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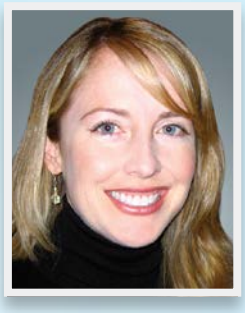

As healthcare transforms (slowly) and governance evolves along with it, many things will still remain the same. An effective, high-performing board remains a critical asset to seeing healthcare organizations successfully through this unprecedented time in our industry's history. That board's focus must remain strategic, while holding management accountable to implementation of the strategy, fulfillment of the mission, and moving towards a desired future state. Along those lines, we are seeking answers to some fundamental, governance-level questions: how to build partnerships with others across the care continuum to ensure quality and patient safety throughout the journey; the board's (and therefore the organization's) role in addressing social determinants of health and why; how to be more patient-responsive and adaptive; determining the right (and best way) to include physicians in governance; and how to determine a streamlined governance structure that works for two (or more) organizations that choose to become one. The articles in this issue tackle these ongoing, difficult questions to help boards cultivate capacities to achieve such fundamental, yet evolutionary, goals.

Kathryn C. Peisert, *Managing Editor*

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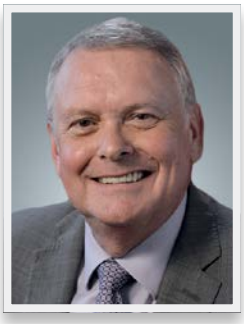
Creating a Successful Post-Acute Care Strategy to Reduce Unnecessary Utilization

By Barry P. Ronan, FACHE, Western Maryland Health System



Barry P. Ronan, FACHE
President and CEO
Western Maryland Health System

In 2010, as Western Maryland Health System (WMHS) embarked on a value-based care delivery journey, the board of directors recognized that such transformational change necessitated a review of our mission and vision statements, as well as our core values. It was obvious that as our care delivery model changed, our culture would, too.

The board felt that our core values of integrity, innovation, compassion, accountability, respect, and excellence still fit very well with our organization's new direction. We amended the mission statement to better reflect the patient-centered approach to care delivery in tandem with our intention to improve the health and well-being of the community. Since the value-based model cares for patients in the most appropriate setting, resulting in less acute care utilization and significantly more care delivery in pre- and post-acute settings, we changed the vision statement to reflect the need to create partnerships with other providers throughout the healthcare continuum.

The relationships between WMHS's pre-acute settings and urgent care providers, independent physician practices, ambulatory surgery centers, diagnostic centers, and in-home providers were well-established. The goal with those relationships was to solidify and enhance them, moving from relationships to working partnerships. However, relationships with post-acute care settings were more challenging for many reasons.

Strengthening Relationships with Post-Acute Care Providers

There are a dozen skilled nursing facilities (SNFs) in the area, including one of our own that regularly accepts discharges from the acute care setting. Owning one of these SNFs compounded the challenge of changing the patient care model because it added inherent competition and posed a variety of trust issues.

For example, a typical scenario at that time might include a physician with two positions: an independent practitioner, primarily, and an SNF medical director, secondarily. If an SNF resident experienced a medical difficulty, staff would make a phone call to the medical director, who would routinely send the patient to the WMHS ED for evaluation. The time of day or severity of illness was irrelevant; the normal procedure was to send the resident, by ambulance, to the hospital. Often, residents simply were dehydrated. After receiving IV fluids, they would be returned to the SNF just a few hours later. Such trips to the ED are physically and emotionally taxing on an already compromised elderly resident, not to mention costly because of the ambulance transfer and other resources dedicated to the resident's diagnosis and treatment. Under value-based care delivery and global budgeting, each ED visit constituted unnecessary utilization.

Our goal and need was to make patient-centered, value-based care the new norm. We had to move our relationship from one as a potential competitor to that of a trusted partner, acting in concert for the good of the patient.

Early in our value-based care delivery journey, we invited leadership from the SNFs to join WMHS leadership in a new venture called "Partnership to Perfection." Establishing trust was paramount to this effort. During a series of meetings, we focused on key areas beginning with education: we explained our new care delivery model and our goal to keep patients healthy and out of the hospital. Next, we asked for their assistance and support. We knew we could not achieve our goals without their cooperation. We went on to train the SNF staff on a variety of treatments that could be performed in their facilities, placed RN transitionists, or liaisons between hospitals and SNFs, in their facilities, and in some locations, replaced their medical directors with SNF specialists (similar to hospitalists, exclusively serving SNF residents). Finally, we provided education regarding the likely direction of care delivery models: that at some point in the not-too-distant future, they too would risk penalties for overutilization. WMHS leadership continue to meet with the group of SNF leaders every other month and the relationships we have established continue to mutually benefit the SNF staff and the health system.

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Key Board Takeaways

Hospital and health system boards should be aware of the deployment of the organization's post-acute care strategies to reduce unnecessary utilization. These strategies can include:

- Creating partnerships across the care continuum to better address patient needs
- Understanding the social determinants of health that may be affecting the patients served by the hospital or health system
- Developing a strategy to address patient needs
- Learning from organizations already involved with reducing utilization to discover what established strategies can be applied at your hospital/health system
- Educating the community and other providers on what you will achieve through such strategies

"Alone we can do so little; together we can do so much."

–Helen Keller

Collaborating across the Care Continuum

In addition to working with SNFs to remodel patient care, we quickly recognized that value-based, patient-centered care requires partnerships across the continuum. From physicians and pharmacies to government entities, the faith-based community, and service agencies, such as homeless shelters and senior living centers, we now collaborate with a multitude of organizations.

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Integrating the Patient Voice into Board Processes for Innovation and Exceptional Care

By Jennifer Volland, D.H.A., RN, MBB, CPHQ, NEA-BC, FACHE, NRC Health

Dr. Harvey and Jean Picker were healthcare disruptors who changed the way patient experience was viewed. It was a seismic paradigm shift for organizations to ask patients about their experiences and use that information to determine what mattered most. Their work advocated for the inclusion of the patient perspective into the design and delivery of health services. The Pickers coined the term "patient-centered care" and they have had an international influence on the healthcare industry.[1]

While their work is widely respected, healthcare has missed the mark by not incorporating patient-centered care into all organizational layers. If survival is based on being a dominant market leader and attracting patients by bringing value, a board disconnected from the patient is a critical lapse resulting in missed opportunities and lost insights. This article explores ways to surmount these oversights.

Action 1: Assess *How* and *Where* You're Hearing the Patient Voice

Board members need to understand the end-user perspective—how patients want to receive care and whether community needs are being adequately represented and addressed. Yet many executives haven't re-evaluated how they view the patient experience.[2] It goes beyond looking at metrics to understanding how patient preferences tie back to the organizational direction and are being translated to care delivery.

When there is a disconnect between the board and patient it can impact success and potentially get the board moving away from what patients want. Healthcare services have increasingly shifted to the outpatient setting.[3] However, many Millennials want self-scheduled appointments and their preferred visit is via an app.[4] Just this one item changes the care delivery setting and allocation of resources. What consumers and patients articulate can make a difference in the future-looking focus taken by the board.

Additionally, the board is concerned with protecting organizational financial health. Payment models are increasingly becoming based on the voice of the patient—including CMS incentive programs, designation programs, and federal grant opportunities.

The Hospital Inpatient Quality Reporting (IQR) Program pays hospitals for reporting specific quality measures. Hospital Compare is a national database that provides five-star ratings of hospital quality to the public using IQR data.[5] It helps consumers know where to seek care and encourages hospital improvement by publishing information on an aggregated overall rating (comprised of up to 57 items), timely and effective care, complication and deaths, unplanned hospital deaths, use of medical imaging, and payment and value of care. These items can be impacted by the board's setting of expectations about creating a patient-centric culture and living it by example.

In one example, a Hospital Compare top-performer indoctrinated into its culture a clear understanding of compassionately responding to the patient/family voice as the most critical reason people come to work in addition to their daily tasks. Feedback is taken seriously. Each board meeting begins with a story shared by the patient. This helps the board stay connected to what is deemed important by patients. While any concerns are handled at an administrative level, reviewing high-level metrics and understanding the patient perspective is invaluable for comprehending how the mission is being translated through the metrics, to the front line, and by the patient. It also sets the tone and focus for the remainder of the meeting.

While the board helps set strategic goals aimed at quality and safety, it generally doesn't manage the operations or work directly with employees. Some organizations have taken an extra step of adding patient representation to the board quality committee. Having this structure helps build accountability by ensuring patient experience metrics receive the time and attention deserved beyond just a "reviewed" stamp at general board meetings.

Key Board Takeaways

To ensure the patient perspective is effectively integrated into the board's work:

- Assess how the board is currently hearing the patient voice to achieve a full understanding of their view.
- Make sure the board quality committee is monitoring the right patient experience metrics, and is viewing current data.
- Consider adding patient representation to the quality committee.
- Have a clear governance charter so the board doesn't get too involved in operational details.
- Don't wait to change the system to be more patient-responsive and adaptive—this should be a priority now.

Action 2: Within the Quality Committee, Have Metrics, Alignment, and Data Agility

There are three strategic items a quality committee should be considering about its patient experience data:

- What are the most important items to be monitoring, and do we have metrics? Gaps occur without diligently asking those two questions. For example, at one hospital, patient satisfaction and employee engagement metrics were being monitored but provider engagement metrics were missing from the strategic plan. Subsequently, it wasn't included for review by the committee. This was an essential yet unmonitored metric given nationally high rates of provider burnout. When physicians are burned out they have difficulty making connections with patients, which can

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1 "Father of Modern Patient Care," *The Times*, October 28, 2006.
2 "Through the Eyes of the Patient: Looking beyond HCAHPS to Improve Patient Experience," *Becker's Hospital Review*, October 19, 2016.
3 Jennifer Zaino, "Changing Priorities Shift Hospital Focus to Outpatient Strategies," *Healthcare Finance*, August 25, 2014.
4 Scott Swonger, "Millennials and Healthcare: 5 Trends You Can't Afford to Ignore," Windham Professionals, January 24, 2018.
5 CMS Hospital IQR Program Reference Checklist, FY 2020 Payment Determination, CY 2018 Reporting Period.

Physicians in the Boardroom: Contemporary Considerations for a Common Practice

By Todd Sagin, M.D., J.D., Sagin Healthcare Consulting

Over the past decade there has been growing recognition of the importance of physician leadership in our nation's hospitals and health systems. As these institutions struggle to transform to meet contemporary demands for quality, safety, and cost efficiency, it has become increasingly apparent that physician insight and buy-in are essential factors. Healthcare boards are recognizing this need to enhance physician engagement by exploring new tactics for doctors to participate in and impact the governance of their organizations.

In recent years, more and more boards have decided to increase the number of physicians sitting as directors. Adding clinicians has generally been perceived as a practical necessity as the governance of healthcare entities has become ever more complex. Physicians bring numerous strengths to a hospital board, including clinical expertise, an insider's view of the organization, and operational/frontline experience. Nevertheless, there are many considerations that should be weighed when governing bodies seek greater participation of physicians in their work. This special section will explore these considerations, various tactics for physician engagement in governance, and the potential political, legal, and financial ramifications of the decisions made.

A Brief History of Physician Involvement in Governance

In the 20th century, there was wide variance in physician presence on hospital governing boards. At most institutions, it was common for the President of the Medical Staff (or Chief of Staff) to be present at board meetings to report on credentialing recommendations and represent the voice of the physician community. These medical staff officers might be at these meetings as a guest, a non-voting board member, or a full voting director. Since the board is charged with oversight of the medical staff, such representation at the table made good sense. It was also common to find a retired doctor serving as a full board member—in most cases someone who had previously practiced locally and was well-regarded in the professional community.

In non-profit institutions, physician board participation has typically been limited by tax rules that require boards of such organizations to minimize the number of "insiders" serving in governance. "Insiders" are those whom the IRS sees as financially tied to the hospital (e.g., through direct employment, contracts for services, or use of the institution's facilities to generate income) and therefore motivated by their private economic interests. In past decades, the IRS provided a "safe harbor" from enforcement action if physicians (or other insiders) comprised no more than 20 percent of the governing board's voting membership. Thus, it was rare to see more than one or two doctors on the typical board of a non-profit hospital.

Until recently, hospitals and physicians had a sometimes contentious working relationship, which also limited many boards' willingness to include physicians. In the 1980s and 1990s, managed care frequently undermined formerly collegial relations between doctors and hospitals. In later decades, hospitals and doctors found themselves competing with one another as physician-owned surgical and diagnostic centers multiplied and hospitals moved more aggressively into ambulatory services. Boards often were not willing to let potentially competing physicians into their strategic planning sessions.

The healthcare environment has continued to evolve dramatically as the needs of doctors and hospitals have once again grown more symbiotic with the rise of physician employment. The shift toward value-based purchasing and heightened public concerns about quality and safety has required hospitals and doctors to increase their collaboration. Hospitals have moved into new territory with the assumption of financial risk through ACOs and clinically integrated networks (CINs). Healthcare organizations are challenged to engage in population health management and expand their footprint outside the traditional walls of their hospitals. To be successful in these changes, hospitals and physicians have needed to partner with greater synergy, forcing governing bodies to be more cognizant of the perspectives and needs of their practitioner communities.

Key Board Takeaways: Discussion Questions

Should there be more physicians serving as board members? If so:

- What is the right number or percentage of doctors?
- How should they be selected? What qualifications should they possess?
- Should they be voting or non-voting board members?
- Should they be *ex officio* members (e.g., Chief of Staff, CMO, VPMA, or President of the employed physician group)?

Should more physicians be standing guests at board meetings? If so, should they be:

- Medical staff officers?
- Physician executives?
- Representative of employed physician group?
- Physician representatives elected at large?

Should more physicians sit on board subcommittees? If so:

- Which committees (e.g., professional affairs, strategy, quality)?
- How many spots on these committees should be held for physicians?

What alternatives to board membership should be considered that can bring physicians and board members together? For example, should board members participate in a standing joint council that periodically brings together key physician stakeholders, senior management, and trustees/directors?

Should some board members attend medical staff assemblies or standing committee meetings to build social capital with physicians and inform board oversight of the medical staff?

Several other changes have pushed consideration of physician board membership into greater prominence. Enormous consolidation has taken place throughout the industry with ever-greater numbers of hospitals merging into multi-campus health systems. Where historical local hospital boards have been merged into a system governing body, the involvement of medical staff leaders has become more problematic. Furthermore, system board members are less likely to have regular contact with the physicians practicing in their facilities and risk becoming more remote and detached from the perspectives of the medical community. One result has been a push for more physician board members. This has been facilitated by the tax authority's more relaxed posture regarding the number of insiders on the board, which now states that at a minimum, a non-profit hospital or health system should ensure that a majority of voting members of the board are "independent community leaders" who have no personal economic stake in the hospital's strategic decision making; this has allowed more space to appoint physician board members than in the past.

The pressures of recent years have also caused many boards to become more rigorous in their own self-management. It is common for boards to create a grid of needed competencies to inform the selection of future board members or drive a needed expansion of board seats. In particular, the need to focus more on quality has driven many boards to bring more physicians into their deliberations.

Boards are anticipating growing problems with physician recruitment and retention, caused by the rise of physician employment by insurers, private equity groups, and large contract single-specialty companies, along with retiring baby boomers creating an acute shortage. At the same time, the retreat from a private practice model to employment has made many doctors more mobile and transient in their work commitments. An indicator of a health system's attractiveness as a good professional home may be whether it provides an adequate presence of physicians on the board.

Why Physicians on the Board?

Promotion of quality: Many boards struggle to improve quality and safety in their hospitals. While board members understand the importance of driving the quality agenda, they often feel they lack the expertise to set meaningful quality goals or to evaluate the effectiveness of the medical staff and management in meeting those goals. Physician board members, especially those with extra training in quality improvement and peer review, bring a critical dimension.

Promotion of hospital–physician alignment: Ongoing hospital success in a transforming healthcare environment will depend on strong physician integration and collaboration. Having physicians on the board can serve to reassure medical colleagues that physicians' interests will be addressed at the highest levels in the organization. This becomes increasingly important as doctors are asked to relinquish more of their historical autonomy and become part of integrated teams focused on the hospital's mission. Physician board members provide legitimacy to the board in the eyes of the medical community, and provide insight regarding which strategies for physician alignment and engagement are likely to succeed.

Insight into the institution's frontline challenges: Because physician board members are often practicing within the hospital, they become important sources of feedback regarding how the institution is functioning on the frontlines. This provides a source other than management to inform board members about issues such as workforce morale, adequacy of staffing and support services, patient perceptions of care, and more.

Expanding Physician Presence on the Governing Board

The case for adding physicians to the board is becoming increasingly compelling. Physicians are critical players in driving and sustaining any significant transformation in healthcare structures, processes, and results. The knowledge, insights, and support of doctors are critical to the effective redesign of healthcare delivery systems. Physician leadership in our healthcare institutions has grown exponentially as manifest in an increased number of physicians in executive roles (VPMA, CMO, CMIO, CQO, CCOO, etc.),[1] serving management roles in hospital-employed physician groups, acting as medical directors of hospital service lines, and providing governance to ACOs and CINs.

The upsides of physician boardroom participation are fairly clear. Doctors bring clinical knowledge and a sense of the direction medical science is leading the field; have insider insights into struggles on the frontlines; are acutely tuned to the concerns and complaints

1 These abbreviations respectively stand for Vice President of Medical Affairs, Chief Medical Officer, Chief Medical Informatics Officer, Chief Quality Officer, and Chief Clinical Operating Officer.

of patients; bring familiarity with tactics to improve the quality of care; can communicate the worries of the medical community; are especially helpful when performing medical staff oversight; and can foster engagement of their peers in the important strategic efforts undertaken at the institution.

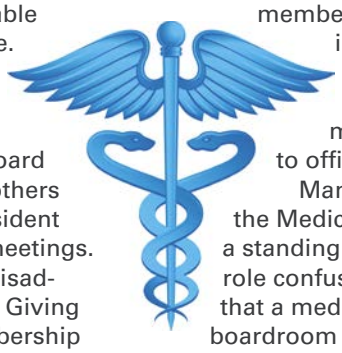
However, there are downsides to increased physician board presence. Physicians can be intimidating to lay board members who may be reticent to voice questions and opinions at variance with those of the medical experts in the room. Because physicians on the board are frequently still in practice, they tend to draw board discussion into the weeds where their personal concerns and experiences can be addressed. Adding physician spots on the board may push out opportunities for others or it may increase board size to a point beyond the ideal. Physicians often see their board service as representing the interests of the practitioner community and fail to understand their fiduciary role as a board member. Furthermore, adding physicians to the board can trigger concerns by the IRS that can jeopardize non-profit status.

Which Physicians Should Serve in Dedicated Board Seats?

Once a board has decided to add physicians to its membership, a key question is, "Which physicians?"

Medical Staff Officers on the Board

Historically it has been common to have the President of the Medical Staff (or equivalent) attend board meetings. However, there is considerable variation in how this is done. Some boards give these individuals full voting membership, while others choose to grant *ex officio* board status without a vote. Still others make the Medical Staff President a standing guest at board meetings. There are advantages and disadvantages to each approach. Giving a medical staff officer membership without a vote can bind that individual to the fiduciary responsibilities tied to governance but preserve more seats for additional insiders who might be desirable as board members. It can also allay the worries of some lay board members that physician self-interest might bias critical board decision making. However, denying the vote may appear as a diminution of status in the eyes of the medical community and undermine efforts to make physicians feel like true partners at the leadership table.



Giving the President status as a voting board member makes a statement that the input of clinicians is considered a priority, but it does have downsides. Since medical staff officers typically turn over after one or two years in office, their board membership is relatively fleeting. This means they rarely have the opportunity to build social capital and relationships of trust that enable a board to challenge itself with hard questions and decision making. Furthermore, serving as a full voting board member can create role confusion for an elected medical staff officer who may be torn between a fiduciary duty as a board member to put institutional interests first and his/her responsibility to advocate for the practitioner community that elected him/her to office.

Many boards choose to have the Medical Staff President serve as a standing guest. This eliminates the role confusion and everyone is clear that a medical staff officer sits in the boardroom to represent the voice of the physician community and advocate for practitioner interests. At the same time, it facilitates communication between the medical staff and the board, promotes transparency between these parties, and ensures physician concerns will be heard and considered in critical strategic planning and decision making.

Creating an *ex officio* position on the board for a medical staff leader is also problematic as more and more hospitals are folded into health systems with a common governing body. Systems with multiple medical staffs need to determine which medical staff officers should attend board meetings. It is neither practical nor wise to have every medical staff represented at the table once more than two or three hospitals comprise the system.

Other Physician Leaders as Board Members

In contemporary hospitals and health systems, it is common to have physician leaders beyond just those in elected medical staff positions. Boards sometimes look to these clinicians to bring valuable perspectives and expertise to their member ranks. The most common of these leaders are CMOs and Presidents of hospital-employed physician groups. The former is valuable because he or she brings both clinical and executive skills and often works with multiple medical staffs in a multi-hospital system. The latter may be valuable because as more and more physicians become hospital employees organized into a multidisciplinary group practice structure, the health system has a critical interest in the effective functioning of this entity.

Physician Board Members in Multi-Hospital Health Systems

In multi-hospital health systems, the issue sometimes arises whether each institution needs a physician seat at the system governing body. As already mentioned, this can be impractical when inviting chiefs of staff to attend

board meetings. In most cases, a system board is unlikely to have enough member seats dedicated to physicians to allow someone from each hospital medical community. When creating dedicated physician seats or expanding their number, it is important for the board to communicate that its selections to fill the spots will be based on needed competencies and not geography. In most cases it is inadvisable to let an expectation take hold that each hospital will have a physician "representative" on the system board.

Of course, physicians can be appointed to local or regional hospital boards if these have been maintained in the health system. This makes good sense when such subsidiary boards are carrying out tasks delegated from the system board (e.g., credentialing and privileging).

Competency-Based Selection of Physician Board Members

Once the board moves beyond *ex officio* spots for physicians, it should fill any additional physician seats as it does any other board vacancy. A best practice is for the board to create a grid of needed competencies and then see where deficits exist in the skill set of the current board complement. It is important to remember that medical school training alone does not provide doctors with the competencies for which they are often sought. For example, the typical clinician does not have expertise in quality improvement techniques, performance data management, population health, practitioner competency assessment, or other areas where the board members tend to turn to doctors for insight. The selection process for physician board members should be rigorous to ensure that the board's effectiveness will be enhanced by their addition. In the past it was common for a board to seek out a well-respected, newly retired practitioner to fill an empty board seat. Historic service in the community or high regard for clinical acumen are no longer sufficient attributes alone to justify a seat on most boards. Retired doctors may not be familiar with the challenges that physicians face today in their private offices or in their new settings as employed practitioners. Boards may be better served looking to the ranks of mid-career physicians who have sought out additional management training, had experience in administrative roles, and have demonstrated leadership capabilities. In selecting a physician board member, the board should communicate clearly that it is seeking specific abilities in the individual it chooses. This may help reduce potential political fallout in various physician constituencies who will be disappointed that their favored candidate was not selected.

Should Physician Board Members Be Sourced from Inside or Outside the Community?

Many boards add practicing community physicians to their membership. Such individuals can provide the board with the insights of someone actively negotiating the challenges of modern clinical practice and the perceptions of someone who regularly uses the services of the hospital. However, choosing which practicing physician should sit on the board can prove politically sensitive. Should such doctors only be chosen from the ranks of private practitioners? Given that most physicians in private practice are both collaborators *and* competitors with their local hospital, appointing one of their own can assure this group that the board wants "collaboration" to prevail.

Should new appointees to the board be drawn from the growing ranks of hospital-employed doctors? Some argue that such doctors can never serve objectively because their paychecks come from hospital management. On the other hand, excluding this group deprives the board of participation from a physician whose interests are fully aligned with the institution and whose input is not compromised by competing self-interest.

Should physician board members be drawn from influential large practices or from small or solo practices whose voices are less likely to reach the ears of board members? As hospitals focus increasingly on the outpatient setting, should physician board members be drawn from those who are hospital-based or from the expanding cadre of physicians whose professional activities are largely based outside the hospital's walls? While these are all relevant considerations, a board will be best served by looking to its needed competencies and selecting the physician who can best provide them.

When should a board consider going outside its community to seek board candidates? In some locales it may be difficult to find a physician with the desired competencies to fill an open board seat. Going outside the community lets the board seek out strong options from a national pool

of candidates. For example, the board might seek out a national expert in quality and patient safety or a respected physician executive with deep knowledge regarding the handling of professional affairs. Bringing external experts onto the board is a common practice in many corporate boardrooms outside of healthcare. However, there are some clear downsides to going this route. Such individuals may wish to participate virtually in board meetings to avoid extensive travel. This creates a board member who has less ability to build valuable relationships with board colleagues and fully participate in board discussions. An external or outside candidate may have less credibility with local physicians. In addition, it is sometimes necessary to pay these practitioners for their time and reimburse them for travel expenses. Large health systems may find the cost of an outside board member insignificant relative to the advantages. Smaller hospitals may find it an essential expense because the expertise their boards require is simply not available in their own communities. Of course, paying some board members for their time and not others can create its own problems. Many board members give extraordinary amounts of time and dedication to their institutions and would likely feel affronted by a decision to pay an outsider for their periodic appearances at board meetings.

As discussed further in this article, from wherever physician board members are drawn, issues arise relating to conflicts of interest, potential impact on tax-exempt status, and compliance with the many laws addressing healthcare fraud and abuse.

A board will be best served by looking to its needed competencies and selecting the physician who can best provide them.

Physician Participation on Board Subcommittees

Board subcommittees are often comprised of a mix of board members and non-board members. This provides an opportunity to involve more physicians in governance activities than a limited number of physician-designated board seats would otherwise permit. These committees also provide an important setting for physicians and board members to interact, communicate, and build working relationships. This familiarity in turn builds social capital and trust that can pay off when controversial issues raise friction between the board and the medical community.

Some subcommittees are better choices than others for physician participation. Obvious candidates are professional affairs committees (commonly focused on medical staff oversight including credentialing, peer review, and corrective actions) and quality and patient safety committees. When boards establish special or *ad hoc* committees to explore strategic options including possible affiliations or mergers, physician involvement should be robust.

Each board subcommittee chair must be sensitive to potential conflicts of interest that may involve physician members. It is also important for the chair to ensure that physicians do not dominate discussion. As clinicians whose livelihood is directly impacted by board work, doctors frequently attend these meetings with passion and strong predilections. These feelings should be harnessed constructively but need to be kept in perspective by lay members of the committee.

Legal, Financial, Regulatory, and Ethical Constraints to Physician Membership on the Board

Increasing physician participation in governance implicates a number of legal and tax issues with important ramifications for non-profit healthcare organizations. Serving on the board often puts these physicians in a position where they may contribute to decisions that have an impact on their own incomes or those of community physicians with whom they compete. Legal and tax issues that can arise include the following:

- Has the physician board member complied with fiduciary duties of loyalty and duty of care?
- Do the number of physicians on the board create a concern about "insider control" that could jeopardize the organization's tax-exempt status?
- Is there an issue of "private inurement" or "private benefit" that could jeopardize tax exemption or subject the organization or its physician leaders under the IRS's "intermediate sanctions" rules?
- Could an outside party claim that physician participation creates an

anti-competitive conspiracy in violation of federal or state antitrust rules?
- Is there a possibility that physician decision making at the governance level will implicate fraud and abuse statutes or regulations?

A complete discussion of these issues is beyond the scope of this article. Boards should always engage knowledgeable legal counsel when making decisions regarding physician participation in governance and whenever confronted with any of these issues.[2]

Fiduciary Duties of Physician Board Members

All members of a hospital board have fiduciary duties as members. Primary among these is the duty of loyalty, expressed in the Model Nonprofit Corporation Act[3] as: "A director shall discharge his or her duties as a director, including his or her duties as a member of a committee, in a manner the director reasonably believes to be in the best interest of the corporation."

This can be a challenging concept for new physician board members to embrace. Doctors frequently come to the board perceiving themselves as champions on behalf of the physician community. This is especially true if the physician sits on the board as an *ex officio* member because of a position he/she holds as an officer or leader of the hospital medical staff, ACO/CIN, or an employed physician group practice. The physician's fiduciary duty is to subordinate their personal interests *and* those of the group he/she represents to the interests of the hospital or health system.

This duty of loyalty has the potential to be compromised when a transaction being considered or undertaken by the board poses a real or potential conflict of interest for one or more physician board members. Examples include:
- Competition between the hospital and private medical practices or other ambulatory business ventures
- Physician compensation
- Medical staff membership and privileging concerns
- Physician recruitment and retention agreements
- Medical staff development planning
- Network and compensation arrangements with third-party payers

A conflict-of-interest transaction is defined by the Model Nonprofit Corporation Act as "a transaction with the corporation in which a director of the corporation has a direct or indirect interest." A board with diverse physician representatives in its makeup is more likely to find one or more of these members with a conflict on any number of the issues the governing body tackles. Of course, the mere presence of a conflict of interest does not violate the duty of loyalty. But directors with real or potential conflicts *must* disclose them and they and the board must then act carefully to ensure the transactions they undertake are fair and appropriate. Boards that have a significant number of physician members should be especially careful to adopt rigorous disclosure policies and educate all board members in the importance of compliance.

Another fiduciary issue that must be contemplated when boards add physician members is the duty of care. All board members are required to fulfill a duty of care to the organization by acting 1) in good faith; 2) in a manner he or she believes to be in the best interest of the corporation; and 3) with the care an ordinarily prudent person *in* a *like position* would exercise under similar circumstances.

In looking at this last requirement, courts may take into consideration the special background and qualifications of the individual director. The duty of care compels board members with special expertise or knowledge to use it on behalf of the organization. Therefore, a court might hold a physician board member to a higher standard of care than a lay board member when applying the duty of care to a transaction involving a medical matter. Furthermore, lay board members are entitled to rely more heavily on their board colleagues who possess specialized medical expertise when such knowledge is needed.

IRS and Tax-Exempt Considerations

How many physicians can sit on a hospital board?[4] This question is often asked as physicians push for greater representation in governance. The number is of concern because of long-standing worries by tax authorities regarding undue "insider" influence on the decision making of tax-exempt hospitals. Specifically, a non-profit hospital or health system will be unable to maintain its tax-exempt status if it is controlled by physicians or other "insiders" whom the IRS regards as being motivated by their own private economic interests. In decades past, the IRS provided a "safe harbor" from enforcement action if physicians comprised no more than 20 percent of the governing board's voting membership. However, in concert with the trend to place more physicians on hospital boards and with the growth of complicated integrated delivery systems, the IRS has taken a more relaxed approach in recent years. At a minimum, a non-profit hospital should ensure that a majority of voting members of the board are "independent community leaders" who have no personal economic stake in the hospital's strategic decision making. This requirement applies to corporate committees with board-delegated powers as well. Practicing physicians affiliated with a hospital, even if not directly employed, are not considered "independent" because of their "close and continuing connection with the hospital" at a professional level. It is important to note that the prohibition against insider control applies not only to physicians but also other hospital employees such as the CEO, CNO, or physician executives such as a VPMA or CMO. On the other hand, this concern might not exist where a physician from outside the community is brought in to provide the board with unique expertise.

2 This article has been written to provide general information and is not intended to provide specific legal advice on the matters covered. Readers are recommended to obtain competent legal counsel to fully explore the issues discussed in this publication.

3 The Model Nonprofit Corporation Act, Third Edition, was adopted by the American Bar Association in 1987 with a third edition released in 2008. More than half of the states have adopted it in whole or in part to govern non-profit corporations under state law.

4 ACO boards structured according to the CMS guidelines for the Medicare Shared Savings Program (MSSP) have different requirements regarding the number of physicians on the board. For more information, see, e.g., http://bit.ly/2xmTACq.

Case Example: Scripps Health

Scripps Health has undergone a dramatic transformation from a struggling health system losing $15 million a year in 1999 to a $2.9 billion enterprise (2.3 percent margin) in 2017. The health system has been named to Fortune's "100 Best Companies to Work For" 11 consecutive years.

Unlike many other non-profit health systems, Scripps has opted not to include physicians on its board. Its 16 members represent a variety of industries and eight members are retirees. Despite the lack of physician representation on the board, the importance of physician engagement in decision making is critical at Scripps.

Chris Van Gorder, President and CEO, credits much of Scripps' success during his tenure with the formation of a Physician Leadership Cabinet (PLC), which acts as an advisory committee to hospital leadership and the board. The PLC has significantly enhanced trust and collaboration between medical staff and administration. Physician leaders' voices are consistently heard and acted upon, as demonstrated by the fact that 100 percent of PLC recommendations have been adopted during the 18 years since the PLC's existence.

Physician leaders have also been elevated in the recent restructuring of health system operational leadership. Scripps eliminated the CEO position at each of its regional hospitals and has adopted an operational model by which each hospital is jointly led by a non-physician chief operations officer and a physician operations executive. The restructuring provides more balance to local leadership between administrators and medical staff and is also expected to reduce costs.

Many lawyers advise governing boards to limit "insiders" on the board, including physicians, to no more than 30–40 percent of the board's complement of voting members. They also recommend that in light of the IRS's rules against "private inurement" and "private benefit,"[5] a non-profit hospital should exclude from participation on any compensation committee, practicing physicians who receive (directly or indirectly) compensation from the organization for services as employees or as independent contractors.

Antitrust Concerns Relating to Physician Board Participation

Physicians serving on the board are in a position to undermine the business success of competitors on the medical staff. Decisions that can suggest anticompetitive behavior include (but are not limited to) determinations regarding medical staff membership and privileges; the opening or closing of specific clinical services; the selection of other physicians to serve on the board; and decisions about adverse actions or disciplinary measures against other medical staff members. In addition, access by a physician board member to competitively sensitive information about a competing physician can raise concern under antitrust laws. As a prudent practice, physician board members should recuse themselves from discussion and decision making that can give even the appearance of unlawful anticompetitive behavior.

Fraud and Abuse Statutes and Regulations

Hospital and health system decisions regarding physicians always have potential to run afoul of federal and state efforts to prevent fraud and abuse. Any payment to physician board members should be carefully reviewed by counsel to ensure that fraud and abuse laws are not implicated. A board with strong physician presence must always take care that physician preferences don't push the board into making decisions that could create liability under these laws. A further discussion of this topic is beyond the scope of this article, but resources for further information abound.

> Physician participation at the governance level can be increased by allowing more physicians to attend board meetings as invited standing guests and recognizing that they come to represent a specific constituency. This approach avoids problematic growth in board size, inadvisable numbers of insiders on the board, and role confusion on the part of doctors who attend board meetings.

Preparing Physicians for Board Service

Physicians face some unique challenges when they assume board roles. As already mentioned, they often become confused and conflicted around the tension between their fiduciary duty of loyalty and their desire to represent the hospital medical community. Doctors also tend to be hands on problem-solvers and lack a good understanding of the difference between governance and management. For this reason, they often want to get into the weeds rather

5 In addition to the general protections against insider control, non-profit hospitals also must take special precautions to avoid financial arrangements with physicians that could be regarded by the IRS as "private inurement" or "private benefit" (i.e., diverting tax-exempt funds for the enrichment of private individuals or entities). The IRS developed intermediate sanctions rules in 1996 to allow the IRS to penalize "insiders" who improperly benefit from dealings with 501(c)(3) or (c)(4) public charities (which includes most tax-exempt hospitals). These provisions impose sanctions on disqualified persons ("insiders") who receive benefit from the not-for-profit hospital that exceeds fair market value. Sanctions can also be applied to "organizational managers," such as board members, who knowingly approve such transactions. Physicians serving on a hospital board are generally considered "insiders" for purposes of intermediate sanctions rules. See Internal Revenue Code, Section 4958. Under the Code, intermediate sanctions may be used as an alternative to revocation of the tax-exempt status of an organization when private persons improperly benefit from transactions with the organization. The sanctions include paying back any "excess" payments that took place, plus stiff penalties.

than focus on larger strategic issues and institutional vision. Physicians are also typically self-confident and are sometimes hesitant to reveal their lack of knowledge about issues being discussed in the boardroom.

Physicians should be given a thorough orientation to board service just as any other new board member will receive. However, some customization may be warranted to address the concerns above. It can also be particularly helpful for new physician board members to be paired with an experienced member as a mentor. Regular discussion with a mentor can reinforce the messages communicated in orientation and provide the new physician with both feedback and a role model.

Alternatives to Increased Physician Board Membership

Placing a large number of physicians on the board of a hospital or health system is not the only tactic for strengthening trust and alignment with community doctors. Nor is it the only approach to make available to the board the expertise and insights of medical professionals. Hospitals and health systems across the nation utilize a variety of mechanisms for increasing their working relationships with their medical communities.

Physician Advisory Councils

One such approach is the use of an advisory body of physician leaders who meet periodically throughout the year with members of the board. Many hospital CEOs have done something similar by establishing their own "physician cabinets" to ensure effective communication with the medical staff. For the board, the advantage of such advisory bodies is the opportunity to include broad representation from the medical community, the avoidance of legal and regulatory complications, and the ability to keep the advisory council flexible and informal so its membership and functioning can be quickly adapted to any current crisis. Such bodies might meet quarterly with the board or more often if circumstances warrant. The message communicated to the medical community is that the board values its input and is interested in hearing firsthand about their concerns, without them first being filtered through intermediaries such as the hospital CEO. This structure also allows the board to hear from physicians other than the officers of the medical staff who traditionally report to the board on physician concerns. As noted above, the elected medical staff leader attending board meetings in any particular year may or may not be an effective communicator or someone who can represent the full diversity of views held by the medical community. Advisory councils allow for input from diverse physician perspectives and can ensure that the board hears from key physician stakeholders even when they are not holding leadership positions on the medical staff. Such councils also make it easier to include the voices of non-physician practitioners, a growing cohort of clinicians at most hospitals.

Physician Participation in Board Retreats

Another tactic for enhancing communication with doctors is to invite a significant number of formal and informal physician leaders to board retreats. This might be an annual or semi-annual event and it can be a topical retreat or simply an opportunity to foster intense dialogue about the directions in which the board is leading the hospital or health system. As with advisory councils, this approach enhances critical dialogue between the board and physicians and assures doctors that they have the attention of board members even if they do not hold large numbers of board seats. These retreats are also an occasion for building social capital between board members and doctors. If tensions have historically been high between doctors and hospital leadership, these retreats can be facilitated by an outside expert to take full advantage of this opportunity to break down barriers and find common ground for collaboration.

Conclusion

The primary reasons for including physicians in governance are: 1) having access to critical medical expertise for the purposes of quality and patient safety improvement and medical staff privileging and credentialing; and 2) to maintain and/or improve relations between the hospital/system and physicians. Whether the physicians are voting or non-voting board members, or engaged via an advisory council, boards must ensure that physicians contribute significantly to strategic-level and quality-related leadership decisions affecting patients and the community. There are many options, as discussed in this special section, that accomplish these goals while appropriately addressing conflicts of interest, representational issues, and other concerns. Boards that do not have sufficient engagement of physicians in governance are putting their organizations in a poorer position to meet today's increasingly high expectations of survival in a dynamic healthcare industry.

The Governance Institute thanks Todd Sagin, M.D., J.D., President and National Medical Director of Sagin Healthcare Consulting and Governance Institute Advisor, for contributing this article, and Brian J. Silverstein, M.D., Director, The Chartis Group, and Governance Institute Advisor, for contributing the case example on Scripps Health. Dr. Sagin can be reached at tsagin@saginhealthcare.com.

Leveraging Data to Achieve Economically Viable Population Health Management

By Yomi Ajao and Christopher Liu, COPE Health Solutions

Most healthcare organizations operate in pluralistic payment environments today, with significant portions of their revenue stemming from various arrangements along the payment spectrum—from fee-for-service (FFS) to shared savings, dual risk, capitation, and everything in between. The trend overall, however, is toward more risk-based payment models that are changing the relationships between payers and providers. CEOs and boards of hospitals and health systems, medical groups, and provider organizations of all types are grappling with the challenges stemming from the push toward value at the state and national level. As payers progressively delegate financial risk and accountability to providers, value-based payment models are incentivizing hospitals and health systems to develop population health management capabilities as a means for controlling costs and improving patient outcomes. Many of these organizations are just beginning to explore the world of downside risk and the management of attributed populations, whereas others are expanding their investments into existing population health management programs.

Organizations just getting engaged with or considering risk contracting arrangements and more advanced organizations alike are quickly realizing that the effective use of data plays an integral role in successful population health management. Many hospitals and health systems have access to troves of clinical and financial data, particularly through medical and pharmacy claims. Having a robust analytics strategy to understand in great depth the flow of dollars into and out of the hospital or health system is critical to reliably assess opportunities to enhance performance under current risk contract configurations. Through analytics, these organizations can better track the health of their members and impact the overall cost of care. In doing so, they can assess the historical and projected costs of the population, the financial impact of initiatives, and the viability of ongoing and prospective risk contracts.

How to Use Data to Enhance Population Health Efforts

When assessing performance in a value-based payment arrangement, organizations should adapt various key performance and quality indicators (KPIs) into their reporting systems. Traditionally, hospitals have relied on volume-based metrics to gauge performance. Metrics such as admission counts, patient days, and total discharges are effective in a FFS model but fail to address what matters most in a risk-based environment: the overall health of the provider's population. Rather, global per member cost and utilization metrics are key to better controlling and managing overall cost and quality and are used to measure the performance of specific populations. For example, measuring inpatient admits per 1,000 allows organizations to depict overall health and total costs while simultaneously identifying population health issues that require attention.

Organizations can further enhance their population health programs through meaningful segmentation of their members into populations and sub-populations—by disease state, geography, demographic, payer, network, etc. This allows for increased accountability, identification of inefficiencies, and realignment of resources across the organization. By aggregating clinical data into distinguishable segments, operational leaders can begin to identify opportunities to enhance services provided.

An example of this segmentation is the identification of diagnoses that are contributing to the highest costs within their population. For example, a health system may find that it spends a significant amount on knee replacements for its members. Typically knee replacements for patients without major chronic conditions can be done at an outpatient surgical center at a much lower cost than in an inpatient setting. Shifting these surgeries away from the hospital setting can not only reduce total annual per member costs, but lower the risk of hospital-acquired conditions and increase patient satisfaction. In addition to high-cost diagnoses, the organization may look to review its pharmacy and drug utilization. By analyzing pharmacy claims, it can assess appropriate use of generics, prescriber adherence to formulary drugs, and over and underutilization of specific drugs.

Additionally, through claims data, hospitals and health systems can identify how often their members are utilizing services outside of the organization's network of providers—often a large contributor adding to the total cost of care. Drilling down to the physician/practitioner level allows for referral patterns to be analyzed, and lays the groundwork for downstream

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Key Board Takeaways

For healthcare organizations on or starting down the path to embracing value-based care delivery models, the board should:

- Ensure that the principles of population health management are reflected in the organization's mission and purpose.
- Assess the organization's population health management strategy and make sure that executive leaders are well positioned to manage risk.
- Incorporate population health management and data into governance and organizational decision making.
- Prioritize investments in data analytics, supporting IT infrastructure, and continued education.

To best utilize data, healthcare organizations should:

- ✔ Adapt various KPIs into their reporting systems.
- ✔ Aggregate clinical data into distinguishable segments.
- ✔ Identify how often members are utilizing services outside of the organization's network of providers and investigate why this is occurring.
- ✔ Employ data to pinpoint opportunities to increase revenue through premium enhancement and member management.
- ✔ Use data to set targeted benchmarks for organizational performance.

Creating a Successful Post-Acute Care Strategy…

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When working with these partners, our community health workers and patient navigators focus on addressing the social determinants of health for recently discharged patients. Interventions regularly include arranging for meals, transportation, medications, follow-up primary care physician appointments, and providing telemonitoring equipment in patients' homes. Care coordinators follow up with every discharged patient, addressing any needs that may have arisen. Care coordinators also are located in physician offices to assist patients with avoiding unnecessary readmissions. Teams of staff make an effort to see patients in locations close to where they live, including churches, community centers, shelters, and even municipal buildings. These teams arrange for follow-up appointments or find a primary care practitioner if the patient does not have one. Providing transportation for some of the most medically challenging patients has proven effective, with a direct correlation to reduced readmissions.

With the help of our partners, WMHS also has created seven community gardens throughout our service area to feed victims of food insecurity. In addition to the community garden plots, the health system maintains several plots and donates the harvest to the local food bank. Fruit trees encircle some gardens, providing fresh fruit to anyone who maintains a plot.

The goal of our post-acute care strategy is to provide patients with optimal care and for them to remain healthy upon returning to the community. We have learned that patient-centered care must be personalized, intensive, and involve one-on-one creative engagement. Nothing is "off the table," whether it be arranging for a follow-up appointment with a primary care physician, obtaining medications, providing healthy meals, arranging for transportation for one of our many patients in rural locations, or setting up remote monitoring in the home.

Partnerships Key to Post-Acute Strategy

Partnerships with key providers continue to be the most essential component of our post-acute care strategy. Our results reflect improved patient care and success: We have reduced admissions by 27 percent since 2011, readmissions by 26 percent, and ED visits by 15 percent. Each improvement is directly tied to our comprehensive post-acute care strategy.

The Governance Institute thanks Barry P. Ronan, FACHE, President and CEO of Western Maryland Health System, in Cumberland, MD, for contributing this article. He can be reached at bronan@wmhs.com.

Leveraging Data…

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investigations to identify specific causes. For example, an organization may discover that a high percentage of outpatient cardiology diagnostic tests are referred to out-of-network specialists. In some cases, this may simply be due to the referrer not being aware of in-network resources or the financial impact of sending members out-of-network. In these and similar cases, physician education can be a boon for hospitals and health systems trying to reduce unnecessary out-of-network utilization.

In addition to reducing the overall cost of care, organizations can employ data to identify opportunities to increase revenue through premium enhancement and member management. Member risk scores are large drivers of premiums—organizations managing higher risk members demand higher rates from payers. When investigating its population, an organization may find that it receives disparate risk scores for members belonging to populations that overlap or are fairly similar. Rather than differences in acuity, this discrepancy may in fact be due to gaps in coding across members. Through analyses of the population and claims, the organization can identify and fill those gaps so that member acuity is more accurately reflected in the data. Furthermore, by undertaking regular review of member data, the organization can ensure that members are properly aligned to appropriate insurance products and ensure proper re-enrollment at the end of each cycle. For example, the organization may identify members above age 65 who are enrolled in Medicaid but not in Medicare. Getting these members properly enrolled in Medicare can often generate significant premium increases for the organization.

Claims data analysis can also contribute to an organization's performance improvement and quality processes. By diving into specific areas of operations, organizations can set targeted benchmarks for performance. Decision-support tools such as dashboards provide leaders with quick insight to their areas of focus. They allow for leaders to track KPIs over time as well a present an illustrative snapshot of their organization in real time. Setting target benchmarks can be done through both internal and peer-based performance.

Succeeding in today's pluralistic payment environment requires that hospitals and health systems be able to nimbly navigate the myriad of upside and downside risk arrangements, especially for those moving a significant portion of their book of business into dual-risk and capitation arrangements. Boards must engage in discussions to ensure proper alignment of mission and purpose to population health management strategies. Organizations that have invested wisely in their data capabilities will be well positioned to take on the challenges of population health management and downside risk contracts, enabling them to fulfill their community healthcare responsibilities and position themselves for long-term financial success.

The Governance Institute thanks Yomi Ajao, Vice President, and Christopher Liu, Senior Consultant, at COPE Health Solutions for contributing this article. They can be reached at yajao@copehealthsolutions.com and cliu@copehealthsolutions.com.

Integrating the Patient Voice into Board Processes…

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equate to dissatisfaction with their profession and turnover, reputational impact in the community, and ultimately lost dollars.

- Are we focused on increasing performance, building loyalty, or both? Similar appearing metrics can provide a very different focus. A Net Promoter Score or "would you recommend" question provides information about loyalty. How individuals rate a specific facility or provider focuses on performance. The metric must align with the strategy.
- How recent is the data? If the organization relies on mail surveying to obtain patient experience data, competitors are using next-day information. Decision making from stale data hinders being nimble and responsive to patient preference for direction setting.

Action 3: Know When the Board Is Wading Too Deep

While the board needs to understand the patient voice, caution must also be taken to avoid getting too far into the details. Having a clear governance charter helps mitigate operational decision making by handing items to leadership while still holding them accountable for outcomes.

Since directors are selected based on specific areas of expertise or community standing, the board composition may not fully represent the entire population being served. Boards need to use discretion and judgement about their involvement and when the patient voice needs to be the appropriate source for decision making.

Action 4: Act with Urgency

Whether one believes healthcare's needed changes will come by internal influences or external forces, when Millennials become CEOs, they will demand it as the largest generational cohort having grown up with technology. The entire healthcare model is redefined when individuals can Skype with a provider based on reputation and brand anywhere in the country for a low flat-fee or have a medical diagnosis provided via their phone. Without changing the system to be more patient-responsive and adaptive, Millennials will redesign healthcare in a way that fits their own preferences.

Getting to an efficient healthcare system means understanding how patients want to engage with the organization and creating pathways where they can be a co-designer and participant. The patient views and preferences need to be represented at all levels in the organization when making decisions that impact them. Perhaps the best question to ask is: If all the work being done within the walls is about the patient, why wouldn't you want their voice heard at the highest level possible?

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Establishing Strong Governance Structures…

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back from the politics and emotions affiliated with the legacy organizations and their histories. The key is to look at the potential of the *future* organization, and what it will mean in terms of improving and strengthening healthcare for generations to come. Differences between two organizations likely are not so significant that they warrant drawing a line in the sand and terminating that potential.

To be successful, the leaders from one or both partnering entities must be willing to make concessions. For example, perhaps the leaders of the previously mentioned $5 billion organization agree to 50-50 governance, even if they continue to disagree with the other party on the weight of the health plan. While such decisions may be difficult, they are worthwhile if they help solidify the partnership and enable both organizations to move forward with building a better, combined health system.

The governance success of similarly sized merging entities really relies on building on the past with a firm focus on the future. Leaders should thoroughly assess cultural commonalities between the two partners, and the strengths that each bring to the new health system board. They should clearly define the mission and governance goals of the new organization, and determine how best to achieve those by leveraging and expanding existing strengths.

For instance, one health system's existing board may have strong clinician representation, while the other's board may have strong representation of progressive business leaders. Both are valuable characteristics, and should be integrated into the structure and processes of the new board of directors.

Mergers of like-sized organizations can be some of the most difficult partnerships to execute. Healthcare leaders involved in similar negotiations should remember that establishing a new organization is an opportunity for a fresh start. The key is focusing on building optimal governance for the future organization.

Hotly debated issues now—such as board leadership and board representation—often become moot within a matter of a few years, as the new organization becomes increasingly integrated and legacy leaders are replaced or evolve over time to a mindset focused on one common mission for the new, combined organization.

The Governance Institute thanks Mark E. Grube, Managing Director and National Strategy Leader, Kaufman, Hall & Associates, LLC, and Governance Institute Advisor, for contributing this article. He can be reached at mgrube@kaufmanhall.com.

Establishing Strong Governance Structures for Mergers of Equals

By Mark Grube, Kaufman, Hall & Associates, LLC

Healthcare is experiencing a rise in partnerships among larger hospitals and health systems that are coming together in "mergers of equals" to strengthen their positioning in the face of rapid industry disruption.

Organizations seeking such partnerships share common goals of building economies of scale, ensuring financial stability and strategic flexibility, and establishing a framework for organizational transformation and innovation. An effective merger, however, requires effective leadership—and mergers of equals pose a unique set of challenges when it comes to combining board governance.

Many of these challenges center on the fact that the term "mergers of equals" is a misnomer. Each organization is unique, with its own history and set of strengths and weaknesses. Whether it is a discrepancy in revenue, EBITDA margin, market share, or some other factor, no two organizations truly qualify as "equal."

Healthcare leaders considering partnerships with like-sized organizations should come to terms with this fact, and take the long view—focusing on how the combined organization could benefit the communities served over time. As unique entities, legacy organizations often include deeply entrenched governance structures, cultures, and traditions that can make decisions such as identifying the new board chair particularly difficult. Overcoming these challenges requires creativity, collaboration, and in many cases, concessions.

Merging organizations should approach decisions related to the design of their boards with a clean slate. They should not be tethered to the legacy structures of the partnering organizations, but rather focused on creating the optimal governance structure for the new organization.

A New Approach to Governance

The number of large-system transactions—involving organizations with annual revenues of $1 billion or more—fluctuated between five to six announced deals between 2011 and 2016, and jumped to a high of eight in 2017. Three such transactions were announced in the first half of 2018.[1]

These mergers are creating a whole new level of scale in healthcare. The joining of Catholic Health Initiatives (CHI) and Dignity Health, for example, will create the nation's largest health system, with combined revenues of $28 billion, and 140 hospitals and more than 700 care sites spanning 28 states.[2] The April 2018 merger of Advocate Health Care and Aurora Health Care brought together two systems with about $11 billion in combined annual revenue and 27 hospitals serving approximately three million patients per year.[3]

Several of these recent partnerships have taken a 50-50 approach to governance. The joint board for Advocate Aurora Health, for example, includes an equal number of directors from Advocate and Aurora,[4] and the new governing board for the combined Dignity Health and CHI will include six members from each legacy board and both organizations' chief executive officers.[5] For the merger of Bon Secours Health System and Mercy Health—which is expected to close this fall—Bon Secours' current board chairman will lead the new board while Mercy Health's board chair will be vice chair.[6]

Yet reaching agreement on equal governance is rarely easy. Historically, most hospital and health system mergers have involved the integration of smaller entities into larger organizations. Structural governance changes were minimal, as the smaller entity came under the umbrella of the larger organization's existing board.

With mergers of similarly sized organizations, however, both entities have significant scale and resources, and well-established legacy governance structures. In many cases, leaders from one or both organizations have a somewhat biased view of the strengths that their hospital or health system bring to the table. Disagreements over the appropriate distribution of governance responsibilities often arise as a result.

For example, leaders from a $5 billion organization may argue for a 60-40 split in governance in its partnership with a $3 billion organization, but leaders from the $3 billion organization may press for 50-50 representation, arguing the value of its established health plan. Similar debates have scuttled numerous deals, even those with the strongest business cases.

Focusing on the Future

Healthcare leaders who find themselves in similar situations should try to step

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Key Board Takeaways

Mergers of equals are creating a new level of scale in healthcare as large, multi-billion-dollar health systems partner, posing unique challenges in combining board governance structures. Keys to overcoming these challenges include:

- Approach governance design with a clean slate.
- Build on existing strengths with a firm future focus.
- Weigh debates over equal board representation against the long-term potential of the future organization.
- Avoid drawing lines in the sand over disputes about organizational merits that have the potential to disproportionately negatively affect the outcome of an otherwise promising deal.

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2 Dignity Health, "Dignity Health and Catholic Health Initiatives to Combine to Form New Catholic Health System Focused on Creating Healthier Communities" (press release), December 7, 2017.
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4 Guy Boulton, "Aurora Health Care and Advocate Health Care to Merge," *Milwaukee Journal Sentinel*, December 4, 2017.
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6 Philip Betbeze, "Bon Secours, Mercy Pick Post-Merger Name, CEO," *HealthLeaders*, July 23, 2018.