BoardRoom Press

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

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Disruptive Strategy: Thriving in a Pluralistic Payment Environment

Philanthropy as a Strategic Revenue Source

SPECIAL SECTION

Innovation Leadership: The Role of Governance in Value Creation

New Excise Taxes on Compensation Arrangements for Select Highly Paid Employees

ADVISORS' CORNER

Five Ways to Improve Board Performance

We're Obsessed

This year at NRC Health, The Governance Institute's parent organization, we are obsessed with consumerism. Why? It's difficult to imagine a time in history in which healthcare experienced as much change as it did in the concluding weeks of 2017. Super-mergers—CHI and Dignity—unforeseen combinations—CVS and Aetna—and the looming threat from outsiders like Google, Apple, and Amazon entering healthcare reveal a deepening battle for today's consumer. Hospitals must no longer look or act like hospitals, and hospital-centric organizations need to transform and evolve into health improvement organizations that seamlessly funnel patients through convenient, accessible, and high-value care settings. This will require health system leaders and boards to make big shifts in 2018 to retain the loyalty of today's consumer.

This issue of *BoardRoom Press* focuses on disruptive strategies to accelerate value and how to lead innovation. What does all this have to do with consumerism, or governance for that matter? A high-performing board becomes a critical asset to any organization seeking to accelerate change and implement strategic initiatives. From the inside out, if the board can think of itself as a disruptive and innovative game changer, and build those capabilities from the board level on down, the organization it oversees has a much stronger chance of recreating itself in the eyes of the consumer. Look for more from us throughout the year on how to build a consumer-centric board.

Kathryn C. Peisert, *Managing Editor*

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Five Ways to Improve Board Performance

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Disruptive Strategy: Thriving in a Pluralistic Payment Environment

BY MICHAEL J. ZACCAGNINO AND TRAVIS FROEHLICH, COPE HEALTH SOLUTIONS

Today, CEOs and boards of health systems, medical groups, hospitals, community-based organizations (CBOs), and provider organizations of all types are challenged with mapping the best way forward in a pluralistic payment environment. On the one hand, the market is increasingly characterized by risk-based payment models that incentivize and encourage providers to reform the delivery system and invest in population health programs and infrastructure. These contracts incentivize providers to better manage the health of the communities they serve in the most efficient manner possible. On the other hand, fee-for-service models continue to be pervasive in most markets, encouraging a volume-based approach to clinical program development and system building.

As CEOs and boards consider their organization's vision and mission and formulate strategy, many feel that the industry has reached a "fork-in-the-road," while others are considering a pluralistic path forward. That is, some healthcare leaders have embraced the values that underpin population health as non-negotiable and have decided to advance value-based delivery system reforms alongside their volume strategies, despite payment complexities and inequities. While every organization arrives at this conclusion for different reasons, most agree with the premise that providing patients and families with better, more affordable care is just the right thing to do, and by extension will increase consumer engagement and lead to market expansion and growth opportunities. This strategic position has gained momentum in recent months, as many boards are challenged by the level of inertia related to both state and national payment reform.

To advance on both volume- and value-based strategies, CEOs and boards must think "disruptively" as they navigate and map the organization's future. Budgets, investment plans, strategic priorities, governance models, and in some cases, even the organization's vision and mission must be recalibrated.

Three Strategies to Consider When Embracing Volume- *and* Value-Based Delivery Models

As healthcare boards think about the future, here are a few strategies that they should consider adapting for their organizations.

Key Board Takeaways

For healthcare organizations on or starting down a "disruptive" path and embracing both volume- and value-based delivery models, the board should:

- Test its mission to make sure that population health is reflected in the organization's purpose.
- Revisit its strategy and make sure the organization is well-positioned for the future.
- Incorporate population health into its governance and determine whether the CEO and executive team are positioned to execute in a pluralistic environment.

1. Test the Mission to Ensure That Population Health Is Reflected in the Organization's Purpose

To deliver service to the community in a sustainable manner, boards should consider the economic and moral imperative to provide high-quality, affordable healthcare. This imperative is driving a challenging, multi-stage transition, where *both* volume *and* value are key to the organization's success over time. High-performing organizations must consider assessing whether their vision (i.e., desired results), strategy (i.e., focus), intermediate tactics, and investment plans reflect this dual focus.

Many boards continue to think about patient care, research, and teaching as top priorities, reflecting performance through traditional hospital and provider fee-for-service metrics such as patient volume, cost per case, and length of stay, as opposed to population health management measures such as vaccination rates, emergency department visits and other utilization rates per 1,000, and avoidable admissions. Similarly, many organizations continue to invest in replacement hospitals, recruitment of expensive specialists, and high-end medical technologies, while under-funding population health programming (e.g., patient engagement or care management) and infrastructure (e.g., health analytics or performance improvement).

2. Revisit Strategy and Make Sure the Organization Is Well-Positioned for the Future

By reframing the organization's mission and desired results, the board will reset the stage for strategy formation and investment planning, aimed at advancing both the value and volume agendas, enabling improvements in community health status, quality, growth, and affordability, as well as the financial health of the organization. More specifically, many providers have become adept at managing revenue cycle, supply chain, labor spend, and inpatient/outpatient volume. However, relatively few are proficient with delivery system restructuring, payment system reform, or service-based program development that meets community needs and advances both the volume and value agendas (e.g., co-locating primary care and behavioral health). By pursuing these and/or similar strategies, the organization will experience some critical "wins" and begin to develop "muscle memory," which will be a key organizational asset throughout the journey.

While entering into merger or acquisition work may be beneficial for some organizations, the notion that this form of system development will lead the way is likely flawed, and doesn't fully account for the financial and clinical implications associated with excess overhead/capacity; community, member, and patient needs; or the opportunity costs associated with this work. Specifically, system building of this sort may make it difficult for the organization to invest in CBO partnerships and care management systems, as well as in physician alignment, network development, clinical integration, managed care solutions, and population health infrastructure—all initiatives central to the organization's long-term success.

As one example, efforts that reduce network leakage (i.e., care provided outside of the organization's physician and facility network) may be advanced more easily if the organization is not in flux. Reduced leakage translates into more volume

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Philanthropy as a Strategic Revenue Source

By Betsy Chapin Taylor, FAHP, Accordant Philanthropy

Healthcare organizations across the country now seek alternative and expanded sources of revenue to enable capital plans, population health programs, innovation initiatives, and a range of other strategic imperatives. As organizations consider ways to finance their futures, many now seek to strengthen a revenue source that has often been under-optimized or poorly utilized in hospitals and health systems: philanthropy.

The Financial Potential of Philanthropy

Philanthropy—voluntary charitable giving from individuals, corporations, or foundations—can be a vibrant and sustainable source of revenue with a return on investment (ROI) that often surpasses all clinical service lines. To place the opportunity in context, $390 billion was given in charitable contributions to U.S. not-for-profit organizations in 2016 with $33 billion of that benefitting health causes.[1] Of money directed to health causes, $10.1 billion went to U.S. not-for-profit hospitals and health systems, and the amount given to healthcare organizations has been on a consistent, upward trendline.[2]

When considering ROI philanthropy becomes compelling for hospitals and health systems. The median hospital operating margin for 2016 was 3.4 percent.[3] However, the median operating margin for the typical healthcare foundation or development office is 75 percent.[4] Thus, an organization must earn approximately $29 million from clinical operations to put $1 million on the bottom line, or it could raise just $1.3 million in charitable contributions to achieve the same financial impact. Healthcare organizations must also consider whether potential exists to earn another $29 million each year by adding clinical services, growing market share, etc.—for many, it does not. Further, earning additional revenue through clinical services can also require substantial investment in capital and other infrastructure—while building a fund development organization relies mostly on annual operating dollars after an initial capital investment in donor data management software.

While median financial performance provides insight into opportunities, performance in philanthropy is sensitive to a range of controllable and uncontrollable variables. For example, financial opportunity for philanthropy is reliant upon the healthcare organization's own brand strength, payer mix, market share, patient satisfaction scores, and more. Opportunity is also sensitive to community wealth, population density, and propensity for charitable behavior. However, there are performance levers the healthcare organization can control, including the focus of fund development efforts.

More than 90 percent of charitable dollars contributed in the United States come from *individuals* through outright gifts, bequests, family foundations, and donor advised funds.[5] Organizations that maximize charitable income focus on relationship-based giving (i.e., "major" and "planned" gifts) rather than tactics such as special events and direct mail. A mature development program must focus the majority of its resources to cultivate relationships with individual donors with affinity for the healthcare mission and the desire to affect positive change by investing in the healthcare organization's most-compelling priorities. Developing authentic relationships with donor investors unleashes the potential of philanthropy to transform healthcare.

The largest gifts to healthcare organizations generally come from grateful patients and family members. As a result, progressive organizations place a keen focus on engaging physicians and clinicians as partners in recognizing those who are grateful and who feel inspired to develop a relationship with the healthcare organization through philanthropy. Nurturing grateful engagement is an area of significant opportunity that must be advanced with not only deep integrity but also a well-defined strategy, knowledge of HIPAA privacy rules, tailored staff training, agile use of data, and other infrastructure.

As healthcare organizations confront the rising road ahead, philanthropy can be harnessed as a sustainable, growing, high-ROI revenue source. For many, the relative impact of philanthropy when considering net operating dollars to net charitable dollars is considerable. Beyond direct revenue, a vibrant philanthropy program has a range of financial halo effects including strengthening bond ratings.[6] There is also growing awareness of the link between philanthropy, employee engagement, patient satisfaction, and patient loyalty; while additional research needs to be done in these areas, early information shows promise that creating an organizational culture conducive to philanthropy can elevate financial health, employee engagement, and patient experience.

Key Board Takeaways

Philanthropy can be a valuable, alternative revenue source in healthcare. As boards are exploring the financial potential of philanthropy, they should consider the following:

- More than $10.1 billion is given to U.S. not-for-profit hospitals and health systems annually.
- Philanthropy has a robust return on investment of $4.00 for every $1.00 invested.
- Philanthropy supports capital plans, population health programs, innovation initiatives, and more.
- More than 90 percent of charitable dollars contributed in the United States come from *individuals*.
- The largest gifts to healthcare organizations generally come from grateful patients and family members.

The Board's Role in Advancing Philanthropy

As governing boards consider how to leverage the potential of philanthropy as a strategic revenue source, here are six steps they can take now to advance philanthropy:

- Relationship-based giving is the greatest driver of total dollars, so support

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1 *Giving USA 2017: Annual Report on Philanthropy for the Year 2016* (available at https://givingusa.org).
2 Association for Healthcare Philanthropy, *2017 Report on Giving for FY2016 USA* (available at www.ahp.org).
3 Ron Shinkman, "Moody's: Non-Profit Hospital Medians Extremely Healthy," *Fierce Healthcare,* April 28, 2016.
4 *Giving USA 2017.*
5 *Ibid.*
6 "Fundraising at Not-for-Profit Hospitals Largely Untapped but Increasing," Moody's Investors Service Special Comment, March 2006.

Innovation Leadership: The Role of Governance in Value Creation

BY JIM FINKELSTEIN AND SHEILA REPETA, FUTURESENSE

We have experienced and witnessed generations of geniuses and inspiring entrepreneurs take chances—fail at some, make mistakes, and in creation, think up new things and make them happen.

Key Board Takeaways

In today's healthcare industry it is critical that boards push past routine business innovation and consider more dramatic and radical changes that will allow their organizations to thrive now and in the future. The board plays an important role in stimulating and encouraging innovation throughout the organization. As boards consider their innovation profile by defining innovation, the tolerance level for risk, and strategic partnerships, they should consider the following:

- Innovation is not a nice to have, but a survival tactic that needs to be integrated into the DNA of the organization.
- Board makeup matters—seek after proven change agents and innovators to compose the board.
- Don't confuse new technology for innovation. True innovation is about a new way of thinking with demonstrated value.
- Innovation will look different based on organization type. Rural hospitals can pull together resources innovatively, health systems can flex their reach, and independent hospitals can strive to build partnerships to find solutions that are all innovatively building toward fiduciary responsibility and sustainability.

We see many diverse organizations be innovative and push the envelope. *Forbes* notes that the top 10 World's Most Innovative Companies in 2017 ranged from biotechnology to household products and specialty chemicals to application software. Topping the list were Salesforce, Tesla, and Amazon. Conspicuously absent from the list: healthcare. While the *Forbes* list featured legacy and emerging industries alike, none were in a core industry like healthcare that faces continuous growth in importance and need as the global population ages. Currently external factors and essential need make healthcare ripe for innovation, but hospitals and health systems are not leading the charge.

This is not to say that hospitals and health systems are ignoring innovation; it is more a matter of degree and scope of innovation. In a report in *Healthcare IT News*, it was noted that, "Seventy-five percent of hospital executives believe that *digital innovation* is important and, among those with 400 or more beds, the same percentage is gearing up to create an innovation center, if they have not already established one."[1] The article went on to note that the five main areas in which hospitals are innovating are:

1. Patient-generated data and customized services
2. Network utilization and management
3. Referral management and in-network retention
4. Social community support
5. Convenient patient access—including telemedicine

But is this focus more about evolution of existing technologies than a revolution to reinvent how business is done? In an article in *Harvard Business Review*, Gary Pisano writes about how companies have a choice about balancing technological innovation and business model innovation.[2] Pisano suggests that when creating an innovation strategy, leaders need to ask two questions:

- Does the innovation require a new business model or leverage an existing one?
- Does the innovation require either new technical competencies or leverage existing technical competencies in the organization?

Naturally, innovations that require new business models or new technical competencies will require significantly more time and energy to execute, and will involve a higher level of risk. Good governance does not merely include thinking about the innovation itself, but good strategy involves considering additional risk factors for innovation including whether or not this innovation has high levels of risk by needing new competencies and/or business models. Good governance will likely include a balanced "portfolio" of aggressive, high-risk innovation, as well as lower-risk innovations that will expand or transform current systems and processes.

Becker's Hospital Review featured Michael Dowling, President and CEO of Northwell Health, who explained the looming threat on the horizon for hospitals by saying, "In order to keep pace with newly formed organizations and partnerships, hospitals and health systems need to innovate."[3] He referred to the CVS-Aetna and Optum-Davita deals and the intended disruption of the industry by Google, Amazon, and IBM Watson.

Long gone are the days when hospital governance was limited to financial discretion and corporate oversight to remain financially viable. As healthcare organizations progress down the road, boards must now wrestle with how to keep the financial wheels of the bus running forward, but also consider how they are powering the vehicle. As the rest of the world is starting to run on solar power, healthcare cannot continue to run on gasoline, so to speak. Healthcare boards must revisit all they know and do regarding innovation to not just survive but thrive in the future.

> "There is a way to do it better—find it."
>
> —*Thomas Edison*

Boards, Governance, and Innovation

We all understand that the role of the board is to govern and help to keep the wheels on the bus, to operate within the guardrails; and the role of staff is to plan, strategize and execute, and drive the bus without taking it over the cliff. Effective governance

1 Tom Sullivan, "Here's Where Hospitals Are Investing in Innovation Today," *Healthcare IT News,* September 21, 2017.
2 Gary Pisano, "You Need an Innovation Strategy," *Harvard Business Review,* June 2015.
3 Michael J. Dowling, "Michael Dowling: 4 Most Important Healthcare Trends in 2018," *Becker's Hospital Review,* December 18, 2017.

of innovation needs to have a degree of harmony and aligned purpose combined with a transparent diligence to ensure that rules and guidelines are followed.

However, in the healthcare industry, an environment where disruption can threaten the very existence of traditional, legacy businesses, we must consider pushing past routine business innovation to consider more dramatic and radical changes to ensure eventual migration to a more sustainable business model. The board needs to embrace change, innovation, and creativity—and have the breadth of experience and competencies to understand and guide such potentially dramatic shifts.

To understand the role of the board in stimulating and encouraging innovation, we are taking a look at four key questions regarding innovation in healthcare governance:

- What is innovation?
- Why innovation and why now?
- How do you build innovation into governance practices?
- How do you sustain innovation long term?

What Is Innovation?

First, let's refine the definition of innovation as it applies to healthcare today. According to the Department of Commerce,[4] innovation and how it should be measured is: "The design, invention, development, and/or implementation of new or altered products, services, processes, systems, organizational structures, or business models for the purpose of *creating new value* for the customers and financial returns for the firm."

This definition of innovation emphasizes *value creation*. Value creation goes way beyond the optimization or even the extension of existing processes or procedures or ways of doing business as usual. Efficiency is a good goal; effectiveness is a desired outcome. But these conditions do not necessarily mean that true innovation has occurred.

Jack Hughes wrote in a *Harvard Business Review* article:[5]

> "Organizations have nearly perfected implementing the industrial model of managing work—the effort applied toward completing a task. For individuals, this model ensures that we know what we're supposed to do each day. For organizations, it guarantees predictability and efficiency. The problem with the model is that work is becoming commoditized at an increasing rate, extending beyond manual tasks into knowledge work, as data entry, purchasing, billing, payroll, and similar responsibilities become automated. If your organization draws value from optimizing repetitive work, you'll find that it will be increasingly difficult to extract that value."

Dan Beckham, President of The Beckham Co., also notes there is a difference between invention and innovation and why it is important to differentiate between these two: "Innovation is doing something differently to generate significantly more value. An invention is not an innovation. It becomes an innovation only when it is applied in such a way as to generate significant *new value*."[6]

So how does this show up in today's healthcare environment? We see hospitals and health systems moving to find ways to add more value in their innovative efforts. The concept of hospitals and health systems investing in incubators, labs, innovation offices, etc. has become more commonplace. Examples of this include Akron (Ohio) Children's Hospital's Center for Patient Experience Innovation (Akron, OH), The Innovation Institute (La Palma, CA), and New York-Presbyterian Hospital's (NYP) Innovation Center (New York, NY). In some cases, hospitals typically invest as some portion of owner or member in the entity and the entity itself functions as a friendly "Shark Tank" for healthcare inventors. These two marry innovation with invention. They extract the value from invention leading to true innovation. This value is realized as hospitals investing in a new revenue stream and diversifying financial approaches, as well as fostering inventions that when they come to fruition will become innovative technologies demonstrating value.

We have seen inspiring inventions in healthcare over the past 50 years. Some of the more recent inventions include bacteria-killing light bulbs, mini pacemakers, augmented reality, units that can test for strokes, artificial retinas, and robot nurse assistants. Yet truly innovative hospitals and health systems are identifying ways to drive maximum value from these ideas by getting those inventions to a greater market outside their walls for additional revenue streams.

> "We cannot solve our problems with the same thinking we used when we created them."
>
> —*Albert Einstein*

Why Innovation and Why Now?

The words "hospital" and "viability" are frequently heard in the same sentence. How do we know we're on the precipice of change and everyone needs to innovate to stay viable? Because change and innovation are becoming the new norm—players who have historically led the healthcare industry are finding themselves in dire financial

4 *Innovation Measurement: Tracking the State of Innovation in the American Economy,* A Report to the Secretary of Commerce by the Advisory Committee on Measuring Innovation in the 21st-Century Economy, January 2008.

5 Jack Hughes, "What Value Creation Will Look Like in the Future," *Harvard Business Review,* May 17, 2013.

6 Dan Beckham, "How to Foster Innovation in Health Care Delivery," *H&HN,* October 19, 2015.

situations, and movers and shakers outside the industry are coming in to change things. What has worked in the past will no longer be viable in the future.

Innovative or outside-the-box thinking used to be considered a nicety and potentially risky behavior for boards. But in this day and age, for small to mid-size hospitals and health systems, *not* having conversations about financial diversification and how to innovate revenue streams is quickly becoming the risky behavior.

External Players Are Coming in to Shake Things Up

For example, we see Amazon, Berkshire Hathaway, and JPMorgan Chase combining forces to form an independent healthcare company. An article in *The New York Times* explains their motives for playing in the healthcare space: "The alliance was a sign of just how frustrated American businesses are with the state of the nation's healthcare system and the rapidly spiraling cost of medical treatment. It also caused further turmoil in an industry reeling from attempts by new players to attack a notoriously inefficient, intractable web of doctors, hospitals, insurers, and pharmaceutical companies."[7]

As external players enter the healthcare arena they will see old problems in new ways and find solutions through unique technologies and tools they bring from their experience outside of healthcare. Healthcare will need to find creative ways to innovate against or partner with these outsiders.

Changing Consumer Profiles and Expectations

As millennials enter an age where they will be more influential consumers of healthcare (with their own aging, as well as their children's needs), their definition of customer service, patient care, and access to records is changing the landscape of a minimal standard of care. Telemedicine, easy access to medical records, online scheduling, etc. will all become industry standards vs. market differentiators as millennials continue to become more active healthcare consumers.

One such example of this shift in mindset to innovate comes from the Cleveland Clinic. CEO Dr. Toby Cosgrove describes the change in attitudes about patient medical records as such, "…we opened our medical records—what's often called 'the chart'—to patients any time they want to see their own charts. The charts really aren't the hospital's; they belong to the patients, and we think it's their right to have that information." Essentially millennials see their patient data as theirs, not the hospital's, and Cleveland Clinic has evolved and pivoted to this consumer mindset.

Innovation is not just about a new method, idea, or product—it's about a revolution or a metamorphosis in order to survive the future.

> "I could either watch it happen or be part of it."
>
> *—Elon Musk*

How Do You Build Innovation into Governance Practices?

So now that we assume that the value creation from innovation is both a critical defense to disrupters and an important offense to ensure survival, we need to establish how to build innovation into governance practices. Let's look at how you build the board of the future and the expected competencies and personal skills that are necessary to be successful in the future.

Board Composition and Scope of Expertise

Good governance is only possible when the board consists of a diverse group of people with different points of view and backgrounds. In the current healthcare environment, it is critical for boards to have a wide range of expertise in various topics, including technology, quality, social media, finance, environmental safety, clinical expertise, human capital/organizational development, and hospital administration.[8]

Boards need to take a look at their areas of expertise and identify the holes that might currently exist. After identifying those gaps, a strategy should be developed to fill those expertise gaps when replacing board members, or by augmenting the board by bringing in subject matter experts to help advise the board.

Personal Skills

In addition to subject matter expertise, there are some behavioral competencies that should be considered for the selection of board members. When we think of needed competencies, we frequently consider things like good decision making, strong communicators, and analytical thinkers. But as innovation becomes a driver of governance, those competencies need to be refined and redefined.

A list of more refined competencies necessary during times of disruption and change to consider include:[9]

- *Leapfrogging mindset*: creating or doing something radically new or different that produces a significant leap forward
- *Boundary pushing*: broadening mindsets and problem solving, as well as pushing the limits of the team in which they serve
- *Data-intuition integration*: the ability to supplement hard data with gut instincts or loosely related data when no such hard data exists
- *Adaptive planning*: the ability to manage uncertainty and plan to drive results, all while modifying assumptions and approaches accordingly since periods of innovation are also clouded with uncertainty
- *Savoring surprise*: the ability to revel in and adapt to surprises—both pleasant and unpleasant

7 Nick Wingfield, Katie Thomas, and Reed Abelson, "Amazon, Berkshire Hathaway, and JPMorgan Team Up to Try to Disrupt Health Care," *The New York Times,* January 30, 2018.
8 Carol Geffner, "Trustees Playing Game with Higher Stakes," *Trustee,* September 12, 2016.
9 Soren Kaplan, "5 Critical Competencies for Disruptive Innovation and Change," Excerpt from *Leapfrogging: Harness the Power of Surprise for Business Breakthroughs,* August 2012.

As a matter of course, we do not seek these skills and competencies on boards. Many traditional, conservative boards believe that these individuals and/or their skill sets will be disruptive and dilutive to their interests of control, fiduciary responsibility, and "keeping the wheels on the bus."

We challenge that thinking to say that without disruptive, innovative thinking in today's world, organizations will collapse inward amongst themselves through ignorance of competitive threats or will simply disappear through neglect. In healthcare, some organizations that are not innovating are merging to survive. And many are simply out of business.

Innovation is like oxygen—it is necessary to keep from becoming stagnant and irrelevant. Boards that do not have the aforementioned skills and competencies engrained in their definition of successful board members will have difficulty moving forward.

> "Innovation distinguishes between a leader and a follower."
>
> —*Steve Jobs*

How Do You Sustain Innovation Long Term?

According to Peyman Zand, Partner at Pivot Point Consulting, there are three ways to advance innovation in healthcare:[10]

- A culture that promotes the free exchange of ideas
- An emphasis on internal cross-functional collaboration
- An openness to external expertise

As the walls of financial pressures and prudence seems to sap the time and mental energy of boards, it is important that innovation is not simply a hopeful action. Dedicated time needs to be set aside to determine a strategy. Boards must find ways to implement these mechanisms to continually build innovation in their organizations. Time must be reserved on the agenda regularly to discuss innovation strategy and practices.

Some practical ways that boards can be engaged in innovation include:

- Build behavioral definitions of what innovation in governance looks like—how does it show up in governance at your organization?
- Assign board roles and responsibilities that integrate innovative competencies.
- Set aside funding for innovation—true innovation needs a defined budget and capacity to help drive, support, and sustain these efforts.
- Build an innovation committee, which helps to ideate new concepts and ideas and supports the creation of new initiatives.
- Define innovation goals for top leaders; if you're going to cook innovation into the DNA of the organizational cake, it's important to articulate expectations of top leaders within the organization. These criteria can also be used to measure annual performance, and as selection criteria for top leaders in the organization.

In addition to building practices, true innovation comes from assessment and measuring progress. There are two ways to assess innovation on your board:

- **Behavioral**: Are board members individually, as well as the board as a whole, assessed on a defined set of criteria and competencies to measure effective performance? If not, this is a crucial board practice that should be implemented.
- **Inventory**: When vacancies on the board arise, it is essential that you know the "state of the state" of innovation on your board. Are you regularly assessing the critical areas addressed above (economic perspective, technology, quality, clinical expertise, environmental safety, human capital/organizational development, social media, and hospital administration) to see where you might have overload on knowledge and where you might be lacking?

The flip side of innovation feels like risk. But to minimize this, good governance allows experimentation and flexibility with managed and measured risk. The measured part of risk is managed by measurement of outcomes. Cleveland Clinic, a leading innovator, argues that measurement and outcomes are the two guardrails used to help mitigate some of the risk in an innovative environment.

Summary and Call to Action

As healthcare organizations move toward taking action on innovation in governance practices, there are several things to consider:

1. Innovation is not a nice to have, but a survival tactic that needs to be integrated into the DNA of the organization.
2. Board makeup matters—seek after proven change agents and innovators to compose the board.
3. Be willing to disrupt the business to move forward rather than stay stuck in "business as usual."
4. Don't confuse new technology for innovation. True innovation is about a new way of thinking with demonstrated value.
5. Don't rest on your successes. Healthcare and the world around it is changing at a breakneck pace. Today's successes may not sustain in the future. To stay ahead of the curve, ensure your eye is always on tomorrow's tomorrow.

Governance in innovation was once a luxury, a nicety, but as the landscape of healthcare continues to change, innovation will become the fuel of financial viability and success. Good governance will not only include consideration, but implementation and regular practice of strong innovative practices in the future.

The Governance Institute thanks Jim Finkelstein, President and CEO, and Sheila Repeta, Senior Consultant, of FutureSense for contributing this article. You can learn more about their company and work at www.futuresense.com or contact them at jim@futuresense.com and sheila@futuresense.com.

10 Peyman Zand, "Advancing Innovation in Health Care," *H&HN*, September 27, 2017.

New Excise Taxes on Compensation Arrangements for Select Highly Paid Employees: Implications and Action Steps for the Board

BY BRUCE GREENBLATT AND STUART HARVEY, SULLIVAN, COTTER AND ASSOCIATES, INC.

The Tax Cuts and Jobs Act of 2017 includes two organization-paid excise taxes that have implications for the executive compensation programs of tax-exempt hospitals and health systems. This article summarizes the act's provisions and identifies actions that healthcare organizations should take to understand the expected tax liability and its implications.

Overview of Excise Tax Provisions

The two excise taxes of 21 percent apply *only* to the following compensation arrangements for a limited group of the highest-paid employees ("covered employees"):

- Taxable compensation over $1 million
- "Excess parachute payments" (payments made contingent on a termination of employment; this applies only to certain arrangements, as defined below)

The excise taxes are paid by the tax-exempt organization, not the employee. The following definitions are important in understanding the scope of the taxes:

- **Effective date**: The excise taxes apply to organizations for tax years beginning after December 31, 2017.
- **Covered employees**: An employee (or former employee) who is one of the five highest compensated for the current tax year *or* any prior tax year beginning after December 31, 2016:
  - » Any employee may be considered a covered employee, not just executives (see below for an exception for certain compensation paid to licensed medical professionals).
  - » Once an individual is a covered employee, the designation remains—even as a former employee. Therefore, the number of covered employees may grow beyond five if there is year-to-year variability in the five highest-compensated individuals.
  - » Organizations with multiple tax-exempt entities may have multiple sets of covered employees.
  - » Identification of covered employees begins one year earlier than the effective date of the tax (i.e., tax years after December 31, 2016 vs. 2017).
- **Compensation**: Generally includes all taxable income subject to federal withholding (with limited exceptions):
  - » The portion of compensation paid to a licensed medical professional (including a physician) for the performance of medical services is excluded; however, amounts paid to such an individual acting in another capacity (such as administration, for example) are not excluded. The exclusion applies for purposes of determining the five highest-paid employees and the compensation subject to the tax.
  - » Compensation received by an individual from multiple entities under common control is aggregated, and the tax liability is similarly spread among those entities.
- **Excess parachute payments**: There are two steps for determining if the excess parachute payment excise tax applies:
  - » First, the excise tax is triggered when "parachute payments"—defined as the present value of amounts paid contingent on separation from service—are more than *three times* the individual's average taxable compensation over the past five years ("base amount").
  - » Second, if triggered, the tax is assessed on "excess parachute payments," which are amounts that exceed *one times* the base amount.
  - » Thus, there is a difference between what triggers the tax and how it is calculated—a substantial excise tax results even if parachute payments are only marginally above three times the base amount.

Key Board Takeaways

The 2017 tax reform legislation includes two organization-paid excise taxes that apply to all tax-exempt healthcare organizations on compensation arrangements for "covered employees": 1) a 21 percent tax on taxable compensation above $1 million, and 2) a 21 percent tax on "excess" termination payments. The taxes are effective for tax years after December 31, 2017. Covered employees are the five highest-paid employees during any tax year after December 31, 2016; compensation paid to physicians for the performance of medical services is excluded. Boards should:

- Determine the covered employees and estimated excise tax liability (short and long term).
- Assess the implications of compensation decisions on the excise tax.
- Evaluate potential compensation program strategies.

The excise taxes are likely to have a more significant impact on large health systems, those with multiple entities, and those that are affiliated with universities. Smaller health systems and hospitals may have only one individual with pay over $1 million, typically the CEO, so may face less significant liability and complexity.

Outstanding Issues

There are several outstanding issues that are not clearly addressed in the legislation, which make it difficult to determine the precise excise tax pending further IRS guidance:

- **Definition of tax year for measuring compensation**: Since the law references the employer as being liable for the tax, the tax may be calculated based on the covered employee's compensation attributed to the employer's tax year. It is possible, however, that the IRS could define this as taxable compensation for the calendar year that ends within the organization's fiscal year (similar to the Form 990 disclosure rules).
- **Determining compensation for the performance of medical services**: For physicians with both clinical and non-clinical duties, the approach for allocating compensation among the various duties will need to be clarified.
- **Entities in a related group**: The tax is assessed on each tax-exempt organization. Clarity is required to determine the organization at which an individual is "employed" for those organizations with multiple entities.
- **Calculation of excess parachute payments**: The law contains references to the "golden parachute" rules of IRC section 280G for determining some, but not all, aspects of excess termination payments.

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Disruptive Strategy…

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for the organization, while at the same time concentrating care and positioning the organization for better adherence to clinical protocols—key to producing optimal clinical outcomes and reducing the cost per encounter and cost per episode of care.

As part of the strategy refresh, the board must engage in discussions about the pace and cadence of the organization's journey and frequently assess its place in the competitive landscape.

3. Incorporate Population Health into Governance and Determine Whether Leadership Is Positioned to Execute in a Pluralistic Environment

High-performing boards recognize the need to collaborate in the current environment. Success in a pluralistic payment environment will be in large part determined by board effectiveness. In order to thrive, boards must be comprised of leaders, not just from the provider organization itself, but from the patient and member community, housing authorities, schools, social clubs, religious institutions, and other CBOs. This approach, while politically challenging in some markets, will yield tremendous "downstream" results, as providers shift from treatment-centric enterprises to organizations working to improve the health of the communities they serve.

In order to make this change, providers may also need to recast the governance structure and systems and invest in board development. For some organizations, this may mean considering the addition of a population health subcommittee of the board, for others it may mean adopting more "whole-person" or population-based performance metrics, and still others may need to contemplate revisions to the nominating and recruitment processes, as well as to board and committee memberships. Other elements of the board's responsibility in this regard include recruitment and ongoing development of the CEO. Boards might also be required to support the CEO in assessing whether the organization has the appropriate configuration of executive talent to execute on strategy and meet daily operating requirements.

While refining the organization's mission, recalibrating its strategy, and developing the capability to lead and manage in a pluralist payment environment will result in significant strategic "disruption," there is no better formula for enabling the board and CEO as they work to fulfill their community and fiduciary responsibilities, and position the organization for long-term success.

The Governance Institute thanks Michael J. Zaccagnino, Executive Vice President, COPE Health Solutions, and Travis Froehlich, Board Member, COPE Health Solutions, and former Chief Strategy Officer, Seton Healthcare, for contributing this article. Mr. Zaccagnino can be reached at mzaccagnino@copehealthsolutions.com and (646) 768-0006.

New Excise Taxes on Compensation Arrangements…

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Action Steps

Boards should work with legal, compensation, and finance professionals to understand the estimated tax liability and evaluate potential compensation program strategies:

- **Determine the tax-exempt entities that are subject to the excise taxes**:
  - » Assess if changing employment models is appropriate to minimize the number of covered employees.
- **Review the potential excise tax on compensation over $1 million**:
  - » Determine the current and projected covered employees for each entity based on expected taxable compensation, considering turnover and potential recruitment and succession initiatives.
  - » Estimate the projected tax liability as a baseline from which alternative approaches can be evaluated (e.g., a five-year projection). Consider the impact of future salary increases, vesting/payout of incentives and deferred compensation, performance, and other factors.
  - » For physicians, ensure compensation is adjusted for amounts related to the performance of medical services and that the allocations are consistent with fair market value requirements.
- **Review the potential excise tax on termination payments**:
  - » Review all plans, programs, and employment contracts to determine whether excess parachute payments may occur. Assess if any changes should be considered.
- **Review compensation program design**:
  - » Determine if there are any unintended excise tax consequences of expected compensation increases and deferred compensation/retention arrangements due to the lump sum nature of payouts. Assess if adjustments are appropriate.
- **Periodically revisit excise tax projections and compensation strategies**:
  - » Update projections annually and revisit compensation strategies.
  - » Understand the impact on the excise tax exposure prior to approving compensation changes.

Boards of tax-exempt healthcare organizations must carefully consider the implications of the excise taxes since they are a new cost of doing business. In that regard, it is critical to complete an ongoing, comprehensive review of these taxes and their impact on recruitment, retention, recognition, and cost. Since some details of the law's application are uncertain, organizations should monitor future guidance as they determine any possible liabilities and plan for potential strategic adjustments to their compensation programs.

The Governance Institute thanks Bruce Greenblatt, Managing Principal, and Stuart Harvey, Principal, Sullivan, Cotter and Associates, Inc., for contributing this article. They can be reached at brucegreenblatt@sullivancotter.com and stuartharvey@sullivancotter.com.

Philanthropy as a Strategic Revenue Source

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minimizing special events and increasing relationship-based giving.

- Significant donors expect to have a relationship with the CEO, so recognize the CEO's participation in philanthropy as a valuable activity in his or her goals.
- Donors wish to achieve a social impact through giving, so help drive the selection of significant, strategic priorities for philanthropy to support.
- The largest gifts to healthcare come from grateful patients, so support development having access to HIPAA-approved data and to clinicians.
- Most foundations are under-resourced relative to the opportunity, so support boosting budgetary investment in experienced staff and program infrastructure.
- Healthcare fund development has changed significantly in the last 10 years, so ensure a new—rather than incremental—strategic plan to guide efforts to optimize philanthropy.

The Governance Institute thanks Betsy Chapin Taylor, FAHP, President of Accordant Philanthropy, for contributing this article. She can be reached at betsy@accordantphilanthropy.com.

Five Ways to Improve Board Performance

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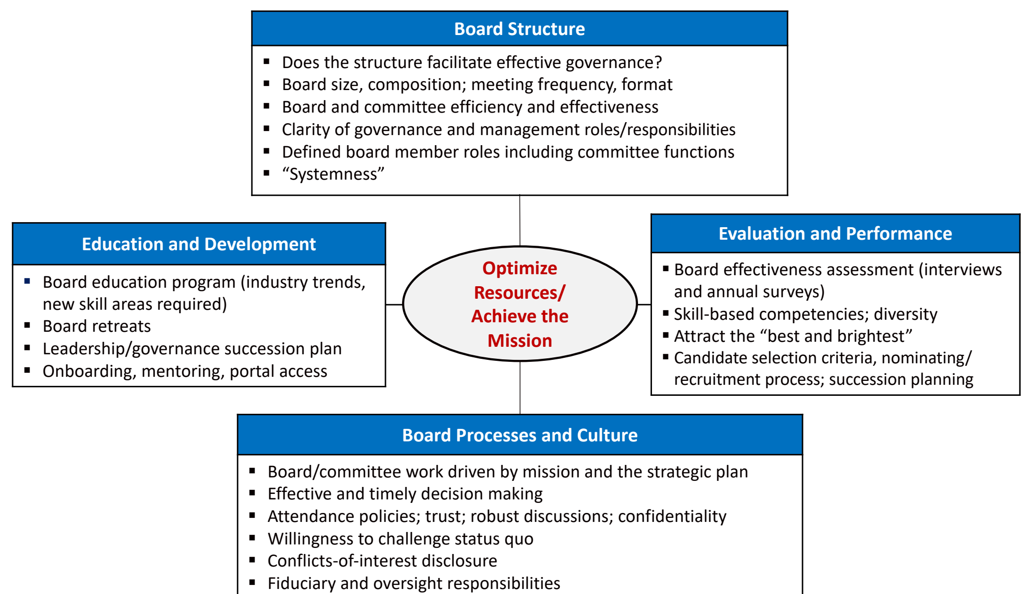
the BoardCompass® survey by The Governance Institute), a periodic comprehensive assessment should be conducted of the board structure, processes, and practices. **Exhibit 1** illustrates four areas of evaluation to consider. To start, select a few areas to assess and compare to best practices, tailored to your board's unique needs. It's also important to conduct an annual board self-assessment covering individual directors and the board as a whole.

Exhibit 1: Governance and Board Assessment—Approach



Source: Premier Inc., Steven T. Valentine and Guy M. Masters.

5. Onboarding, Mentoring, and Ongoing Education

Properly onboarding new directors is essential as healthcare becomes increasingly complex. Informal chats with seasoned directors will not suffice. One-to-one sessions with senior leaders to review key areas (e.g., finance, legal, healthcare trends, board policies and procedures, duties and responsibilities, clinical, physicians, human resources, quality, etc.) are critical. Mentors should also be assigned for the first year of service. Periodically ask seasoned board members what they would like to have been taught when they were new, and include these ideas in the orienting process. Continuing education is also crucial for director development. When planning for ongoing education:

- Consider conducting education sessions either immediately prior to board meetings, or as part of the actual board meeting agenda. Pick timely topics of a strategic nature, and engage subject matter experts to lead presentations.
- Distribute relevant articles or other background materials beforehand so that directors come prepared and can participate in questions and answers with greater confidence.

Continuous Board Performance Improvement

Boards must be able to work together effectively as dynamic, thoughtful, proactive leaders of complex organizations. The board needs to be structured, organized, and led to facilitate effective governance. Each element of good governance (e.g., size, structure, agendas, meeting frequency, support resources, timely and accurate data and performance information, and individual competencies and backgrounds) combines to determine whether or not the organization will survive and thrive in this dynamic and changing environment. Choose a few of these areas or others that help your board make incremental improvements in governance best practices to ensure success.

The Governance Institute thanks Guy Masters, Principal at Premier, Inc., and Governance Institute Advisor, for contributing this article. He can be reached at guy_masters@premierinc.com. Steven T. Valentine, M.P.A., Vice President of Strategic Advisory Services at Premier Inc., also contributed to this article.

Five Ways to Improve Board Performance

BY GUY M. MASTERS, PREMIER INC.

When was the last time that your board changed something in its practices, processes, or structure that significantly improved its effectiveness? What is preventing your board from achieving its highest level of potential performance? Do your directors sometimes struggle to understand their roles and responsibilities and the practical differences between governance and management? Do board members tend to get involved with day-to-day operations, make requests for operations-level data, or go around the CEO to confer directly with staff in the name of becoming "better informed" about the organization and performance of senior leaders?

Effective boards take measures to consistently discuss and reinforce the appropriate duties, roles, responsibilities, limitations, and accountabilities for their directors. The following are five recommended areas to examine to further optimize the time, talents, and energy invested by board members in governance activities.

Key Board Takeaways

Board performance improvement requires objectivity and openness to change. If your board hasn't changed anything significant in the way it operates for a long time, there may be opportunities to fine-tune and calibrate processes and practices that will leverage the board for greater impact and effectiveness. Specific areas to assess include:

- Streamlining board and committee meetings and agendas
- Right-sizing the board and reducing layers of governance to increase efficiency, accountability, and nimbleness
- Refocusing, rejuvenating, and sunsetting board committees
- Evaluating board performance, structure, processes, and individual members
- Onboarding, mentoring, and education

1. Streamline Meetings and Agendas

How many times does the board meet each year? How long do typical board meetings last? Is the content and purpose of each meeting significant? The Governance Institute's 2017 Biennial Survey of Hospitals and Healthcare Systems reports that most boards surveyed (59 percent) meet 10–12 times annually.[1] Fifty-seven percent of responding organizations indicate that board meetings are between two- to four-hours long. Frequent and lengthy meetings can be indicative of inefficiencies, including inappropriate or overly ambitious agenda topics, overly detailed committee reports, and side-track discussions that are not focused or drift off-topic. To improve board effectiveness in this area, consider the following:

- Streamline the board meeting process to focus on strategic and policy issues, reduce reporting time by making materials available in advance, and facilitate discussions so they remain informative and additive (i.e., no "piling on").
- Create board and committee agendas that are highly focused, narrowly defined, and specific. As a rule, strategic discussions should occupy at least 50 percent of board meeting time.
- Use consent agendas and streamline committee reports (e.g., recommendation, summary, body, and exhibits).
- Trust the work and recommendations of the committees and avoid rehashing previous discussions, details, and decisions that committees have already worked through.
- If your board and committee meetings are exhausting rather than energizing, examine the demands and commitments for directors and eliminate ineffective meetings.

2. Right-size the Board

How large is your board? Does it seem too big, too small, or just right? The biennial survey shows an average board size of 13, a slight decrease since the 2015 survey. Overall, most boards are streamlining and reducing membership to increase efficiency, accountability, and nimbleness. However, for healthcare systems that are in acquisition mode, the opposite trend is at play, often increasing board size to add seats for the acquired entity(ies). Larger systems have also added regional and division layers of governance that can become cumbersome and bureaucratic. Is it time to downsize the number of members on your board or to eliminate unwieldy layers of governing bodies? Assess the pros and cons of reducing the size and layers of the board to make governance more direct, centralized, and efficient.

3. Refocus, Rejuvenate, and Sunset Board Committees

How many committees and subcommittees does your board have? How would you rate their overall effectiveness, value, and contribution toward getting board work done? When was the last time you eliminated a committee that fulfilled its purpose? Highly effective boards understand that board work gets done through their committees. Less effective boards rehash, question, and repeat analysis and assessments already done by their committees. This can be evidence of a lack of trust in the committee and its efforts, and undermines credibility and confidence in its members. Effective committees should:

- Have clearly articulated annual goals and expectations of work product, aligned with the strategic and operating plans of the organization.
- Provide a rationale for continuing each committee annually, with suggestions for how it could be improved in the coming year. Health systems should consider sunsetting committees that have fulfilled their purpose.
- Give an annual stewardship report to the board summarizing accomplishments (relative to its annual charge) and contributions toward achieving the strategic plan.
- Rotate membership periodically to broaden exposure and gain new perspectives and input.
- Provide succinct, accurate, purposeful reports to the board with specific recommendations for action, using consent agendas as much as possible.
- Committee reports to the board should be made by management, with backup from the committee chair as needed.

4. Assess Board Performance, Structure, Processes, and Members

In addition to conducting annual board effectiveness self-assessment surveys (e.g.,

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1 Kathryn C. Peisert and Kayla Wagner, *The Governance Evolution: Meeting New Industry Demands*, 2017 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute.