitals need to wrestle is this: How do we, sustainably, fulfill our mission in a rapidly changing and highly stressful environment? The independence/affiliation/merger decision must *derive from* careful consideration as to what alignment and strategy will support sustainable mission fulfillment.

Brand enhancement:

- We don't need this: A strong local brand, a history of community leadership, and high patient satisfaction all mitigate the need for brand enhancement through merger.
- We can get it another way: Clinical affiliations with nationally renowned brands (Cleveland Clinic, MD Anderson, etc.) can be negotiated based upon mutual interest.

Ease of recruiting and retaining talent:

- We don't need this: Attractive locations, cultures marked by high engagement and satisfaction, and a few marquis names can all go a long way to facilitate the recruitment and retention of talent. Residency training programs (both clinical and administrative) or affiliations with strong residencies that allow for regular rotations can also bolster recruitment efforts.
- We can get it another way: Strong programs to support the development of young men and women who have deep roots to the community can bolster recruitment even in remote areas. Such programs involve the identification of talented and interested youngsters in middle school and high school, offering jobs and opportunities for mentoring, scholarships, etc.

The opportunity to build new or more robust clinical programs (either specialty or population medicine—that is, programs involving risk financing and care across the continuum of sites of service):

- We don't need this: Larger independent hospitals may well have enough depth and breadth to offer a full complement of clinical programs. Institutions with few local competitors that have invested in an infrastructure to support risk contracting are often able to mount population health efforts on their own as well. Ownership of—or partnership with—home health, SNF, rehabilitation services, and nursing homes allow care across the continuum without full system membership.
- We can get it another way: Regional collaboratives, telemedicine, and clinical affiliations by program or service line allow smaller organizations to offer services that they otherwise would not be able to present to their communities. Partnership in regional clinical integration efforts allow smaller organizations to participate fully in population health initiatives.

Protection from competitors in the near or neighboring marketplace:

- We don't need this: Geographically isolated facilities have less to worry about when it comes to local competition. Also,

institutions with high brand loyalty and/or differentiated service offerings (either clinical specialization or service excellence) need less protection, at least in the short term.
- We can get it another way: Affiliation with high-profile brands, a strategy mentioned above, can also proffer protection from local competitors. Developing marquis services is another strategy. A genuine local merger of equals, when not deemed anti-competitive, can also allow rationalization of services across traditionally competitive campuses, without as much dilution of autonomy as happens when an individual hospital joins a larger system.

Access to provider-owned insurance vehicles (assuming that a potential acquiring system includes such a vehicle):
- We don't need this: Isolated hospitals have less need of tight integration with insurance products, as they have less reason to be concerned about insurance companies diverting referrals. Organizations whose cost structures and outcomes are superb also have less to fear. Hospitals at both ends of the economic spectrum—that is, with high reliance upon government payers or, alternatively, ready access to high-wealth communities—also have less vulnerability. In the later situation, retail services and patients unwilling to accept restrictive insurance products provide a buffer from the negotiating power of insurers.
- We can get it another way: Again, clinical integration can bring some of the same advantages of having a "captive" insurance company. Direct-to-employer contracting is another strategy, although, in fact this is a strategy more talked about than practiced.

Next Steps

Having conducted a self-assessment along the lines suggested above, what is next?

Your conclusion might be that you are well positioned to remain independent. Many healthcare organizations are still able to be successful on their own or by developing unique partnerships.

For example, the Lawrence Memorial Hospital, in Lawrence, Kansas, is a public hospital. That is to say it is formally owned by the City, with board members appointed by the Mayor. It is also completely independent, and receives no funds from the municipality. Many such hospitals have requested purchase by for-profit entities, or have looked to nearby systems for management or takeover. While the Lawrence Memorial board goes through an annual exercise of evaluating its capacity to remain independent, so far the decision has been to remain solo. Gene Meyer, its long-tenured CEO, credits the hospital's commitment to quality and service, its ability to reinvest in its physical plant, and the community support that follows exemplary performance in these areas. Lawrence Memorial achieves 70 percent market share in its local service area, despite the fact that 30 percent of the population works out of town, and most recently generated an 8 percent margin. *These accomplishments obviate the need for a system partner.* In fact, Lawrence Memorial is careful to spread referrals among numerous larger entities in its surrounding geography, wanting to be a "friend to all" and not invite polarized competition.

Baptist Easley Hospital, in Easley, South Carolina, has created a unique formula for (relative) independence. Previously a member of the Palmetto Health System, Baptist Easley found itself challenged by an aging facility and in need of resources. It was also located at the periphery of Palmetto's geography, actually closer to the Greenville Health System. The unique solution crafted by the Baptist Easley board along with leaders of the Palmetto and Greenville systems was to house Baptist Easley in a 50/50 joint venture between Palmetto and Greenville. Michael Batchelor, the CEO of Baptist Easley, came from the Greenville system, but Baptist Easley has its own board, selectively participates in various ventures of both "parent" systems, and has in fact brought the two otherwise competing systems into greater dialogue. It values the ability to pick and choose among initiatives arising from either of its joint venture parents.

Going through an internal review along the lines suggested above, many hospitals are likely to come up with an equivocal answer: in some ways independence works, in other ways—more or less depending upon the analysis—it does not. In such circumstances, there are three critical questions to ask.

1. Are there affiliation strategies available to us short of a full-asset merger, strategies that give us what we need? The answer to this question is an unequivocal "yes." We can arrange options on a rough continuum from complete independence to full-asset merger into a larger system:
- Clinical affiliation of selected programs (including residency programs) to include telemedicine
- Contracting for or collaboratively developing infrastructure services (purchasing, back-office, facilities, etc.)
- Creating regional consortia to offer and disperse more comprehensive clinical or infrastructure services
- Participation in a clinically integrated network (involves data sharing and the pursuit of best practices, but

allows joint contracting and risk contracting)
- Joint ventures

As the examples above illustrate, many—perhaps even most—of the organizations that have successfully remained independent have availed themselves of one or more of these affiliation strategies.

Even with full integration into a larger system, endowment assets almost always remain within local control, including the option to raise additional funds earmarked for local use.

2. If "it is only a matter of time" until we will need to join a system, how do we explore our options—or indeed present ourselves to the market—in a way most advantageous to the long-term realization of our historical mission, and when should we do so? The rule of thumb for successful negotiations is to enter from a position of maximal strength. This suggests that, if "the handwriting is on the wall," you want to initiate the search for an acquirer sooner rather than later. The strength of your current position offers leverage that might mitigate losses in autonomy.

Another option worth considering involves entering a more modest affiliation (see above) with the understanding that this allows both parties to organically build a strong collaboration. This collaboration may in fact mitigate the need for a full-asset transaction. Even if it does not, it allows relationships to deepen, synergies to be explored, and problems to be addressed—such that when the move to full integration takes place, it is a much less dramatic or disruptive event.

3. If we decide that we need to merge into a much larger organization, are there "critical success factors" that we should be aware of? Below are several issues where critical questions need to be asked. The answers to these questions should, in turn, begin to build a profile of more and less desirable affiliation partners, and will highlight issues for discussion during the "courtship" (negotiation) process:
- Alignment of mission, vision, and culture: Independent institutions need to look carefully for fit in these fundamental dimensions of system identity. They need to look past the verbiage, and look at the values that have been demonstrated in the activities and decisions of system leadership. Important dimensions of culture include the rigor of accountability systems; the commitment to service, quality, and safety; attention to developing people; sensitivity with which hard decisions are made; inclusiveness or the lack thereof; and the ability to engage providers in an orientation to the future.
- A track record of successful system expansion: Much can be learned by studying how earlier system acquisitions have gone. How do entities new to the system feel about their assimilation into the larger entity? Have promises been kept? Has value been added? How disruptive was the process? Has the system learned along the way? Are central or "flagship hospital" programs made relevant and available to affiliate hospitals? If so, is this done in a collaborative or imperialistic manner?
- A clear and future-oriented strategic plan: Does the entity with which you are considering affiliation have a clear plan for the future? Does this plan include accommodation to the inevitable shift from inpatient to ambulatory care? Does it include attention to population health and the ability to accept risk? Does the system demonstrate the ability to adapt overarching plans to local realities across its geography?
- Resources adequate to realize that plan: A strategy without resources is doomed to remain aspirational, rather than actual. So you want to ask hard questions about resources, and the ways in which resources are deployed. Does the system have reserves or access to capital that it can invest in turning its strategy into reality? Does it make an operating profit? What is its track record with respect to philanthropy? What is its bond rating? Its cash position? What promises can it make regarding a local capital infusion, if your entity should agree to enter the system? How will your particular ongoing capital needs figure into the system's five-year capital plan?
- Respect for local traditions and unique market factors: While system-wide strategic clarity is essential, so is enough flexibility to take advantage of opportunities across the system, and mitigate risks that are unique to each geography. Has the system that you are thinking about joining shown the ability to strike a balance between staying consistent to core strategic initiatives on the one hand and flexing to meet local realities on the other hand? Is there receptivity at the system governance level to input from local boards, and is there a spirit of inclusiveness when system strategies are being formulated?

Conclusion

Despite the wave of consolidation sweeping across our industry, independence remains a viable and sometimes in fact preferable strategy, so long as a hospital has a clear plan for sustainability. Planning needs to be forged and tested through a frank appraisal of external realities and internal capacities. This article suggests a way of performing the necessary appraisal with rigor and objectivity, and a path forward based upon the results of that assessment.

In the final analysis, every hospital board needs to find a sustainable way of fulfilling the mission of its institution. Neither independence nor affiliation should be seen as an end in itself; each needs to be assessed in order to guide thoughtful, responsible decision making about the future. This, precisely, is where the duty of care and the duty of mission converge.

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

Leading Operational Change at the Board Level: Navigating the First Mile

BY ROGER A. GERARD, PH.D., SLOAN & GERARD CONSULTING, AND DAVID A. SHORE, PH.D., HARVARD UNIVERSITY AND UNIVERSITY OF MONTERREY (MEXICO), BUSINESS SCHOOL

Key Board Takeaways

Creating stakeholder alignment around change is difficult, but five steps can be taken to ensure that the "first critical mile" of desired changes have a higher probability of success:

1. Listen respectfully to all stakeholders.
2. Assess "readiness" and expect different levels in differing parts of the organization.
3. Respectfully help those who cannot accept the change to be successful somewhere else.
4. Ensure a balance of leader styles, offering a variety of perspectives regarding the changes required and the approaches needed.
5. Fully support board/executive decisions, regardless of your own opinions.

Deciding to change things is relatively easy. However, creating stakeholder alignment around that change is another matter. Creating capacity, infrastructure, and a culture to support change is difficult, requiring patience, listening, resources, and respect for people undergoing change. This article explores how to get started, what to expect, and how best to lead in a supportive, intentional way.

Change Is Complicated, But Necessary

Today's board and executive leaders are bombarded by demands for change: changing healthcare systems, programs, products, services, customer expectations, technologies, and social/political interest. Healthcare reform means change! Some expect change to occur by simple edict, the "make it so" approach, but such simplistic expectations are insufficient in today's healthcare organizations. While research suggests that change is built into the human condition (we are all "experts" in some way or we could not survive), some are more "change-ready" than others.[1,2] Also, there are differences between self-directed change and change that is imposed externally, our focus. This article describes leadership's role in that "first critical mile."

Many misunderstand change, thinking that change is linear (point A to point B), rational, and that people dislike change. Actually, change is more complicated than that, often circular, messy, and emotional, occurring in a fluid environment—everything is changing as you bring about change. Transition is difficult and usually chaotic, despite our best efforts. Further, change is often accompanied by urgency, due to quality or financial performance issues. Before experiencing the integration of change, it is necessary to experience "dis-integration," the undoing of current paradigms, relationships, structure, etc.—a prospect neither optional, nor easy. While uncomfortable, many will gladly engage in change when there is clarity of purpose. It's often not that people dislike change, they dislike *being changed*.

Leading Change within the Practical Realities of Daily Work

Change can be incremental, transitional, or transformational, all affecting those engaged in the change process. How change is experienced from within determines readiness for change, requiring two things: *capacity* (or wherewithal) and *the desire* (willingness) to change. Absence of either means low readiness and can occur at all levels, including the board and executive suite. Reasons for low readiness offer clues for how leaders should bring about change successfully. Most lack of readiness is honest and should be dealt with helpfully, responding to the needs of those who must execute the change. This is an opportunity to learn, and to refine approaches. Consider the following algorithm:[3]

- *If desire is high and capacity is high,* engage people as "coauthors" of the change. Authorship leads to ownership.
- *If desire is high and capacity is low*, determine what is missing (skills, safety issues, knowledge, etc.) and provide it via training, resources, process changes, etc.
- *If desire is low and capacity is high*, coaching and perhaps discipline is in order. It is time to clarify expectations.
- *If desire is low and capacity is low*, the leader must use strong, perhaps autocratic direction, a very time-consuming approach. It may be time for new talent.

A proper approach early increases the probability of successful execution. But it requires that the leader first diagnose why readiness is lacking, and then employ an appropriate approach.

Dealing with Resistance as Change Takes Place

Often, change initiatives encounter resistance beyond simple lack of readiness. Someone will not want change to occur for reasons personal, professional, rational, or emotional. In healthcare, research suggests that nearly 25 percent of medical professionals suffer some level of burnout,[4] and as many as 45–60 percent of employees are disengaged. The reasons are many: unclear and changing expectations, long hours and work–life imbalance, loss of control, lack of emotional support, chaos in the environment, etc. Invariably, despite changes to remedy these issues, a small percentage might never comply, the cynics, rebels, apathetics, and naysayers. All are classic victims expecting your empathy, while really wanting you to reverse the change. They want, in their self-declared "victimization," vindication and work for it in vindictive ways. Several of these characters are well known by most executives:

- Persecuted Paul: "You guys just don't care about us!" (cynic)
- Polly Policy: "This change will violate bylaws, policy, regulations, labor contracts, etc." (naysayer)
- Gang Up Gary: "We've all talked, and we think this is a bad idea." (rebel)
- Social Sally: "Let's go have coffee…I'm sure you'll understand once we talk." (apathetic)

continued on page 10

1 John Kotter, *Leading Change,* Harvard Business School Press: Boston, MA, 1996.

2 William Bridges, *Transitions: Making Sense of Life's Changes,* Perseus Books: Reading, MA, 1980.

3 Adapted from Kenneth Blanchard and Paul Hersey, *Management of Organizational Behavior: Utilizing Human Resources,* Prentice Hall: New Jersey, 1984.

4 B.D. Wood and J.B. Killion, "Burnout among Healthcare Professionals," *Radiology Management,* November/December 2007.

The Roles of Quality, Safety, and Technology…

continued from page 4

personnel. Administrators and board members need a strategy with possible outside consulting assistance to select and manage the most effective and efficient providers and agencies that can produce savings in the post-discharge phase. Once identified, physicians will be attentive as to which post-acute care providers they choose when discharging their patients, as prudent selections will increase their share of the episode's net savings.

Quality, Safety, Technology, and the Future of Inpatient Care

Physicians and hospitals are voluntarily pursuing risk-bearing, commercial contracts in order to maintain their incomes, but CJR is not voluntary. For the first time in its history, Medicare is mandating that selected hospitals accept inpatient and post-discharge financial risks for total hips and knees, which are usually a large portion of their businesses. Now that CMS has developed CJR as a working model that transfers significant financial risks onto hospitals, most physicians and healthcare executives believe it is going to be extended, first to other hospitals, then to additional patient groups.

Viability under CJR and future bundle payment models requires conservation of hospitals' finite resources. These efficiency efforts create net savings that are achieved primarily at the physician level. Distributing net savings among the hospital and physician participants using an objective, quality-based method will virtually guarantee physician endorsement and the success of any bundle payment model. To accomplish these quality improvements, patient safety, and efficiency goals, hospital administrations and boards must equip doctors with technologies that produce reliable clinical information for individual physicians, including down to individual lab test and X-ray levels. These tools plus inpatient and post-acute provider collaboration will ensure hospitals' ongoing success as they approach this latest crossroads of American healthcare.

The Governance Institute thanks William C. Mohlenbrock, M.D., FACS, Founder and Chief Medical Officer, Verras Healthcare International, for contributing this article. He can be reached at bmohlenbrock@verras.com.

Leading Operational Change at the Board Level…

continued from page 9

There are many similar victim variations, none your friends. It is not compassionate to avoid conflict in these situations, when a simple "no" is the necessary response. This small percentage consumes a great deal of board and leadership time and energy, seldom accepting the changes required wholly and completely. It is ineffective to organize your approaches or invest time in those who do not have the organization's interests in mind. If your goal is to please or satisfy them, they will continue to ask you to do so, regardless of your or your organization's needs. Consider helping these people find success somewhere else.

Five Steps to Take in the "First Critical Mile" of Major Change

Boards and leaders can ensure changes have a higher probability of success. These five steps will get things off to a good start:

1. **Listen respectfully to all stakeholders**, especially opponents and adversaries. These teachers will inform your plan.
2. **Assess "readiness,"** and expect variation in differing parts of the organization. Respond to capacity issues with resources, training, and coaching. Respond to desire issues with listening, and kind insistence that change be accomplished, that personal enrollment is expected. Be prepared to negotiate and conciliate. Ensure attention is paid to "endings" (emotions around what people are letting go of) as you prepare for new beginnings.
3. **Respectfully help those who cannot accept the change** to be successful elsewhere. After effort has been made, in the final analysis, if you can't change the people, you have to change the people.
4. **Ensure a balance of leader styles**, leaders who can, by virtue of their natural styles, offer multiple approaches to the changes required. Autocratic leaders are highly effective for low readiness, while participative leaders are more effective for a high level of readiness.
5. **Fully support board/executive decisions**, regardless of your own personal opinions regarding those decisions. Leaders must speak with one voice. Failure to visibly support the change in the eyes of those who must execute and then live with the changes undermines everyone.

Change leaders recognize that different types of change demand different approaches. Proper diagnosis of readiness and the ability to use more than one leadership style is complex. It requires that board and executive leaders build balanced executive and management teams with differentiated skills and styles to offer an array of leadership possibility for what might occur. Leading change requires time and patience in a world that offers little of either. Leaders set a pace allowing for successful integration ("re-freezing") and the "final miles" of realizing and sustaining the benefits of change. This also takes talent and experience, recognizing change leadership as a practice learned over time.

The Governance Institute thanks Roger A. Gerard, Ph.D., Executive Coach and Management Consultant and Owner of Sloan & Gerard Consulting, and David A. Shore, Ph.D., former Associate Dean of the Harvard University School of Public Health, current faculty of Harvard University, and Adjunct Professor of Organizational Development and Change at the University of Monterrey (Mexico), for contributing this article. They can be reached at rgerard@athenet.net and dshore@fas.harvard.edu.

Creating a Successful, Integrated Physician Culture

continued from page 3

next several years. For instance, another piece in our process was to identify quality criteria that physicians in the population health corporation will have to meet each year if they want to stay in the program. Importantly, with the support of our board, which recognizes that this is a long-term project, we hope that our efforts toward physician integration and population health management make a difference in keeping the community healthy over time.

Physician Employment

Another area in which our organization has been successful in integrating physicians into our culture and administration is physician employment. Over the past four to six years, many existing physician practices have looked to our organization for partnership due to the increasing complications, burdens, and expenses of managing solo or small practices, such as the expense of adding an EHR system, the diminishing rates of reimbursement, and the need to keep up with myriad reporting requirements.

One reason our organization has been successful is because of our decision to partner with, rather than merely hire, physicians who are already established in the market and their community. We are able to call it a "partnership," and continue to build tremendous trust with our physicians and within the greater physician community, because we have limited restrictive covenants in many of our physician employment contracts. For this reason, if a physician ever wants to give up their independence to work with our organization, they know that they will not have to leave the area if they subsequently decide to return to private practice. Our institution of this practice in physician employment contracting has built up a tremendous amount of confidence and trust between our organization and the medical staff in the area.

When I became CEO 11 years ago, we had about a dozen employed physicians. Even then, our board saw the need to grow our employed network of physicians, and today we employ over 170 physicians in our organization. Although we took our time hiring, it was to our advantage in that we were able to be selective, especially among primary care physicians as they are the foundation to a successful population health and clinically integrated system, and choose the very best to join us.

Our journey to achieving an integrated physician culture has been underway for seven years and our experience thus far has justified our belief that open communication with physicians is a necessary prerequisite for building strong relationships leading to trust and loyalty amongst the administration and medical staff, and ultimately to better outcomes for our patients.

The Governance Institute thanks Donald P. Fesko, O.D., FACHE, CEO of Community Hospital in Munster, Indiana, for contributing this article. He can be reached at dfesko@comhs.org.

The Consumer-Centric Imperative for Healthcare Providers

continued from page 12

providing the fact-based foundation that enables change in healthcare delivery.

How to Get Started

Board and C-suite commitment and alignment provide the impetus for the first step, which is a readiness assessment. Organizational readiness can be assessed through a careful examination of:

- Market and organizational factors, including employer and insurance market characteristics, pricing, consumer-centric access, patient-centric experience, and relevant products, services, and bundles
- Comparative competencies in generating and applying consumer insights, organizational support structure, and leadership for sustainability

The assessment includes both qualitative and quantitative aspects of the organization's capabilities and market position relative to what is needed. Data derive from public and proprietary commercial and organizational sources.

For example, strategic pricing is on the radar screens of many governance and management teams as they review their prices to make their organizations more attractive. As part of an organization's readiness assessment, an eight-market national survey looked at consumer willingness to pay a higher price for services at a high-quality, well-recognized hospital versus other hospitals and facilities in the region.[3] The results showed that brand-recognized organizations could command higher prices, particularly with high-acuity care, but also with services perceived to be non-differentiated commodities, such as MRIs and lab services. Knowing this enabled the hospital to develop a pricing strategy based on solid estimates of price and volume trade-offs. The strategy covers different services to be delivered based on modeled price risk, consumer willingness to pay, potential payer/employer activity, and fairness principles.

In addition to strategic pricing, readiness-assessment considerations include: consumer insights generation, consumer insights application, consumer-centric access, patient-centric experience, relevant products and services, organization, and leadership. Each of these eight considerations can and should be thoroughly addressed. Significant investments will be needed over time to understand and deliver consumer access requirements, improved customer experience, enhanced usage behavior, and other variables. Through the organization's strategic capital planning and allocation process, boards must ensure support for consumer-centric investments that will start moving the readiness needle to meet growing consumer expectations and needs.

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.

3 A proprietary survey by Kaufman, Hall & Associates, LLC.

The Consumer-Centric Imperative for Healthcare Providers

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

Consumerism, disruption, innovation, retail, transformation, big data. A new set of words is dominating the healthcare lexicon. The vocabulary reflects the fact that smartphone-connected consumers have catapulted healthcare delivery into the on-demand economy made possible by technology.

Market forces are beginning to impact the performance of healthcare organizations that are not moving quickly enough to address changing consumer needs. In markets where consumers are highly activated, and thoroughly shopping for services based on price, access, or other dimensions, the competitive positions of slow-to-move organizations may be at risk.

To ensure the continued financial health of legacy organizations, hospital and health system boards must do three things: understand the imperative for consumer-centric service delivery, assess the current environment and organizational readiness to provide such delivery, and encourage and support investments in appropriate strategies.

The Consumer-Centric Imperative

The role of the individual in healthcare is quickly moving from passive *patient* to active *consumer*. Individual consumerism is being driven by more frequent and meaningful out-of-pocket costs, new and varied care delivery competition, transparency of cost and quality data, and technological innovation.

The imperative for providers is to make the consumer central to delivery models. The needs of an activated consumer should drive key business development and investment decisions, as well as the organization's growth and consumer retention strategies. For example, if there is a need for improved access to services, an investment in virtual/telehealth delivery and electronic messaging might be appropriate. Meeting the consumer-centric imperative enables providers to define and deliver on their value proposition to consumers, and by extension then to payers, employers, and other stakeholders.

Achieving consumer-centricity is not an initiative or a program, but a foundational organizational competence requiring in-depth information about consumer preferences and expectations. Meeting the imperative involves a continuous effort to develop consumer-centric capabilities and deliver solutions that change to meet new needs over time.

The Current Environment

According to results of a survey of hospital and health system senior executives, many healthcare organizations lack a sufficient understanding of consumer needs and strategies to meet those needs.[1] Ninety-six percent of respondents said that understanding patients as consumers is very important. However, only 13 percent said that their organization understands consumer needs and wants very well. Similarly, only 15 percent were very confident that their organization has a clear strategy and action plan for becoming more consumer oriented. These findings suggest that healthcare boards and management teams need to take a hard look at their organizational readiness for a more activated consumer, including their understanding of consumer segments and strategies for pricing, access, and experience, among others.

Forward-thinking organizations are starting to make the investments needed, but most healthcare providers have significant catching up to do relative to experienced, consumer-savvy retailers, such as Walgreens and CVS Health. These companies are investing in and delivering low-acuity healthcare services that previously were the domain of physician practices and hospitals.

"Informed intuition" will not be enough to guide providers' approaches going forward. Organizations will need a consumer strategy that positions them for distinct advantage in the face of growing competition.

Consumer-Centric Considerations

Putting the consumer at the center of answers to key business questions requires real data, advanced tools and techniques, analytics, and insights. Early work is required to understand consumer behavior related to healthcare purchasing and usage decisions, and in developing smart customer relationship management strategies that will help retain consumers.

In a recent study, eight in 10 consumers indicate that—more than any other industry—healthcare should meet or exceed their expectations.[2] Yet when asked to select from an array of emotions to describe how they feel during a healthcare journey, "confusion" often tops the list. The room for improvement appears to be significant.

Understanding the healthcare consumer's path to purchase and preferences by segment will be critical. Segments may be defined in many ways, for example, by attitude and behavior (expressed by consumers as "only the best will do" or "just make this as simple as possible"), healthcare conditions (healthy, chronic-not serious, and chronic-serious), and need (wellness, routine, and acute).

Hospitals will need answers to new questions. For example, which consumers prefer retail clinics, physician office visits, or virtual visits, and for which kinds of conditions? How will the population segments want to access primary care? "Tech-savvy immortals" will want a primary care practice that can provide fast, electronic answers to their basic health questions; a "family planner" consumer will want a practice focused on pediatrics with 24/7 access.

Consumer insights should inform strategies related to population health management, virtual/telehealth services, and other growth strategies and innovations,

continued on page 11

Key Board Takeaways

Market forces are beginning to impact the performance of healthcare organizations that are not moving quickly enough to address the needs of smartphone-connected consumers. Achieving consumer-centricity requires in-depth information—real data, advanced tools and techniques, analytics, and insights—about consumer preferences and expectations.

Boards must ensure that their organizations take the first step of assessing organizational readiness, and then support investments in capabilities that will be required for future success.

1 "Hospitals and Health Systems Struggle to Address Changing Healthcare Consumer Needs, According to Kaufman Hall Survey Results," Kaufman, Hall & Associates, LLC, December 7, 2015.

2 National Research Corporation's Market Insights survey of healthcare consumers, 2015.