GOOD GOVERNANCE CASE STUDY

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Designing Governance for the Future:
The New St. Luke's Health System

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Designing Governance for the Future:
The New St. Luke's Health System

A Confederation or a System?

St. Luke's Health System, based in Boise, Idaho, came together over several decades through formerly independent hospitals (ranging from community medical centers to critical access and public hospitals) and physician groups, across the southern region of the state, forming various types of affiliations and arrangements until ultimately becoming one organization. This patchwork-natured genesis of a health system is not unlike many in the U.S. today, and the resulting system was also a patchwork—of independent parts functioning on their own, with little more than the St. Luke's name in common. With multiple medical staffs and wide variations in cost and quality of care, the benefits of scale were almost non-existent and the governance structure, on paper, was as dizzying as a Jackson Pollock painting.

Dr. David Pate began his career in general internal medicine and spent about 10 years in private practice. He became interested in the national health reform discussion during the Clinton Administration and believed his experience as a primary care physician gave him some unique ideas of what could be done to improve the healthcare delivery system. This piqued his interest in law, so he went to law school at night to earn his J.D. while practicing medicine by day. Several years later, after gaining experience as a medical director and then going full-time into hospital administration, he was promoted to CMO of a large health system in Houston and then CEO of its flagship hospital. While in that role, a recruiter approached him about an open CEO position at St. Luke's Health System.

Pate took a leap of faith and moved his family from Texas to Boise, Idaho, to take the job as President and CEO in 2009. Dr. Pate recalled, "…we were really a confederation of hospitals, and the changes we were talking about—and the magnitude of those changes—were going to require coordination, alignment, standardization, and streamlined governance across the system."

Over an almost two-year process, Pate, senior leaders, and the system board's governance committee devoted exhaustive efforts researching system governance structure options, reaching out to the various community hospitals for their input and ownership, and then implementing a new regional governance and operational structure with three primary aims:

- Standardize, reduce variation and duplication, and operate like a true health system
- Streamline boards and committees to reduce the time commitment and burden on board members and support staff, while enabling and enhancing governance effectiveness and cross-system communication
- Maintain ties to the local communities to address population and community health

This case study focuses on why St. Luke's saw a need to restructure governance and operations, the key decisions surrounding the restructure, the process for implementation, and results to date.

Organization Profile

The roots of St. Luke's Health System go back to December 1, 1902, when the first hospital opened in a converted Boise home. The hospital was founded by Bishop James B. Funsten, who was acting on an immediate need to provide care to retired Episcopal Church workers, but St. Luke's quickly started accepting other patients, thereby becoming a vital source of care for all members of the community.

The health system first came together as the result of a merger in 2006 of St. Luke's Regional and Magic Valley Regional Medical Centers. Prior to that merger, Wood River Medical Center had already joined St. Luke's Regional Medical Center. Between 2006 and 2013, several additional smaller hospitals joined the system.

St. Luke's has enjoyed the benefit of long-tenured executive leadership, demonstrated by only three chief executives over the past roughly 50 years. Today, more than a century later, St. Luke's Health System is Idaho's largest, locally controlled healthcare system, with nine hospitals, more than 100 clinics, and nearly 14,000 employees across southwest and central Idaho, including roughly 600 employed physicians.

The Governance Challenge:

- Too many boards and committees, with little to no cross-system communication or collaboration
- No ability to realize the benefits of scale, standardize, and devote the best use of system resources

Actions Taken:

- Educating and engaging community board members in a lengthy, bottom-up process to understand the vision and future direction, why the current governance structure would not support it, and soliciting input and ownership into creating the best system structure for St. Luke's desired future position
- Implementation of a regional governance and operating structure, with the system board focusing on strategy and standardization, two regional fiduciary boards overseeing hospital operations in their respective regions, and community advisory boards responsible for community health needs assessments and making recommendations for community health initiatives

Results to Date:

- Enhanced use of resources across the system
- Increased communication and alignment among the community hospitals with system goals
- More clarity on board roles relative to the system as a whole, and agendas and meetings allowing for better decision making
- Better aligned medical staffs, enabling better standardization of care processes and collaborating on quality initiatives
- Community boards maintaining local ties and better positioning the system for population and community health management

Researching the Options

When Pate took on the role of chief executive in 2009, the governance structure included a system board and "entity" boards at Treasure Valley, Magic Valley, and Wood River medical centers. There were also several other boards of managed facilities that eventually became owned by the system. Each entity board had its own set of four to five committees.

Gary Fletcher, retired system COO with an almost 30-year history with St. Luke's, painted the picture. "In the 1990s, the vision from the CEO at that time was to organize ourselves around the care and coordination of our patients. We realized that we were going to need a delivery system to manage the care of patients throughout the region. All of these communities were trying to do the very best they could for their communities and taking care of their patients. But we were operating independently and so there was not the level of coordination, efficiency, and focus on patients that we needed."

Faced with the task of transforming a patchwork quilt into a streamlined system while continuing to add hospitals and physician practices, early questions St. Luke's leaders asked were founded on the need for better care coordination and being more patient-centered:

- How should the medical staffs be organized?
- How should we organize our leadership structure?
- What are the governance implications?
- In what ways do we need to engage community leaders?

It was clear to Pate, even during interviews for his position at St. Luke's, that the existing governance structure supported and facilitated silos across the system, and in fact was the main barrier to fostering "systemness." However, the system was generally successful and was not, by any means, in a crisis situation—often the catalyst for any kind of major structural or cultural change. "Making huge, significant changes seldom occurs in absence of a burning platform, some kind of crisis to precipitate it," said Pate. "St. Luke's was not facing that but I think what led St. Luke's to do this, even though there's always risk with making these big changes, is that the boards, medical staff leaders, and system leaders had already come through the process of deciding that change is coming in healthcare, and we all became committed to being in control of that change and leading the change."

In May 2012, Pate tasked Fletcher and Christine Neuhoff, Vice President and Chief Legal Officer, to lead the research stage of the project, initially gathering information about the various system governance structures in practice. They worked in partnership with the chair of the system-level governance committee, Barbara Wilson, and Director of Governance, Courtney Kirchner-Brumbach. The system governance committee then met on a monthly basis to analyze the options and develop a structure that would work for St. Luke's. They invited the chairs of all existing fiduciary boards to join the governance committee and participate in the planning meetings.

In the words of Barbara Wilson, the question to be answered was: "How can we better position the system to meet community needs and our mission for the future?" They set out to determine a governance structure that would allow them to improve the health of their communities through population health initiatives, standardizing and creating efficiencies in care delivery throughout the system, and driving innovative community partnerships. In addition (and perhaps, more of an immediate need), they knew they needed to find a way to reduce the time required of board members and management by reducing the number of boards and meetings.

"We were wasting an enormous amount of time—board member time and management time," explained Wilson. "That was getting in the way of meeting our mission and aligning our

system for the future. Management was making the same presentation three or four times. We had agendas that were not focused. We were not tapping into external community resources. We were still very much in the mindset of a hospital, not a health system, which is vastly different."

Their research and subsequent monthly meetings of the system governance committee uncovered the following two conclusions:

- Existing governance models largely fall into three buckets: 1) a loose confederation model or holding company with minimal central control (i.e., status quo for St. Luke's); 2) local boards remaining intact but becoming advisory and abdicating all fiduciary responsibilities to the health system board; and 3) elimination of all local boards, retaining one board at the system level.
- Redesigning the governance structure without also restructuring the system/hospital operations structure would not prepare St. Luke's to deliver on the promise of population health management.

George Kirk, director on the Wood River Community Board and the East Region Board, was part of the system governance committee spearheading the restructuring. "I did a lot of learning and listening the first few meetings and what became evident to me right off the bat was that governance in isolation, absent an operating structure that mirrored the governance structure, didn't make a whole lot of sense. So we challenged the managers to come up with an operating structure that they felt was going to mirror the governance structure. From my perspective, they both have to come at the same time."

An idea was generated to take a regional governance and operations approach, leaning away from complete removal of community boards and instead streamlining and revising their role and purpose. Dean Hovdey, board member of St. Luke's McCall Community Board and the West Region Board, described the cultural environment that led them in this direction. "The bridge that needed crossing was understanding the cultural differences between a small community and a city, in terms of community perception and how we are more closely connected as board members in a small town…. Because of our geographic arrangements and our physician referral patterns, we determined that we would be best serving patients with two regional boards, instead of a single health system board."

The governance committee also hoped that a regional structure would be more likely to be accepted by the community hospitals. "Overseeing operations, quality, finances, how to operate the traditional delivery system on an east and west geographic basis was probably the best middle ground," Kirk said. "Some would argue that it was simply adding a layer of oversight or administration between the system and the individual entities but we managed to cross that stepping stone as a committee, basically thinking that our patients in the regions had more things in common than not and that from a patient-centric perspective, the regional intermediate step made sense. Which then left the issue of what to do with the community boards."

"One thing I've learned is that governance, the operation of boards, the makeup of boards, what they do, and the culture of the organization are inextricably intertwined. And to a degree, they create each other."

—Tom Ashenbrener, Director, St. Luke's Magic Valley Community Board, and Member, St. Luke's Health System Board External Relations Committee

The Roadshow: Beginning with the "Why"

Neuhoff, Fletcher, and Kirchner-Brumbach then went on a lengthy process of road trips to meet with each existing hospital board face-to-face and "pitch" the idea of the new regional structure. During these in-person meetings the trio presented where the system leaders believed the organization needed to go in terms of advancing the St. Luke's vision, which involved moving away from a focus on care in the hospital to engaging the community before people become patients, and addressing the health of populations they serve.

"The task was for Gary, Christy, and myself to go out and have conversations with the entity boards to explain that we need to become more efficient and effective," said Kirchner-Brumbach. "Our current structure did not position us to address the new world of accountable care, population health, and value-based reimbursement. In addition, we were very conscious about maximizing our board members' time because they dedicate so much time to this organization. We had an authority matrix showing what would be centralized and what would remain at the local level. And all things came to a screeching halt."

Hovdey explained, "I think the hardest thing for any of these communities was for the local board to give up its fiduciary responsibilities and repurpose itself. They want to be doing purposeful work. So, people weren't afraid of being engaged—it was the concept of not being engaged in important work that initially put people at bay."

After this first attempt, Fletcher, Kirchner-Brumbach, and Neuhoff went back to the governance committee with the realization that the restructure wouldn't be successful if they presented an already "finished" plan—essentially, allowing the presumption that feedback was being asked for as an afterthought rather than showing the local boards that they would truly use that feedback to shape the structure. Perhaps more importantly, in the absence of a burning platform, the team was facing the challenge of convincing the local boards that business as usual was not going to be sustainable.

Questions to be answered included:

- What is our compelling reason to do this, and why now? (And how should we present this message in a meaningful way to the local boards?)
- How much information should we present, and at what pace?
- How do we assure the local boards that their voice would still be heard?

These "road trip" conversations continued across a year-long period, as the shape of the structure developed and evolved. "We had to do a tremendous amount of education to help people understand that the pre-acute care facilities and community access clinics were going to be how we improve health," explained Fletcher. "Managing health must occur in the local communities. We really tried to help people understand how the continuum of care was going to work in the future, and why we needed a primary care focus with local access and regional co-management. Then we needed to explain that while the community boards would no longer have as much fiduciary responsibility, there was an opportunity for them to engage in a more

meaningful way…getting together with physicians from our communities and deciding how care was going to be provided for the future." It was out of these discussions that the primary role and responsibilities of the community boards developed into a focus on population and community health, and conducting the community health needs assessments. (See **Appendix 1. The Case for Change**, an excerpt from a St. Luke's document demonstrating the reasons why the restructure was necessary.)

> "What it took was the development of trust among boards and physicians and leaders throughout the regions, who realized that there's just a better way to do things, and that would come out of working together in combined governance structures, medical staff structures, and leadership structures."
>
> *—Gary Fletcher, retired system COO*

Proceeding in Advance of Certainty

Despite the time involved, feedback gathered, and thoughtfulness behind it, there was not 100 percent certainty that this regional design was indeed the right structure—but the leadership knew that the status quo was not an option. There would not be a perfect, final answer until they tried it on for size, and they were willing to take that risk on.

The resulting governance structure still retains several boards, but with fewer committees and fewer meetings. The system board spends the majority of its time on strategy and future vision and sets standards for the entire system. The East Region and West Region boards, which are fiduciary, oversee the respective hospitals and clinics within their region on quality, finance, and operations. The local boards at each hospital, which had been fiduciary boards, are now advisory in nature. Their primary responsibility is conducting the community health needs assessment, and reporting to the regional boards areas they think are of greatest need—or where the health system can make a meaningful impact—for the health of their individual communities.

Cross-membership is a key element of the new structure. Certain members of the community boards also sit on the regional boards and participate in committees of the regional and system boards. (The community boards do not have committees.) Regional board and committee chairs also sit on the system board and respective committees. (See **Appendices 2 and 3** for diagrams of St. Luke's prior and new governance structure. **Appendix 4** is a map of the East and West regions.)

"When we embarked on this, we knew it would be a continual refinement. We weren't in a position where we thought we had the answers all figured out, but we thought that strategically we were headed in the right direction. We're in a process of refining it but I think it's working really quite well, with all the normal challenges you would expect when you go through any reorganization, governance and operationally."

—Skip Oppenheimer, St. Luke's Health System Board Chair

Tom Ashenbrener, who sits on the St. Luke's Magic Valley Community Board and the system board's external relations committee, detailed the new role of the community boards. "I was really solid on the community board concept and still am. Some people thought that was a bad idea because it was labeled as an advisory board, but it really isn't. It's a board that is able to create more action on a local level because they're not required to do the governance and fiduciary duties of the East and West Region Boards. We're able to serve as the liaison between the hospital, the healthcare providers, and the patients who need it; and the first step is to do the [community health needs] survey that tells us what the need really is. Whenever we assume something in healthcare, we're wrong. So we go out and conduct a tremendously detailed, in-depth survey. We find out what the community health needs are. And then we're able to start working together as a team for accountable care, to try to make the changes to reduce obesity and diabetes, stroke, and improve heart health."

From an operations standpoint, the previous hospital CEOs took on site administrator roles, reporting to two regional CEOs, who then report to the system COO. The regional CEOs also attend system board meetings (although they are not board members). Dr. Pate, system COO Chris Roth, the regional CEOs, and the rest of the senior team meet once a month to discuss system alignment and ensure that their work is being disseminated across the system, rather than staying within the respective regions.

"It is a common perception that CEOs feel they have to know all the answers and when they say things, they have to be able to do so with confidence and be able to convey that they're right. I don't think that's the right attitude. Trust is the foundation of everything and if you're going to build trust with your board, your leadership team, with physicians and employees, I think you have to be honest about it. You acknowledge that we're going through some uncharted territory and a lot of change is coming. And we don't know how everything is going to play out."

—David Pate, M.D., J.D., President & CEO, St. Luke's Health System

Early Days of Implementation

Given the uncertainty, there were some early "stumbles" and lessons learned. The team struggled with messaging—and the timing of the messaging—to get the necessary parties on the same page. The governance committee meetings were at times heated, as misunderstandings created some barriers to moving forward early on. There were strong concerns on the part of the local boards that they were losing their voice at the table and would just become "window dressing." The medical staff physicians feared losing their autonomy and that their priorities were not aligned with the system.

Some skeptics at the outset feared that the cross-population of boards would result in representational governance; others were concerned that, rather than having several silos as before, the two-region structure would result in two silos and still remain a barrier to system goals. According to Roth, "It is a constant challenge to keep us from forming silos, whether it's within communities or within regions. I rely heavily on our leadership teams and particularly the regional CEOs to ensure that we are working across the health system, across service lines, across communities. We have structures of communication and reporting built through our operating teams and through our boards, the regional boards, and the system board, so the right hand knows what the left hand is doing. That being said, it's a constant challenge and we've had stumbles and successes along the way. It's not solely as a result of our restructuring and our governance. Part of that's natural in an organization, particularly one as young as St. Luke's. But that's probably one of our biggest risk points."

There remains some misalignment among the system's physicians as well (both independent and employed), although that is less directly related to the restructuring. Jim Souza, M.D., West Region VPMA, explained, "What's driving the misalignment from a number of physicians is a lack of trust founded in a fear of the future, I think. Frankly, our drive to population health is upending the status quo in terms of the business model of medicine so it's threatening. It does have a link to this governance journey we went on, the perceived loss of autonomy. We have work to do with physician alignment."

In addition, the system experienced some unexpected challenges in 2013, right in the midst of the governance restructure. An unexpected budget variance occurred—the most significant variance from budget in St. Luke's history. Although it was unrelated to the restructuring efforts, the leadership eventually pulled through this crisis to achieve budgeted cash flows for the year. But those involved felt this issue gave more "fuel to the fire" in that they needed to be able to deal with anything coming at them, reinforcing the importance of having an effective and efficient governance structure.

Early Results

During the final phases of implementation, the leadership team made a point to clearly articulate to administrators, board members, and physicians how the decision-making channels would function in the new structure, including who needs to be informed and who needs to provide input. The leadership saw this component as critically important so that all system stakeholders understood how plans would be executed going forward.

The operational change was relatively seamless. "There really was no change in day-to-day duties, overseeing operations, and so forth. Obviously my reporting relationship changed," said Cody Langbehn, Administrator at St. Luke's Wood River Medical Center (formerly the hospital's CEO). "Once the structure was put into place and people actually saw how the east region was going to be run—how Wood River would be represented and how leadership team members and community boards would be represented within this new structure, I think that alleviated a lot of the fears. People saw that this was a way to be successful, a way to restructure that actually could work for not only our local community but for the broader region."

Since the restructure, St. Luke's has recognized some early successes in governance streamlining and communication, better physician integration, and maintaining the vital connection to the community to move forward more swiftly with population health efforts.

Governance Efficiencies

The more streamlined governance model has driven some efficiencies and enhanced board functioning. There is more and better communication throughout all levels of system leadership (both governance and operational). "Rather than have separate fiduciary boards at every single facility making decisions about capital expenditures or physician credentialing, those fiduciary duties have been brought together at the regional level. We now have much better two-way communication between the boards that are actually running the operations of our hospitals and clinics and our health system board," said Neuhoff. "We have a more formal process for ensuring that the information moves in both directions and all of the entities within the health system are working more closely together. And we don't have to go to eight boards to reach a decision."

Preparing board members and senior leaders for board meetings, as well as increasing meeting effectiveness, has been easier as well. "There was an intentional effort to align agendas and board materials, which has had a huge impact," said Kirchner-Brumbach. "Board members are now more prepared for their meetings, they are spending less time receiving reports and more time in discussion and debate. This is one area where we have made great strides; however, there is definitely more room for improvement…going through this restructuring process helped us realize the benefit of those things that are very mechanical in terms of business management principles, but make a big impact on how well the boards are functioning."

Medical Staff Integration

The medical staffs are now working together collaboratively, in a way that was seen as impossible before the restructuring effort, through the system and region-level quality and clinical transformation committees, which have created the ability to standardize protocols and processes while reducing variation in care. Physician leaders are now attending medical executive committee meetings and other physician leadership meetings across their regions, and clinicians are seeing themselves as part of a broader team. In one example, one of the communities needed a part-time cardiologist, which is virtually impossible to recruit from outside the area. The new structure allowed the physician leaders and boards to tackle the problem from a regional perspective, resulting in their ability to recruit a cardiologist who will practice in both

Twin Falls and Wood River. Other examples include sharing equipment and clinical expertise across regions to reduce duplication and improve care, including sharing of DaVinci robotic surgical capability and expanding the sports orthopedics expertise from the ski areas to benefit the rest of the regions.

The physician culture has changed as well. A chiefs of staff affinity group, which had been created prior to the restructure, was not particularly engaged or effective; after the change, the story is different. "From the medical staff perspective, there was none of that cross-talk and the silos were deep and strong," Souza said. "Now we have the opportunity for that cross-talk. The chiefs of staff affinity group didn't have any gas in its engine until after the change in governance. And that group today is really moving forward on standardization of processes that will directly impact quality…progress toward systemization and standardization like we couldn't have had before."

"I knew things were starting to take hold when our physicians started to engage with the Magic Valley leadership physicians in a truly meaningful way," said Langbehn. "All of a sudden, there was someone sitting across the table from our clinicians rather than just a name or a referral number from a hospital 65 miles away, and they were talking about real issues going on in both of the organizations and how they could help one another. Even though we were part of one system for many years we viewed ourselves as competing organizations, competing for patients or service lines. Now the clinicians see themselves as a broader, bigger team to really go after and tackle our quality issues, transfers and referrals, speed to trauma activations, and all these other different initiatives."

"The role I have as a physician is to remind my colleagues, with a message of hope, to quit being afraid of the future and grab it. All of my colleagues are lifetime overachievers…they've been getting straight A's their whole lives, they've mastered all standardized tests that people can concoct. They are used to working 100-plus hour weeks in their training and some of them take on 80-plus hour weeks in their own practices. They're business people, many of them great communicators. The rules of the game have changed. We have to deliver healthcare in a new way—frankly a better way, a way that goes back to our core values. Grab it, lead it. If you lead it, people will follow you."

—Jim Souza, VPMA, St. Luke's West Region

Community Ties

The new structure allows St. Luke's to retain (and enhance) the community connections across the large geographic region. The community hospitals are moving to the same electronic health records to assist with population health management. Now as a system, the resources and relationships have become more real and meaningful, and community board members can better understand the importance of their rural communities being part of the collective system efforts.

But the community boards are being tasked with the most dramatic change of their function and responsibilities when compared to the regional and system boards, and as such, they are still learning. To help ease this transition, former East Region CEO Jim Angle created a project plan to help the adjustment of regional and community board members, covering board policies, procedures, and practices. Agendas are being reworked to make the new roles and responsibilities more clear. It is still a work in progress. "I remain frustrated a year plus into this that, at the community board level, we still spend half our meeting talking about and going through the traditional hospital oversight issues," Kirk said. "I understand the desire to know, as a community board member…I'd like to be able to speak to how the hospital is performing. But it distracts and it takes away from the ability of the community board to get outside the traditional continuum of care to begin to explore ways to better the health of the people in the region. I've been used to walking this way and now you're telling me I need to adopt a different gait, and it's a hard gait to adopt. And yet if we're unable to be disciplined in the notion that we really do need to walk differently, we're going to continue to be stymied."

Community Boards: A New Purpose

"As part of our history and culture at St. Luke's McCall, our hospital staff here had been very involved in our community, in terms of going to the schools, for example, and promoting wellness concepts and looking at healthy alternatives for youths. For years we have had an alternative medicine clinic, and we involved the doctors to host screening opportunities for community members. But now we are asking our own community to look at the hospital as being not just about caring for sick people, but about wellness and preventative health.

So, with our repurposed board, we could land on those concepts that we already had in place. When we developed our first community health needs assessment, these were some touchstones we could feel, that allowed us to get an idea of how we would still be doing very important work within the community and, in many ways, touching our community in a more intimate way than we had as a fiduciary board.

As we started to work more deeply with people from across the whole system, it became easier to be an advocate for our local community while also having a more global view of what we were doing as a system, even across the regions. Together we are better off than any of us were when we were trying to do it on our own."

—Dean Hovdey, Board Member,
St. Luke's McCall Community Board
and St. Luke's West Region Board

New Relationships to Build the Future

Perhaps most importantly, this restructuring process has allowed board members and system leaders who did not have previous relationships to build collegiality and trust across the system, and begin breaking down the siloed "confederation." Today, Pate and his leadership team continue to ponder the ongoing challenges in moving away from the well-known fee-for-service environment to the largely unknown value-based environment, and whether the current redesign will best prepare the organization for this less well-known future.

"Looking back on the past year, I think we knew it was going to be hard work. It's a lot harder than any of us thought it would be. We've seen some successes along the way, some surprises, pleasant surprises. But it's one thing to put a nice structure on paper and map it out; it's another to take several hundred people—leaders, physicians, volunteers, board members—and execute it. It takes daily work and attention, it takes continuous asking of how things are working and never assuming that we've figured it out. We're always evolving, we're always changing, and I think at the time when we say 'we've got it' is probably the time when we've already lost the battle."

—Chris Roth, COO, St. Luke's Health System

There are still questions left to be answered, specifically around further defining and clarifying which boards will have ultimate responsibility for population health. While the community boards have been tasked with community health, there is also an ACO board and a network board working on implementing foundational practices to do population health within the health system's clinics, together with independent physicians, and there is not yet much connection between these various efforts. "They all relate to each other but there needs to be some creative way, as the organization evolves, to bring people together, so that the work of those groups complements each other and it's coordinated in a meaningful way. If we do that, we'll hit the ball out of the park," said Kirchner-Brumbach.

"What we've done isn't going to work for everyone, but you have to start out with a shared vision, and trust and relationships, and then the rest of it can fall into place through a lot of hard work."

—Gary Fletcher, former St. Luke's Health System COO

"Frankly I don't see a light at the end of the tunnel," Pate said in closing. "I think there's going to be rapid change and significant change coming for many years to come. I think we just have to be honest and I think we have to explain to people what the new normal is. And I think this amount of change is the new normal for now. I think that you also have to be empathetic. You have to appreciate the toll that it is taking on your organization and acknowledge it. We don't know what the end game is for our governance restructuring, and this is a process that goes on and on. It's not going to be over with; we're going to constantly reevaluate. And that's what a learning organization does."

Appendix 1. The Case for Change

(Excerpted from a document developed by St. Luke's Health System.)

Executive Summary

As reviewed and amended by the Governance Committee on 5.20.2013.

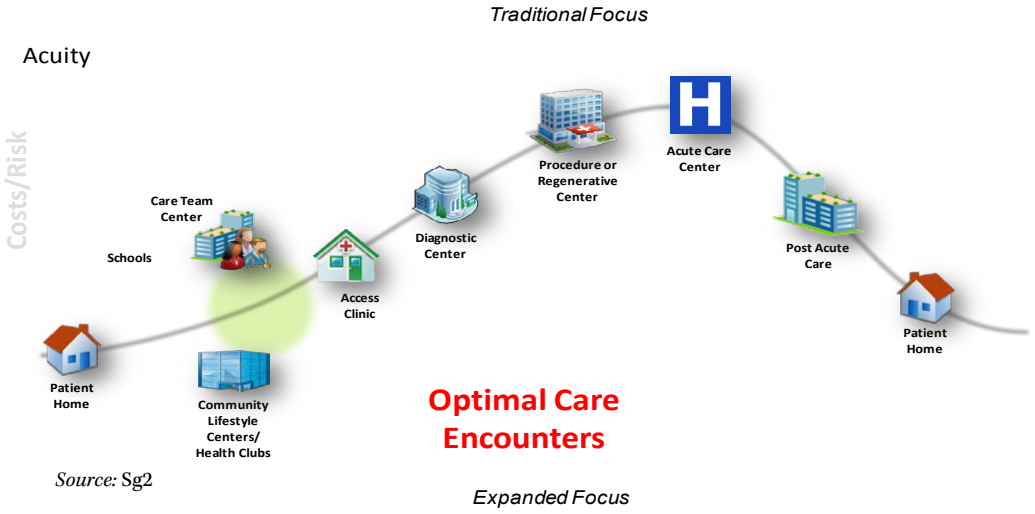
Mission Improve the health of people in our region.
To do this we must shift our organizational focus towards improving health, not just the provision of care.

Vision St. Luke's Health System will transform health care by aligning with physicians and other providers to deliver integrated, seamless, and patient-centered quality care across all St. Luke's settings.
We must broaden our view of a delivery system to expand beyond our traditional focus, to include the provision of health services spanning across all aspects of a person's life.

Aim Population health management necessitates coordinated delivery of services centered on the care of patients and people in the settings *in which they live*. Delivering on this vision requires standardization through the elimination of variation and waste; partnering with community organizations in innovative ways; and, the most efficient utilization of resources possible to prevent illness, improve health, and provide acute care when necessary with exceptional quality. Doing so will meet our triple aim of better care, better health at a lower cost.

St Luke's

Care Continuum



Source: Sg2

Changing Roles
Community Boards-Identifying and addressing the needs of communities we serve and driving local engagement, advocacy, and creativity is a top priority. Community Boards are best positioned to act as the conduit between communities and the delivery system, serving as the "voice of the community," as well as the critical means by which to drive local grass root involvement. *Regional Boards* will serve as a hub of information and input by which collective decisions will be made as to how to plan and most effectively and efficiently allocate resources to best meet the needs of the communities we serve. Aggregating oversight responsibilities will support standardization, increased quality, and lower total costs.

How is this better for our patients?
A population health model, with supporting governance and operational structures, heightens the importance of the patient's experience and engagement, as measured by the triple aim; our goal must be to create an environment for our patients and communicates where people feel and believe St. Luke's is truly involved in and committed to their health. This will require a paradigm shift where our systems must become truly patient and people-centric, beyond our current ambulatory and acute care focus. Community boards enable and empower this important change in focus.

Note: The Governance Committee began their structural effectiveness review by focusing primarily on the governance model. Early on, the Governance Committee expanded this review to include operational restructuring. This was based on their understanding of the importance of ensuring alignment between the operational and governance structures, and to provide compatibility and consistency in approach between the two. As such, operational considerations have been incorporated in the design of the governance structure proposal. Additionally, a proposed operational structure has been developed.

The Case for Change

As reviewed and amended by the Governance Committee on 5.20.2013.

Executive Summary

The current fee for service/volume driven model is in the process of changing. Reduced margins are expected, which will result in service and resource constraints. This can only be mitigated by standardization (elimination of variation & waste), partnering with community organizations in innovative ways, and the most efficient utilization of resources possible to prevent illness, improve health, provide acute care when necessary with exceptional quality, and stabilize the health of people after illness. We are not doing this now to the extent necessary to be successful in a post-reform population health model.

How is this better for our patients?

Population health management requires coordinated execution centered on the care of mutual patients and people in the settings *in which they live*, stretching across the entire continuum of care. A population health model, with supporting governance and operational structures, heightens the importance of the patient's experience as measured by the triple aim, and requires a paradigm shift where our system must become truly patient and people-centric by addressing all of their health needs in the communities where they live.

Is there a role for local board members in the proposed structure?

The role of local community board leaders becomes increasingly important in a population health model. Local leaders are best positioned to build community partnerships, philanthropic support, and provide invaluable insights into local community health needs.

Why are governance and operational model changes necessary?

Delivering on population health will require a shift in focus away from traditional operations towards one centered on meeting the health needs of the communities we serve. This is only possible by reorganizing and reprioritizing the work of our boards and our clinical and business operations.

Our New Reality - Population Health Management in the Post-Reform World

What is population health?

SLHS Definition:

- The active engagement between people and providers in a geographic region to develop shared accountability to drive better health and better care at lower costs.

Sg2 Definition:

- A care delivery model that involves a systematic effort to assess the health needs of a target population and proactively provide services to maintain and improve the health of that population.
- Population health represents a far-reaching shift and it entails much more than just taking on risk in payment.

What are the key components for success in this new reality?

Ability to:

- Considerably reduce the total cost of care.
- Establish a large number of attributed lives.
- Eliminate waste through the implementation of TEAMwork.
- Effectively and appropriately balance and manage limited resources.
- Deliver on the triple aim of better care and better health at a lower cost.
- Consistently deliver care that is of exceptionally high quality, extraordinarily safe, and highly satisfying from the patient's perspective.
- Standardize clinical and operational processes to improve quality and decrease variability.
- Align incentives to a value-based reimbursement model via innovative payor contracting.
- Effectively coordinate care across the continuum, extending outside our current delivery system.
- Partner with organizations in the community to deliver services outside of traditional hospital scope of services.
- Deliver value to the communities we serve, resulting in philanthropic partnerships to fund the continued development of the new model.

Our mission, vision, and goals are currently aligned to this new reality.

Mission/Vision

- To improve the health of people in our region.
- Transform health care by aligning with physicians and other providers to deliver integrated, seamless and patient-centered quality care across all St. Luke's settings.

FY2013 Goals

- Create an exceptional patient experience.
- Create exceptional outcomes through TEAMwork.

So, can we deliver on a population health strategy with the current operational and governance structures?

In short, no.

- The St. Luke's Health System has formed over the past several years from independent regional medical centers, critical access hospitals and physician practices, all of which were built upon strong ties to the communities in which they live, as well as the classic Idaho spirit of independence.
- Although there has certainly been marked improvement, the System continues to function more as a federation than a union of entities aligned behind a singular purpose.
- Resources and investments, including board member time, must be redirected towards the development of population health competencies. Our current structures do not allow for the level of systematic perspective necessary to drive this as we are too caught up in day-to-day administrative issues.

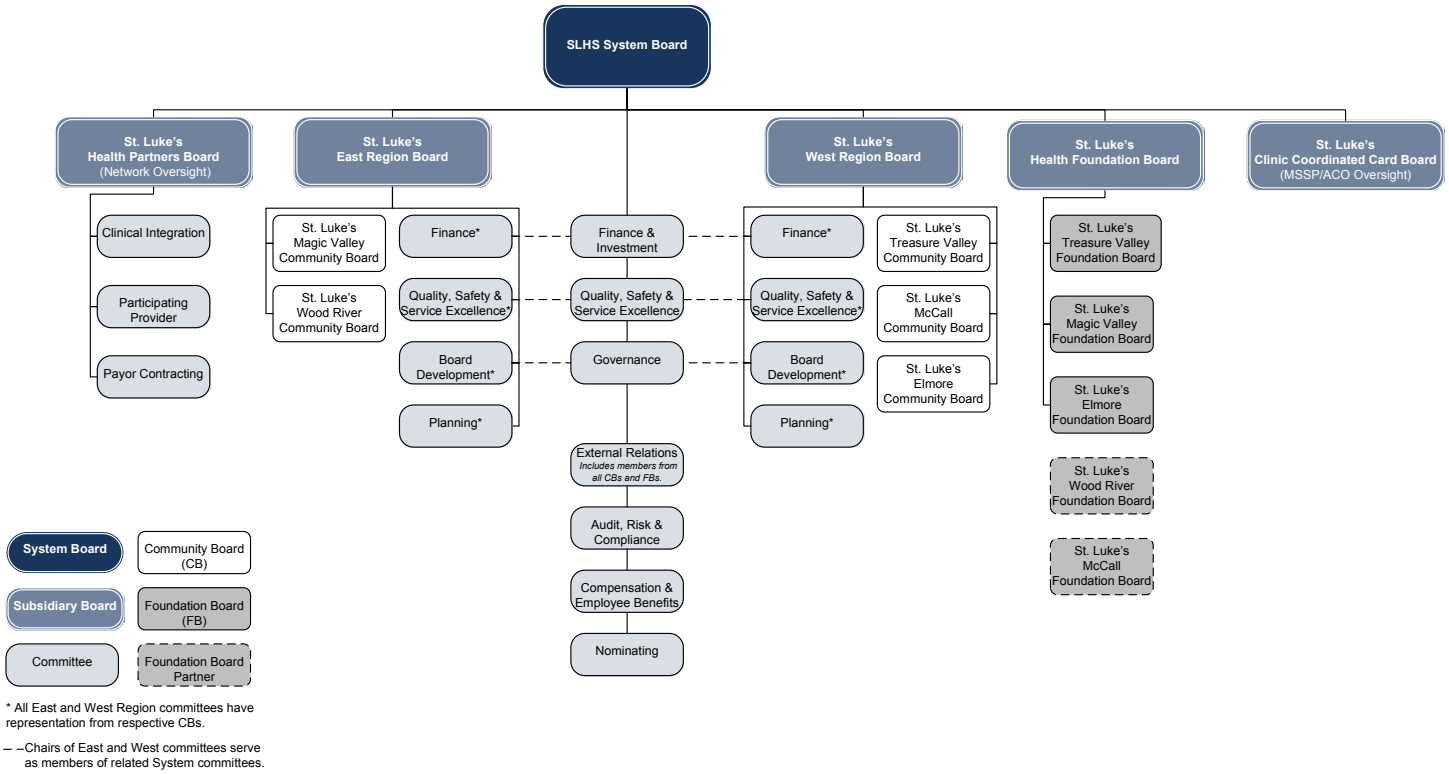
Many opportunities for improvement exist under a new model.

- Increased and improved connection with the people, patients, and communities we serve.
- Coordination of scope of services and service lines from one geographic region to another.
- Collaborative development of evidence based care practices deployed regionally and locally.
- Reduction of redundancy and duplication of effort, due to clearer definitions of roles and responsibilities.
- Heightened and consistent clinical and operational performance, which is currently highly variable site to site.
- Increased communication, planning, and execution of tactics among boards with mutual patients and shared challenges.
- Increased focus on care coordination at the entity level, across and between regions, and with external organizations.
- Effective allocation of limited resources in the planning and delivery of services and programs to meet population needs, ensuring their highest and best use.
- Renewed focus on collective performance, eliminating the tendency to focus solely on entity performance and concerns in some cases to the disadvantage of the System or region.
- Regional collaboration on the best utilization of resources of all types: people, equipment and capital.
- Standardization of supplies, drugs, and operational policies, procedures and practices.
- Utilization of the new structure to leverage lessons learned and develop system-wide best practices for operational and clinical improvements, which have typically been limited to the site/local performance.

Why is a consolidated approach beneficial? Why regions instead of a singular structure?

- A regional governance and operational structure will streamline decision making, enable standardization, simplify lines of authority, increase accountability, ensure the best use of limited board time, and support achievement of the triple aim.
- The trend in healthcare governance is towards centralized fiduciary responsibility. However, a singular governance structure is neither desired nor beneficial given the unique elements of our System. Further, this approach is not politically or operationally feasible given the System's history, characteristics, and the System Board's desire to not increase its own operational oversight. The System Board is currently very nimble; moving to a single board structure would significantly impact this important trait.

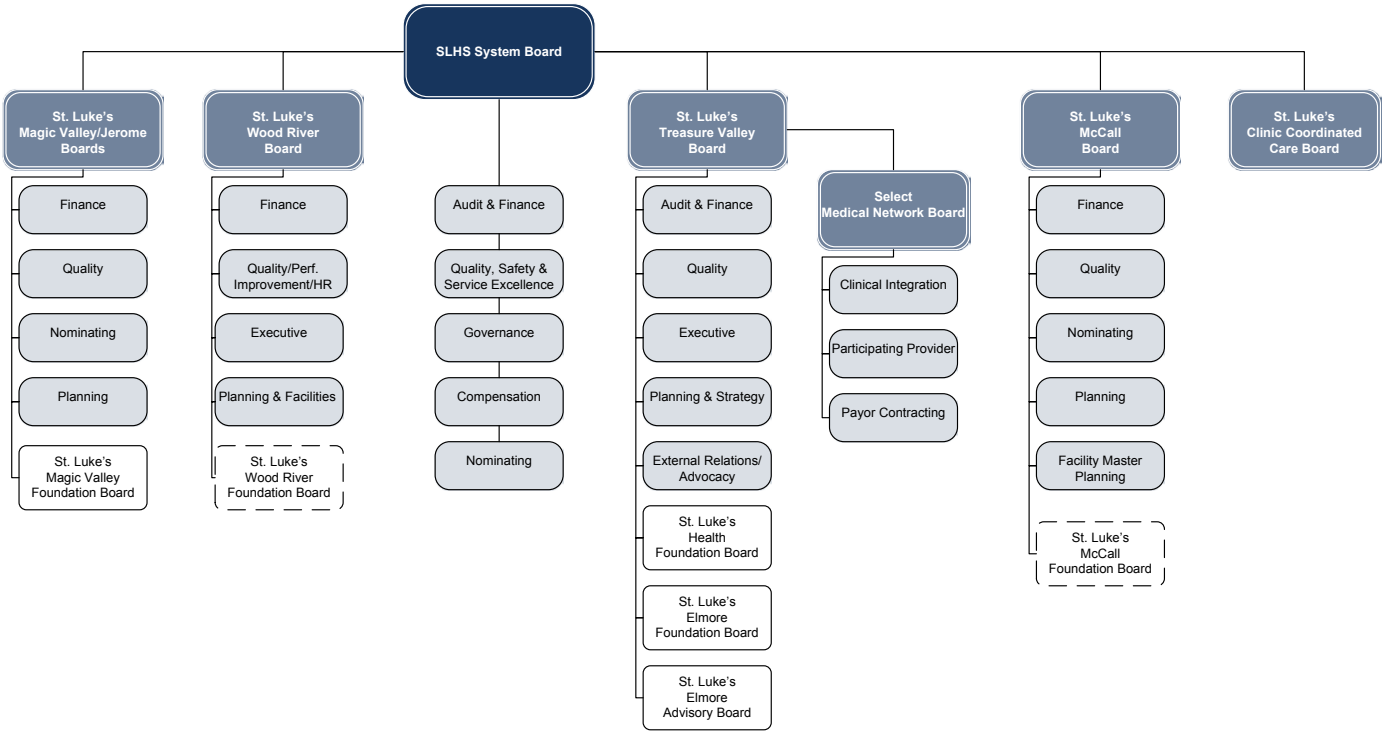
Appendix 2. St. Luke's Current Governance Structure



* All East and West Region committees have representation from respective CBs.

– –Chairs of East and West committees serve as members of related System committees.

Appendix 3. St. Luke's Pre-Regionalization System Structure



Appendix 4. St. Luke's Health System Regions