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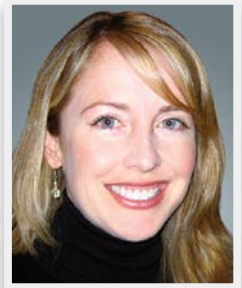

It is more important than ever to stay on top of growth and change in our industry in order to remain relevant, and to maintain our ability to provide the best possible care to the community. Equally important is the relationship between the board and management. A healthy relationship between the two is key to ensuring your organization is running smoothly and performing at its best. Our Advisors' Corner article in this issue demonstrates the growth imperative in the healthcare industry. Healthcare boards will no longer be able to succeed by following the traditional course of change. Embracing innovation within your organization will lead to a smoother transition, and more success when facing the uncertainties of healthcare change. The other articles in this issue all highlight the importance of success trickling (or flooding!) from the top down. Boards and management teams that embrace growth and innovation will set the entire organization up for success during times of change which will, in turn, be reflected in the care received by patients. We hope these articles provide helpful takeaways and generate strategic ideas as we close out this year of immense change and prepare for ongoing success during another year of uncertainties ahead.

Kathryn C. Peisert, *Managing Editor*

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The Enduring Importance of Local, Subsidiary Boards

BY A. HUGH GREENE, FACHE, BAPTIST HEALTH

A. Hugh Greene, FACHE
President and CEO,
Baptist Health

Several years ago, a colleague shared with me that he was able to disband all of the subsidiary hospital boards at their health system. He was gleeful about the simplification of governance. My reaction was contrary to what he might have expected as I responded, "Why in the world would you want to do that?"

In an era in which we are trying to reduce the silos and operate as a system, one could make the argument that local hospital boards are no longer relevant or useful. There is little doubt that a single system fiduciary board is more simple and efficient. However, I would submit that the ongoing engagement of community leaders at the local hospital level has far greater value.

My conviction is based on the fundamental assumption that Baptist Health, as a not-for-profit health system, exists to serve the community. I consider the community to be our "owners" or "stockholders." Therefore, our boards at all levels are providing the input of essential community voices. The more engagement that we have of these community leaders, the more effective we will be in fulfilling our community-based mission.

Local, subsidiary boards are important for the following reasons:

- They know their communities and offer the perspective of those specific geographic constituents.
- Their members are important advocates of the health system within the community.
- Their members are well-informed about healthcare delivery and help to educate others.
- Their members who work in local governance also are essential for our philanthropic efforts, both as donors and in helping to raise funds.

Engaging with Boards at the Local Level

The key to engaging with boards at the local level is to effectively define their roles and find ways to integrate them into the overall system so they feel like part of the larger whole, and to maximize efficiency and minimize duplication of effort.

At Baptist Health, we are pleased with our efforts to integrate our local, subsidiary boards and believe this integration of governance is key.

In our case, there is very little duplication of effort between the local and system boards. The subsidiary board meetings are highly engaged, substantive, and focused on their specific institutions, whereas the system board is more strategically focused.

The local boards' meeting agendas tend to focus at the hospital level on quality of care metrics, financial performance, patient experience measurement and results, and patient-origin data for that facility. Additionally, our subsidiary boards review risk management for their hospitals, including pending legal claims. This activity at the local level frees the system-level fiduciary board to focus on major strategic initiatives and investments.

When integrating local, subsidiary boards into the overall system, consider the following points:

- Do not refer to these boards as "advisory." Our system board is committed to hearing the real input of these boards and consider them essential. Although subsidiary boards are not fiduciary from a legal standpoint, they fulfill certain required responsibilities as defined by the medical staff bylaws, such as credentialing physicians and approving medical staff officers. We have no system-wide facilities committee; rather, we designate this responsibility to the subsidiary boards, whose members have a stake in the quality and the patient experience at their respective hospitals. Our health system board has never been in a position of overturning the recommendation of a local board.
- Health system committees are populated by members of the health system fiduciary board, but also with members of our hospital boards. The health system finance committee, for example, always contains the chairs of the local boards so they have a sense of system-wide capital allocation as well as overall system financial performance.
- We hold an "all boards" educational event once a year. To promote inter-board dialogue, we insist that members do not sit at tables with members from their own board.
- Our annual board strategic planning retreat always includes the chair or a representative of the subsidiary boards.
- Our governance committee looks first to engaged members of the subsidiary boards when filling positions at the health system governance level to ensure the system-level board is composed of committed and informed board members. Board orientation includes a system component that involves the interaction of new members from all of our boards.
- Local board members play a vital role in development efforts and greatly contributed to the resultant success of surpassing our $100 million comprehensive campaign goal.

Key Board Takeaways

Health system boards should consider the following advice when engaging with local, subsidiary boards and integrating them into the system:

- Do not refer to these boards as "advisory;" treat them as essential to the system.
- Populate health system-level board committees with members of the local, subsidiary board.
- Fill vacant positions within the health system board with engaged members of subsidiary boards.

Ensuring the Health of the Community

The result is that we have more than 90 individuals involved in governance from throughout our community, including our health system board, local hospital boards, primary care board, and foundation board. I have no doubt that governance across our system is stronger and more effective because of the engagement of individuals at the local level and the advocacy they provide for our health system. These local subsidiary boards truly are vital and relevant to ensuring the health of our community.

The broad community involvement made possible by these subsidiary boards has been integral to the fulfillment of our community-based mission. I would have it no other way and believe this has been critical to the success of our health system.

The Governance Institute thanks A. Hugh Greene, FACHE, President and CEO of Baptist Health in Jacksonville, Florida, for contributing this article. He can be reached at hugh.greene@bmcjax.com.

Ensuring a Successful Board–CEO Relationship

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

In these complex and uncertain times, it is even more important than ever that the relationship between a board and its CEO is healthy and productive. And yet, boards of some organizations are experiencing difficulties as they try to develop a trusting partnership with their CEO.

For hospitals and health systems, the desire to build a relationship between a board and its CEO is not new. But some trends have surfaced recently that can make it more difficult to have a successful partnership.

Industry Transformation Stress

The first trend is the complexity and uncertainty in the external environment. The healthcare industry is undergoing significant transformation as it focuses on value instead of volume. Some board members react to these changes by demanding more of their CEOs than in the past. For instance, boards are requesting more educational sessions on the external environment, more financial forecasts, and more details regarding potential strategies.

Most of these requests are appropriate given the changing landscape, but some board members dig too deeply into issues because of their own anxiety about the unknown. In some cases, this increased attention is causing CEOs to feel the board does not trust the management team to "do their jobs."

Governance–Management Confusion

A related issue is when board members do not fully understand how their role differs from the role of management. This occurs most often with individuals who have not previously served on the board of a large, sophisticated organization.

Well-meaning, but inexperienced, board members often think their role is to probe into operations to find problems, so they ask questions at the wrong level. The CEO (and other executives) may become frustrated that their board is micromanaging instead of setting strategy, goals and policies, and stepping back.

Authority Disagreement

Another typical source of tension between CEOs and their boards is lack of clarity regarding decision making authority. For example, a board may think it should approve all expenditures, whereas the CEO may want the flexibility for some financial decisions to be made by management within agreed-upon thresholds.

Board Refreshment Progress and Challenges

A positive trend has been the intentional refreshment of boards. Many boards and their CEOs have made a concerted effort to add board members with needed competencies and perspectives. As a result, some newer board members have extensive experience as board members of sophisticated organizations. They often have high expectations of materials and of board meetings themselves. They expect to have focused, strategic-level discussions that have been teed up by materials in the packets. They do not have much tolerance for presentations that are too long or detailed. But this approach requires already busy executives to spend more time preparing for board and committee meetings.

Philosophical Differences

One of the most difficult issues to assess and fix is when there are basic philosophical differences regarding the role of a board. All board members and CEOs know it is inappropriate for a board to be totally dependent on management; boards should not be rubber-stamping decisions. And most agree that it is unwise for a board to dominate management, except in extreme cases like malfeasance.

The challenge is how to govern in the middle—between abdication and domination. The desired relationship is usually a partnership, but the proper balance of power can become an issue.

For instance, some people believe that governance should be slightly more "board-led" whereas others think governance should be more "management-led." Those that lean toward board-led often come from the not-for-profit world, where regulators, legislators, and stakeholders are scrutinizing the actions of public charity boards. These individuals believe that boards should play a highly active role in ensuring effective governance. For instance, they think the board recruitment process should be actively led by the governance committee and its chair, not by the CEO.

The board-led contingent also wants to be engaged in strategic planning early in the process. They are not comfortable with the management team developing major components of the strategy before an in-depth board conversation had occurred regarding assumptions being made and agreement on critical strategic issues to be addressed.

On the other hand, the individuals who favor a more management-led approach to governance tend to have more experience in for-profit businesses or large not-for-profit organizations. They believe that executives are "hired experts," and should be expected to do significant "staff work" before bringing issues to the board. They value a CEO who is actively recruiting potential board members and only bringing highly qualified individuals to the governance committee for their consideration.

The management-led group would also expect executives to bring to the board a complete situational assessment along with specific proposed strategies. They do not care for long processes that overly

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Key Board Takeaways

Some trends have surfaced recently that can make it more difficult for boards and CEOs of hospitals and health systems to have successful partnerships. Below are some recommendations for proactive relationship building between the board and the CEO:

- Help new board members understand their role at the beginning of their board service.
- Develop a matrix that clarifies the decision authority and thresholds for the full board, committees, and the CEO for each governance responsibility.
- Ensure the board chair and CEO work together to identify needed education, develop focused agendas and materials, and keep the board at the governance level during meetings.
- Convene a session in which the board and the CEO discuss their philosophies of governance, agree on their approach, and develop a written agreement of their expectations of each other.
- Discuss performance vis-à-vis the expectations during annual reviews of the CEO and board.

The Non-Traditional Disruption of Healthcare You Aren't Thinking About

BY ROY SMYTHE, M.D., PHILIPS

I will start out by telling you I don't believe healthcare is an enterprise that is, in fact, actually "disruptible." To disrupt is to temporarily destroy, throw into disorder, or break apart something, and in common usage, it also usually implies an event or events that are somewhat sudden. So while I will use the term from this point forward, I will really be implying "evolving on a rapid timeline." Why? Because healthcare is not a flip-phone, in-person video rental establishment, or a desktop word processor about to be destroyed by a handheld computer or an online streaming service. Modern healthcare is the most complex institution in the history of mankind.

> Disruption of the delivery and business models of healthcare is inevitable due to the increasing empowerment of the individual—empowerment in turn made possible by the accelerating democratization of information and technology.

Understanding Human Biology's Role in Healthcare Disruption

In 2014, more than 25,000 English language biomedical science journals published more than two million manuscripts, and that number has increased by about 3 percent annually since then.[1] Obviously, it is not just the number of articles published, but the accretive revelations they provide that have rendered human biology increasingly less mysterious, but ironically, increasingly less comprehensible as well. As a result, we actually passed an important landmark a few years ago, whereby the human brain was no longer capable of comprehending its basic building block—the human cell. Unexpected insights about how the human body works *normally* (new biochemical pathways and regulators, interactions between these pathways, new understanding of how the various organelles function, gene function, and regulation, etc.) just keep coming. I am not even going to mention a parallel line of investigation into disease causation and pathogens, but just multiply everything in this paragraph prior to this sentence by about five times.

What about drug development and manufacturing? As our understanding of biology and disease causation becomes more robust, the targets for traditional and biologic pharmaceuticals increases in tandem.[2] Because of this, one of the more pressing issues we must deal with in the near future is not our ability to create new drugs, but how we will test all of those that are in the pipeline to know if they are safe and effective. Add to this list the financial Rube Goldberg machine we have created via healthcare compensation, reimbursement and payment schemas, and varying practice models. To be complete, we should add in the activities of the only groups that are perhaps even more creative (and I will let you decide what is implied by that) than the biomedical scientists churning out those two million manuscripts—our colleagues in medico-legal fields and healthcare legislation and regulatory activities.

Who knew healthcare could be so complicated? As a matter of fact, it isn't—it's complex, and in the final calculus it is complex not only due to all of the foregoing considerations, but also because healthcare is at its core a social endeavor. This means that human behaviors, biases, likes and dislikes, prejudices, and previous experiences are all unavoidably factored in, therefore, change in human behavior is the ultimate non-traditional disrupter.

At a recent meeting, I listened to Rashid Tobaccowala, the Chief Growth Officer of the Publicis Groupe, a large multinational and public relations firm headquartered in Paris, speak on the topic of business innovation. He mentioned something during his session that has stuck with me firmly ever since: the concepts every industry needs to be acutely aware of in the near future, to avoid "disruption," are the blurring lines of competition and the empowerment of the individual. The former is the topic for this article, and the latter is what will—with accelerating speed and increasing imperative—power the former.

Key Board Takeaways

The most significant non-traditional disrupters of healthcare are going to be those that put more responsibility into the hands of individuals. Below are some suggestions for what hospital and health system boards should do in response:

- Embrace the democratization of technology and information.
- Work on strategies to collect the data that is being generated in these patient-generated healthcare interactions so that it can be incorporated into your EHR.
- Begin to develop strategies whereby these practices can have a positive impact on the bottom line by decreasing the fixed and variable costs of delivering care.
- Consider new healthcare insurance models either as a provider sponsor of risk, or in partnership with payers, whereby patients are given more tools and responsibility, in exchange for lower premiums or other benefits.
- Be aware of retail medicine moving into more complex and chronic disease management. Many of them are already co-developing and selling technologies used by individuals to diagnose and treat disease.

Convenient Healthcare and Telemedicine Are the New Normal

Convenient care clinics more or less exploded onto the scene several years ago, pioneered by the large retail pharmacy chains in the United States, and followed quickly by big-box retailers. I use the term "exploded" because they grew for the first several years by almost 100 percent year over year in regard to numbers of visits. Although at a slower pace, they continue to grow with an expectation that almost 3,000 will be in operation by the end of fiscal year 2017, with the capacity to accommodate 25 million visits.[3] We have learned several things about these clinics over the past few years, including the following:

- They do not improve access for the medically underserved—primarily being located in and utilized by more affluent communities.
- They have not lowered the cost of care by "substituting" for more expensive hospital

1 Michail Kovanis, et al., "The Global Burden of Journal Peer Review in the Biomedical Literature: Strong Imbalance in the Collective Enterprise," November 10, 2016.
2 Rita Santos, et al., "A Comprehensive Map of Molecular Drug Targets," *Nature Reviews Drug Discovery,* December 2016.
3 Accenture, "Number of U.S. Retail Health Clinics Will Surpass 2,800 by 2017, Accenture Forecasts," (press release), November 2015.

or health system visits, but rather have raised overall costs by allowing pent-up demand to be more readily accommodated (representing about 2 percent of all primary care visits nationally, but therefore not "eating into" traditional setting primary care practice volumes).
- Younger adults, female patients, and those with no identified primary care provider were more likely to utilize them.
- They have not been shown to decrease urgent care or emergency room visits.

I no longer consider retail convenient care clinics focused primarily on low-acuity transient problems to be "non-traditional disrupters" of healthcare, but do believe we have learned, or perhaps more accurately, are reminded of two important things from our ongoing experience with retail care, which will support later commentary regarding truly non-traditional players and approaches. Those include the fact that the traditional model of primary care, for various reasons, has not met the access needs of many populations, and for some with less complex conditions, convenience completely trumps doctor, hospital/health system, or payer–patient relationships. As most of you know, these enterprises are increasingly edging into chronic and more complex conditions. While this could have an impact on healthcare provider organization revenue, I don't believe it will be large and again, would not consider this to be entirely disruptive—with one caveat I will later suggest.

Some would consider traditional (phone and/or video) telemedicine a "next step" beyond retail convenient care—and also a disruptor—but again, I do not necessarily agree, and feel the value of this experience has been similar to retail clinics. Most hospitals and physician groups are now participating in a formal way with various aspects of more sophisticated telemedicine care delivery. It is interesting to note (especially with the controversies that have swirled over the past few years regarding regulations and restrictive rules in some states in the U.S.) that "telemedicine" has been practiced for decades. Twenty years ago, if you called your pediatrician's office with a question about your child's condition, or the surgeon's clinic after surgery with a question, you likely received care by phone (i.e., telemedicine). It is important to note that many employers offer telemedicine

services to their employees as a healthcare benefit and encourage them to use the services due to a potential lower cost per visit to the employer. In a recent National Business Group on Health survey, 96 percent of employers interviewed planned to offer telemedicine programs to employees by the end of fiscal year 2018, and all by the end of fiscal year 2020.[4] Depending on the vendor utilized, the clinicians may or may not be employed by a health system or physician group, so while this is not necessarily "disrupting" healthcare, it is posing a growing competitive and financial threat to traditional provider organizations. Teledoc, one example of a telemedicine company that employs its own providers and contracts with many large employers, saw a 59 percent increase in revenue in 2016, and a 43 percent growth in membership to more than 17 million individuals.[5]

There is always a chance that some incredible scientific discovery will take place in the near future, creating significant disruption in the delivery of care. The first new class of antibiotics to be discovered in 30 years was recently characterized—isolated from naturally occurring organisms literally found in dirt in a field in Maine. The inaugural member of the group, Teixobactin, has been shown in laboratory tests to kill many problematic pathogens, so far with the development of no resistance to the drug by the bacteria being treated. These types of advances are promising, no doubt—but again, perhaps not disruptive. Biomedical advances have been occurring in an ongoing fashion for centuries, and should more appropriately be considered incremental innovation or improvement of care, rather than disruption. And don't hold your breath regarding the ability of any drug to outsmart the humble creatures that both live with and wage war against humans daily—life finds a way.

The Most Important Non-Traditional Disruption of Healthcare Is Coming from the Empowerment of the Masses

So it seems as if everyone—especially 25-year-old computer geniuses in Silicon Valley who may or may not know the difference between a barcode and a code blue—are telling us that "disruption" of healthcare is imminent. Is this just hype, or is "evolution on a rapid timeline" for medicine actually imminent? The answer is an unequivocal yes to the latter…as a matter of fact, it is inevitable. Disruption of healthcare is not coming from the logical progression of the doctor or other provider–patient delivery and business model that follows—just transposed physically via a retail pharmacy emptying out a storage room and converting it into a clinic, or on a small phosphorescent screen. The biggest "non-traditional" disruption to the delivery and business model of healthcare in the foreseeable future is the complete elimination of this relationship for some care delivery. Disruption of the delivery and business models of healthcare is inevitable due to the increasing empowerment of the individual—empowerment in turn made possible by the accelerating democratization of information and technology.

The disruption is coming from an amalgam of these two things—the Internet and its ability to deliver information and instruction of virtually unlimited detail to anyone, and increasingly everywhere, as well as technologies that allow individuals to monitor, diagnose, and even treat their own illnesses. Five years ago, I asked a friend of mine who is a healthcare investor his opinion on the concept of "self-care." He laughed and said, "People have been talking about that for years, but I just don't see it happening any time soon…how many 'smart scales' has *your* health system distributed to elderly patients with heart failure?" When I think about his comment now, I recall similar thoughts I had when seeing people carrying briefcases around containing their late 1980s cell phones—transported that way because they were larger and heavier than bricks. We have not been very good at self-care until recently,

4 RAND Corporation, "The Evolving Role of Retail Clinics," 2016.
5 Teladoc, "Teladoc Announces Full-Year and Fourth Quarter 2016 Results" (press release), 2016.

because our access to useful information was poor, and the technologies we had at our disposal weren't very good. However, just like the size and utility of the cell phone, this is changing.

The Democratization of Information and Technology Will Dramatically Change Healthcare Delivery

When I was in medical school, the only way for someone else to get the information I received was to also be admitted as a student, sneak into the biomedical library, or perhaps purchase medical textbooks at the bookstore (which occasionally you could not purchase unless you could prove you were in a formal medical education program). Alternatively, you were relegated to buying "over the counter" home medical advisors—these being the primary medical reference source for the general population for about four centuries, culminating in Dr. Benjamin Spock's *The Common Sense Book of Baby and Child Care,* published in 1955. While the best-selling book of the 20th century is The Bible, Spock's book is actually second on that list, with more than 50 million sold. However, the digital revolution has changed everything—democratizing information of all types. At least four billion individuals are on the Internet. More than one and a half billion of them have sought online health-related information and a billion more have sought information about a specific medical condition. WedMD.com, created in 1996, provides health, wellness, and disease information for general consumption—including links to a large array of images and videos, as well as a "Symptom Checker" capable of suggesting an array of diagnoses based on what an individual types into the platform. It is currently the most visited healthcare-related site on the Internet, and receives more than 30 million visits per month. The second leading site isn't far behind—Drugs.com receives more than 25 million visits monthly, and provides information on more than 24,000 drugs. Where individuals may find health or disease information online are now virtually innumerable and of incredible breadth—recreating a health information "long tail" encompassing not only common conditions, but also the esoteric and rare. The information on these sites is no different from what I learned in medical school; however, the online pictures are unequivocally better than the blurry overhead 35 millimeter slides I used to squint to see from the back of the classroom.

Moore's law, the rule that the number of transistors per square inch on a computer chip doubles every 18 months, has been increasingly applied as well to the democratized technologies (along with advances in materials science and power sources) that will increasingly allow individuals to monitor and diagnose their own disease—and treat it as well. There are diabetes glucometers that send each of your measurements to the cloud where they are analyzed, and a determination is made whether or not to send you encouragement, advice, or an ambulance. The smartphone itself is capable of measuring and tabulating many things related to activity and health, and as of 2016, there are more than 250,000 mobile health applications extant developed by more than 50,000 publishers, and development is driven by a market worth more than 30 billion dollars by 2020. While almost anything can be attached to the device, one company recently acquired by Google, Senosis, has apps that use the existing tools available in the phone, such as the accelerometer, camera flash, and microphone to measure bone strength, the level of hemoglobin in the blood (a red blood cell count), bilirubin (a pigment that collects in the skin when liver function is abnormal), and lung function.[6] Smartphones extant themselves? More than two billion. The world's most successful activity tracking device, Fitbit, has sold more than 70 million units over the past five years, and a host of other devices are now being used by individuals with no provider of healthcare in sight—examples include devices to monitor sleep quality, to treat and monitor sleep apnea, measure virtually every human physiologic parameter, and more. In the near future, we will be using handheld devices to do our own imaging. Sound far-fetched to you? Philips has a handheld ultrasound device called Lumify, which can be connected to an iPhone. While the average person can put the device on their upper abdomen in hopes of looking at their gallbladder, most would be incapable of reading the images. However, the software to allow anyone to make their own diagnosis of cholelithiasis (gallstones) is being written now.

Putting the Disruption in Perspective

Health system and hospital board members should be engaged, and familiar, with the concept of individual empowerment. Many of them come from industries (banking, personal finance, retail, etc.) where individuals were empowered several years ago by technology and have already experienced benefits such as lowered fixed and variable costs of doing business, and increased access to products and services. The empowerment of individuals in healthcare, while it lags behind other sectors, will eventually be even more impressive—and impactful—as individuals are not only accessing information and services online, but also using other technologies in their homes to prevent, diagnose, and treat disease. A number of technologies are already available—some examples include those designed to make aging in place safer (motion and location detection devices, fall prediction, and prevention analytics), improve medication adherence and compliance (digital medication dispensers with video capabilities), improve diabetes management (digital glucometers with reminders and alerts for both patients and their providers), and online

6 Abhimanyu Ghoshal, "Google Bought a Startup to Monitor People's Health without the Need for Complex Hardware," *Business Insider,* August 14, 2017.

virtual asynchronous care. Board members should ask if their organization is working with these or similar technologies, and if not, urge them to do so in order to begin to learn how to leverage them, and provide encouragement based on their experiences in other industries.

It's not just handheld devices that are democratizing access to medical technology for individuals, but also a host of both online tools and diagnostic resources. Companies like Zipnosis have created virtual care capabilities, whereby a patient can answer a series of questions, and a computer algorithm, rather than a physician, renders a diagnosis and treatment plan or "triages" the individual to the appropriate level of care (i.e., suggests that a patient need not see the doctor, should schedule an appointment, or go to the emergency room, based on the algorithm's findings). A doctor later "asynchronously" reviews the findings and suggested treatment, and has the right to rescind the recommendations—but infrequently does. In addition to virtual care, a host of diagnostic modalities are now available as well—blood chemistries, complete blood counts, HIV, hepatitis screening, and even stool microbiome evaluation can all be ordered without the need of a physician. Medicare spends more than seven billion dollars annually for laboratory testing,[7] and this has obviously been a significant revenue source for health systems over the past few decades.[8]

What this means is that the most significant non-traditional disrupters of healthcare delivery in the next decade are going to be those that put more responsibility into the hands of individuals, and those individuals themselves. In aggregate, companies that offer democratized diagnostic and treatment tools and services to individuals will make an increasingly large, and perhaps unanticipated impact on the economics and structures of care delivery. What should hospital and health system boards do in response?

Here are some suggestions:

- Embrace the democratization of technology and information—this is not a reversible trend. Consider partnerships with companies that are supplying these resources to individuals, and even developing your own capabilities in these areas where it makes sense.
- Work on strategies to collect the data that is being generated in these patient-generated and empowered healthcare interactions so that it can be incorporated into your EHR. Your clinicians will have information gaps otherwise, and your ability to understand your patients—both their medical and general service needs—will be compromised if you are unable to do so in the future. Developing partnerships with the enterprises patients are interfacing with directly is a good first step, as many are willing to work with health systems to achieve these goals.
- Begin to discuss and develop strategies whereby these practices can have a positive impact on the bottom line by decreasing the fixed and variable costs of delivering care.
- Consider new healthcare insurance models either as a provider sponsor of risk, or in partnership with payers, whereby patients are given more tools and responsibility, and in exchange, are given the option to have lower premiums for coverage or other benefits.
- While I mentioned earlier that I do not believe retail medicine to be all that disruptive, I would suggest that traditional healthcare providers watch closely as these enterprises move into more complex and chronic disease management. Many of them are already co-developing and selling technologies used by individuals to diagnose and treat disease. If they decide to move heavily in this direction—developing partnerships with the suppliers of these technologies (whom they already work with as channel partners), and bundle them with other services, it could indeed be disruptive.

As I have suggested, this is not a reversible trend, and we should neither be surprised nor discouraged by these developments. Human beings have progressively leveraged the use of machines to be individually more competent at completing tasks, and we will continue to do so. We seem thus far to have an unending ability to develop, grasp the benefits of, and use technology to our individual benefit. We have progressively moved from having no tools (like cars, books, and kitchen appliances) to being dependent on "experts" to use these technologies, to using them ourselves independently and with surprising capability. Healthcare technologies are no different. Diabetics interested in knowing their blood glucose levels, and women wondering if they might be pregnant have been performing diagnostic tests for decades now—the former several times a day, and also treating themselves using the data that they obtain.

We are not talking about draining the ocean here, but if previous human experience is instructive—and it usually is—the waterline is going to move. Complex diagnostic and interventional care will likely always be the purview of the experienced clinician, but low level acuity interventions are fair game for every person at this moment, and more complex ones in the future based on the use of available information and increasingly sophisticated technology. This transition will not happen overnight and there will be no sudden loss of patients or revenue, but healthcare boards and providers would do well to begin to think now about how the lines of competition are becoming blurred, and the non-traditional disruption that is coming as a result of individual empowerment.

The Governance Institute thanks Roy Smythe, M.D., Chief Medical Officer, Healthcare Informatics, Philips, for contributing this article. He can be reached at roy.smythe@philips.com.

7 Suzanne Murrin, "Medicare Payments for Clinical Diagnostic Laboratory Tests in 2015: Year 2 of Baseline Data," Department of Health and Human Services, September 2016.
8 Kelly Gooch, "Uncovering Revenue Sources through Transformation of the Hospital Lab," *Becker's Hospital Review,* May 11, 2016.

How Board Members Can Support Successful Hospital Mergers and Acquisitions

BY JOSEPH J. FIFER, FHFMA, CPA, HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

Riding the wave of excitement that hospital merger discussions can generate, it's easy to gloss over issues and tools that are critical to a merger's success. These include understanding and thoroughly assessing a merger's value drivers, paying attention to cultural alignment, and employing rigorous analytical and planning tools. This article looks at each of these areas and the ultimate goal of coming together to provide improved value and high-quality care.

Be Clear on the Value Drivers

Acquiring organizations may pursue a merger for a variety of reasons: to achieve cost efficiencies through economies of scale, improve market share, expand the physician network, or access a population large enough to make population health management feasible.[1] Board members need to have a clear understanding of the value drivers associated with a proposed merger. These potential value drivers should be reality-tested before a decision about the merger is made. Mergers that improve value delivered to patients and other care purchasers have the best prospects of being well received in the marketplace and succeeding in the long term. That knowledge should guide the board in its evaluation process. For example, if a merger is driven by achieving cost efficiencies, the board will want to give careful consideration to whether there are opportunities to improve care affordability.

Make Culture Alignment Job One

Culture alignment starts with the board. To work smoothly and effectively together, the merged board must blend two separate and distinct board cultures, each with its own established work styles, norms, and traditions. The merged board will be charged with creating a merged mission statement, developing a unified strategy for the organization, establishing a process for financial oversight, and making and communicating crystal clear decisions about lines of authority for major decisions—and that's just for starters. With a to-do list like that, it's apparent that cultural alignment at the board level is too important to be left to chance; it must be closely and carefully managed.

At the enterprise level, cultural alignment is also a key success factor, and one that tends to be undervalued. The overarching goal of any merger is to create a combined entity that is more valuable than either one alone. To accomplish that, the organizational culture should support employees and physicians in their efforts to navigate through the disruption inherent in mergers, build solid working relationships with new colleagues, and understand their role in and value to the merged organization.

Research conducted by the Healthcare Financial Management Association (HFMA) and the Deloitte Center for Health Solutions in 2017 found that organizations that addressed the challenge of combining cultures more adroitly focused on internal and external communications, beginning in the early stages of a transaction.[2] These conversations can help each party gain insights into the other's culture, identify cultural "red lines" that may become problematic, and test assumptions about cultural compatibility.

Follow Best Practices of High-Value Mergers

The HFMA/Deloitte Center for Health Solutions study also found that only about 29 percent of chief financial officers in hospitals involved in mergers between 2008 and 2014 achieved more than half of the cost structure efficiencies projected from the deal.[3]

Researchers identified a group of "high-value" mergers that reported quality improvements and realized more than half of projected cost efficiencies as a result of a deal. The high-value group represented approximately 19 percent of transactions in the study.

Acquirers in high-value transactions are more likely to use rigorous analytical and planning tools. Specifically, they are more likely to have developed a clearly defined, board-approved operating model for the transaction along with a board-approved integration plan that flows from it. Board support throughout the execution of the agreed-upon operating model is a key success factor.

Developing an Operating Model

An operating model includes a statement of strategic vision for the combined entity; identified/validated areas for value capture from the transaction; a plan to realize revenue growth and cost-reduction opportunities; and a description of organization-specific key enablers.

The first step in developing an operating model (early in the pre-merger process) is creating hypotheses about potential value drivers available from a given transaction. This helps ensure that difficult questions are addressed and answered. It will also enable the new entity to differentiate itself in the market.

The second step, which should occur during the early stages of due diligence, is rigorously testing the hypothesized value drivers by creating a tangible list of activities the organization must complete to realize the desired outcomes. This step serves

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Key Board Takeaways

Amid the activity and excitement of merger discussions, the board should focus on understanding and thoroughly assessing a merger's value drivers, paying attention to cultural alignment, and employing rigorous analytical and planning tools. This includes taking the following into consideration:

- Mergers that improve value delivered to patients and other care purchasers have the best prospects of success. That knowledge should guide the board in its evaluation process.
- Cultural alignment at the board level is too important to be left to chance; it must be closely and carefully managed.
- The board should expect to review both an operating model and integration plan for the merger.

1 HFMA, *Acquisition and Affiliation Strategies,* 2014.
2 HFMA and Deloitte Center for Health Solutions, "Hospital M&A: Margin and Quality Improvements Take Effort, Time," October 2017.
3 HFMA and Deloitte Center for Health Solutions, October 2017.

Ensuring a Successful Board–CEO Relationship

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engage less knowledgeable board members in the discussion of possible strategies.

Proactive Relationship Building

Building a successful board–CEO relationship requires focused attention. The first step is to help new board members understand their role at the beginning of their board service. The orientation of new directors should include a written position description and mini-case studies that allow board members to work through scenarios that could be confusing. Assigning a mentor to each new board member can also help them learn the right level of questioning for this board.

A strong board chair can work with the CEO to make sure the board agendas and materials are at the governance level and allow for plenty of discussion. The chair should actively facilitate board discussions, bringing members back up out of operational issues as needed.

In addition, boards should develop a comprehensive authority matrix that clarifies the role of the full board, committees, and the CEO for each governance responsibility (e.g., provide input; recommend; approve). It may also be helpful to increase decision making thresholds for both committees and the CEO.

Perhaps the most powerful method of ensuring a positive relationship is convening a facilitated discussion with just the board and the CEO to discuss their philosophies of governance, agree on their approach, and develop a written agreement of their expectations of each other. These agreements should be reflected in both the CEO's and the board's annual performance evaluation so progress toward a productive relationship is regularly, candidly, discussed and improved.

These practices will provide the foundation for a stronger, more trusting relationship, which would be better for all parties—the board, the CEO, and the communities served.

The Governance Institute thanks Pamela R. Knecht, President & CEO, **ACCORD** LIMITED*, for this article. She can be reached at pknecht@accordlimited.com.*

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as a way of pressure-testing assumptions and a potential merger's ultimate ability to create value. The process also reveals relationships and dependencies that should be evaluated during due diligence and defines outcome metrics that can be used during the integration process. The results can form the foundation of an integration plan tied to the deal's value drivers.

The board should review and approve the operating model to ensure that it supports taking the steps necessary for the deal to achieve value.

Translating the Operating Model to an Integration Plan

Establishing clear lines of decision-making authority is an essential prerequisite for translating priorities to reality. A board-approved plan to guide the integration of the merging organizations can help ensure successful execution. The operating model for the merger that was developed and validated during the early phases of a deal should be adapted to an integration plan. Board approval of the plan empowers the management team to make difficult decisions related to staffing and service distribution in a timely way. Delaying such decisions is a common barrier to achieving results. Having an integration plan also elevates accountability for achieving results to the highest level of the organization.

The integration plan should front-load activities that support the organization's ability to drive value for the merged organization. For example, if the primary goal of the merger is to reduce cost structure by increasing economies of scale, the initial focus should be on business areas that are likely to yield the greatest savings or economies of scale, such as quality, safety, finance, supply chain, human resources, risk management, and managed care contracting. In contrast, if the merger's primary goal is to improve care coordination in support of a provider-sponsored health plan or other risk-based contract, the initial focus should be on clinical alignment strategies such as integrating clinical IT systems enterprise-wide or enrolling acquired physicians into all of the acquiring system's risk-based contracts.

The Value Improvement Imperative

Value is created when the patient or other care purchaser experiences an improvement in the relationship between the quality and the cost of care. Mergers that seek only to increase market power are less likely to succeed than those where the acquirer is seeking to produce the cost efficiencies, gains in clinical quality, and access that patients and other care purchasers need and expect. By taking the latter approach, healthcare organizations will be best positioned to compete in their markets and win market share by offering patients, employers, and other care purchasers a superior value proposition, no matter what the payment models.

Price is an important element of the equation; mergers that increase prices without concomitant improvements in quality will not be viewed favorably in the marketplace. This presents a potential conflict for the board. From the merged entity's standpoint, it may make sense to raise prices post-merger; in some cases, the rationale is to improve payer contracts that have terms that are unreasonable. But if prices increase out of proportion to value, the community does not benefit. Mergers will ultimately be judged by their impact on the total cost of care to patients and other care purchasers. Healthcare consolidation is only a vehicle. Value improvement is the destination.

The Governance Institute thanks Joseph J. Fifer, FHFMA, CPA, President and CEO of the Healthcare Financial Management Association, for contributing this article. He can be reached at jfifer@hfma.org.

Growth Is the Imperative, but How?

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and its patients via video chat and other electronic means.[3]

What products and services? When considering whether and how to expand an organization's offerings, directors should consider the entire spending pie. About 58 percent of U.S. personal healthcare spending goes for hospitals and physician/clinical services, but the remaining 42 percent is spent on home care, nursing care, health and wellness, and other types of care.[4] Healthcare directors need to ask, "How might we participate in some of these other services?"

Redefining the organization's market share as the percentage of total market spend in the service area identifies the size of the opportunity. For instance, if the population in the organization's service area is 5 million and estimated per capita healthcare spending is $10,000, then a health system with net patient care revenue of $1 billion is capturing 2 percent of the total healthcare spend of $50 billion.

Leadership teams should assess which of their existing products and services might be expanded, while pinpointing potential spin-offs and entirely new products and services that would be a good strategic fit. For example, in 2016, Saint Luke's Health System of Kansas City partnered with Bishop Spencer Place, a skilled nursing and assisted and independent living community, to expand its post-acute network for better success with bundled and other value-based arrangements.[5]

On a larger scale, Dignity Health got into the urgent care and occupational health businesses after acquiring U.S. HealthWorks in 2012.[6] Extending both product and customer groups, the deal gave Dignity Health more physical access points and expanded access to employers.

How will we grow? This question should be asked throughout the who, where, and what growth conversation. To expand or diversify products and service lines into existing or new markets, organizations can build, buy, or partner. Each option has advantages and disadvantages. If expanding an existing service, then the build route may make sense. If rapid growth is a priority, then buying or partnering with other organizations may be the preferred avenue. Smaller and specialty organizations (e.g., critical access, independent, and children's hospitals) will want to consider partnership arrangements with larger health systems that are developing networks to manage population health in specific regions.

The Need for Urgency

Given pressures from traditional and non-traditional competitors, boards and executive teams must take steps to grow in directions that will secure future revenues and relevancy. The disrupters are in a hurry to disrupt. The sense of urgency about pursuing growth opportunities must be as pressing in hospitals and health systems.

Robust planning that links growth strategies with financial and operating expectations and performance is a must. Leading organizations will develop innovative plans, make data-informed decisions, track progress, and show agility with resource allocation when opportunities under- or over-perform. Don't delay too long. Organizations must grow to succeed on a long-term basis.

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 Mayo Clinic Web site, "Mayo Clinic Care Network: Collaborating to Enhance Locally Delivered Care."
4 National Center for Health Statistics, *Health, United States, 2016*, Hyattsville, MD, May 2017, Table 94, p. 316.
5 Kaufman Hall, "Kaufman Hall Advised Saint Luke's Health System on Continuing Care Retirement Community Partnership" (press release), December 2016.
6 Kathy Robertson, "Dignity Health to Acquire U.S. HealthWorks, Will Become National Health System," *Sacramento Business Journal,* July 4, 2012.

Growth Is the Imperative, but How?

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

Healthcare transformation is underway. Payment pressures are intensifying from commercial and government payers, the shift of patient volumes to outpatient settings has accelerated, and consumers are becoming more price-sensitive. At the same time, well-funded, non-traditional competitors, such as CVS Health with its popular retail clinics and Smart Choice MRI with its high-quality, low-cost scans, are disrupting the market, threatening core hospital services.

Key Board Takeaways

Amidst the challenges facing the nation's hospitals and health systems, the growth imperative is ever-present. Traditional approaches to growth are unlikely to be successful going forward. Four interrelated questions can help directors focus their conversations about growth:

- Who are our customers? Think broadly, including employers and providers along the care continuum.
- Where are our markets? Look at current markets as well as new ones, including those that can be served virtually.
- What products and services are we offering? Assess opportunities for existing offerings and entirely new ones that would be a good strategic fit.
- How will we grow? Consider build, buy, or partner options.

Robust planning that links growth strategies with financial and operating expectations and performance should guide leadership teams.

For many hospitals and health systems, significant future growth is unlikely to be achieved through historical approaches, such as increasing rates or building a new inpatient wing or medical office building. Healthcare boards that advocate sticking to the traditional course need to prepare for a hazardous ride. The more promising route is to seek new customers and broaden the organization's offerings.

The Who, Where, What, and How of Growth

Four interrelated questions can help all leadership teams—from small critical access hospitals to large regional health systems—to jumpstart conversations about their organizations' growth plans. **Exhibit 1** shows the who, where, and what dimensions of growth consideration—from growing core offerings in existing markets in the lower left quadrant to bringing new offerings to new markets in the upper right quadrant. The "how" continuum of build, buy, or partner can be considered in all quadrants.

Who are our customers? This analysis should provide critical insights into the organization's current and potential patients as well as other customers, ranging from employers to fellow providers. Dividing each customer group into segments based on their needs and preferences, demographics, socioeconomic factors, and attitudes can help identify potential growth opportunities.

For instance, responding to the needs of large local employers, Wisconsin's Bellin Health developed a booming direct-to-employer business, which includes on-site clinics and corporate wellness programs.[1]

Where are our markets? Leaders need to look afresh at their current markets for opportunities to grow their premium offerings and for unmet needs that can be fulfilled. For example, to extend the organization's brand and neonatology expertise regionally, independent Lurie Children's Hospital of Chicago developed outreach partnerships with community providers, including hospitals and outpatient centers.[2]

Additionally, new markets should be considered at the national and international level. Both face-to-face and virtual delivery may be appropriate. For example, through arrangements with more than 40 health systems across the globe, Mayo Clinic Care Network provides specialty consults and second opinions to physicians

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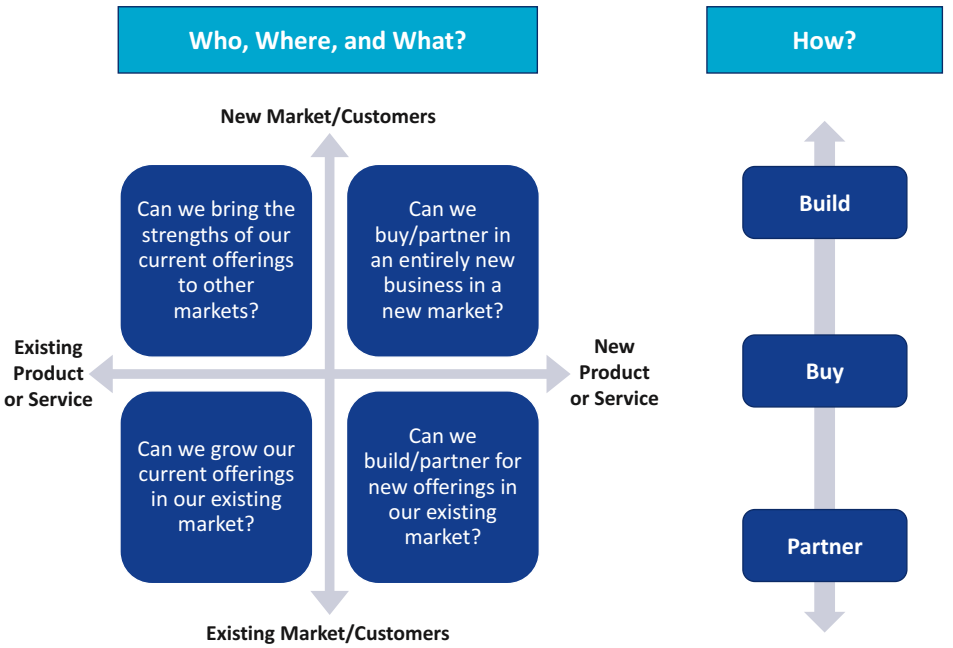
Exhibit 1: The Who, Where, What, and How of Growth



Source: Kaufman, Hall & Associates, LLC. Used with permission.

1 Christopher Cheney, "Bellin's Direct-to-Employer Services Booming," *HealthLeaders,* March 14, 2016.
2 Lurie Children's Hospital Web site, "Partner Hospitals."