BoardRoom Press

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The Power of One Idea

21st-Century Skills for Accountable Healthcare Boards

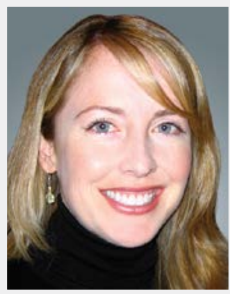
SPECIAL SECTION

The Board's Role in Capital Resource Allocation

Leading for High Reliability

ADVISORS' CORNER

Healthcare Service Lines: A Potent Resource to Promote Physician Engagement



What's Your Resolution?

As we kick off a new year and close the book on the previous year's extraordinary challenges, let's dig into our work and embrace it head on. Indeed, that is the primary human coping mechanism—staying busy—right? Articles in this issue focus on several topics important to boards in the new year and follow along the lines of our new education agenda for this year. Our lead article embraces the power of ideas from everyone throughout the organization, no matter who they are or what their position is, in order to filter out the best ideas to implement to create true transformation.

Within that backdrop, I find that we are still talking about many of the same things in our industry as we were five or more years ago, despite our claims that healthcare is amidst rapid transformation. We are still preparing for population health; still trying to learn what needs to be changed in order to take on bundled payments or two-sided risk. We are still new to the idea of tackling social determinants of health and other issues related to our whole-person well-being that affect healthcare costs but aren't within the typical clinical purview. We are still working in a dual value/fee-for-service world and moving very slowly (most of us!) in expanding our value-based contracts. I challenge all of you to make 2019 a year of rapid transformation. What would happen if we all made the goal of having 50 percent value-based contracts before the end of the year? If all of our patients were treated the same way, regardless of what "contract" they fall under? What would happen if we scrapped the chargemaster all together, stopped cost-shifting, and demonstrated true price transparency? We at The Governance Institute plan to be there with you along every step of the way. Let's make this year a game-changer.

Kathryn C. Peisert, *Managing Editor*

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The Jefferson Hotel
Richmond, Virginia
April 1–2, 2019

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Fairmont Scottsdale Princess
Scottsdale, Arizona
April 14–17, 2019

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The Power of One Idea

By Michael O. Ugwueke, D.H.A., FACHE, Methodist Le Bonheur Healthcare

Key Board Takeaways

It is important that hospital and health system boards be knowledgeable in evaluating strategic systemwide initiatives to ensure management accountability and outcomes. Following are ways in which the board can participate:

- Ensure that ideas have been fully financially and operationally vetted by management.
- Be alert to opportunities to implement ideas from a systems perspective, expanding beyond a departmental or facility solution to apply a concept across the entire organization.
- Ensure ideas remain consistent with the organization's mission, vision, and values.
- Demonstrate that the boardroom values innovation and remain open to challenging the status quo with new approaches that can yield significant benefits.

Methodist Le Bonheur Healthcare is a Memphis, Tennessee-based integrated healthcare delivery system with six hospitals and a full array of outpatient services. It employs more than 12,000 associates and has 2,000 affiliated physicians. When it comes to innovation, leaders look to this talent pool for fresh ideas that could support the continued success of this $2.6 billion organization. In their view, if each person were to offer one suggestion for improvement, there would be 14,000 ideas just waiting to be tapped.

Michael O. Ugwueke, D.H.A., FACHE
President and CEO
Methodist Le Bonheur Healthcare

Although some may consider the thought of evaluating 14,000 ideas impractical, our well-defined mission, culture, and values, which guide our daily work, embrace the power of ideas. As such, the key tenet of our culture is grounded in what we have defined as "The Power of One": a belief that each of our associates has the power to make a difference in the care and service we provide our patients and their families. This concept goes back more than 100 years, when the actions of one individual led to the formation of our organization.

In building on our Power of One culture, the MLH board approved creation of The Power of One Idea program. It is a Web-based, system-wide initiative that encourages associates to generate feasible ideas for reducing operational costs and increasing revenue while improving patient safety, quality of care, and service excellence. Both system leadership and the board preferred this approach of removing waste and instilling a discipline of cost efficiency to cutting costs through reductions in workforce or valuable programs. Regular updates on The Power of One Idea program are provided bimonthly to the board and to the finance committee of the board.

Grounded in our values of innovation and personal accountability, the initiative's objectives are to increase associates' engagement and understanding of cost-savings opportunities in their work areas, recognize and encourage innovative practices, and realize significant operational savings through increased efficiencies.

Here's how the program works: Associates enter their ideas online into The Power of One Idea Web site. Each idea is then evaluated through an approval process that includes managers whose departments or units would be affected by the proposed change. All ideas are examined thoroughly, and detailed process changes are suggested, where appropriate. Additionally, a team projects the potential return on investment. Lastly, each facility's CFO validates the estimated savings before giving it final approval.

Upon initial submission to The Power of One Idea program portal, a site coordinator is assigned to serve as an internal consultant to the ideas team and to connect the team with appropriate subject matter experts. Thus, the importance of resource specialists to whom the team can turn with questions cannot be overemphasized. In addition, a team coordinator keeps the idea moving forward. Based on submissions to date, resource specialists from finance and purchasing have been most consistently involved in scoping and implementing the approved suggestions.

The coordination of multiple departments in gathering all required information and preliminary department-level approvals was initially time-consuming but has been easily manageable without hiring additional staff. With this work, the health system has taken a strong step toward "systemness" by standardizing process improvement across six different hospitals and has nurtured an innovation mindset.

The Power of One Idea program has now become a standing update for each bimonthly board report by the CEO. Further, the board has formed a new *ad hoc* body—the strategic collaboration committee—specifically to discuss new opportunities and initiatives for consideration. Ideas with systemwide implications or significant opportunity will be reviewed with that committee as part of the approval process.

Establishing the Idea Structure

Instead of creating a new position to support the ideas program, the process improvement manager in the office of performance improvement and innovation oversees the initiative. The program director's primary responsibilities are to raise awareness of the initiative, identify site coordinators, and assist in moving the ideas through stages of development and approval. By using a Web-based, on-demand software solution, start-up costs were minimal, and very little administrative oversight has been required to ensure operability of the site.

The program is self-funded, with savings in operational costs covering all program expenses. For each idea implemented, 10 percent of first-year annual savings are returned to associates who submit ideas in the form of a cash incentive. The remaining 90 percent goes to the health system. After the first year, all savings from the idea go directly back to Methodist Le Bonheur Healthcare. The board has been especially supportive of allowing associates to share in the financial benefits they have identified.

Achieving Early Wins

Soon after the program began, several ideas hit home runs, including one for

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21st-Century Skills for Accountable Healthcare Boards

By Jon Burroughs, M.D., M.B.A., FACHE, FAAPL, The Burroughs Healthcare Consulting Network, Inc.

The healthcare industry is going through a revolutionary change as it digitizes, standardizes, commoditizes, and globalizes. Routine healthcare services now increasingly may be found on an iPhone or Android, medical staffs and management teams are standardizing practices to narrow clinical and managerial variation, everyone is seeking more efficient cost-effective approaches, and competition for value-based healthcare services is increasingly global in scope.

Thus, the governance of healthcare organizations requires equally significant change if governing bodies are to maintain their relevance and effectiveness. This article looks at the changes governing boards are experiencing through this period of unprecedent transformation and how they will need to adapt to be effective and relevant.

Practicing Accountable Governance

Below are 10 steps boards can take to be better prepared to tackle the changes their hospitals and health systems are facing:

1. **Effective governance must become accountable governance.** As the healthcare industry is increasingly paid based upon defined clinical and business outcomes, the board must be increasingly held accountable for business and clinical outcomes that meet community, payer, legal/regulatory, and contractual expectations. A culture of meritocracy must replace tolerance and enablement as only those healthcare organizations that aspire to top-decile performance are likely to succeed and flourish in the new millennium.
2. **Conflicts of interest that potentially undermine the integrity of governance decisions must be identified and eliminated.** Boards no longer have the luxury to place the interests of individuals over the success of the organization. The fiduciary duty of loyalty requires that governance be aligned with the interests of the community and its stakeholders and conflicts of interest that undermine this duty should be identified and eliminated. There is nothing wrong with fair market value business relationships that are mutually beneficial to the organization and individuals; however, board membership is no longer the appropriate venue to conduct and execute such agreements as it often leads to the slippery slope of inurement and the loss of public confidence in the integrity of the board's oversight responsibilities.
3. **The board chair, executive committee, or other individuals may not be permitted to act on behalf of the board without the full consent of the board.** Neither the board chair nor individual members of the board have legal standing to make decisions or to take any action on behalf of the full board without the board's advice and consent. Some executive committees do have authority to act on certain matters between board meetings, but this practice is diminishing in frequency and scope. Clear expectations must be set in the corporate bylaws and relevant policies to ensure compliance. Revisit executive committee authority to ensure that it does not overstep the board's ability to practice accountable governance.
4. **Board membership is based upon predefined competence and not demographics.** The increased expectation of governing bodies requires that board members be chosen based upon predefined and diverse competencies such as finance, quality, safety, service, marketing, legal, operations, strategy, and accounting to name a few. Members should be chosen based on commitment and what each member can add to the board as a whole, so that the effectiveness of governance transcends the sum of its parts. When predefined competence cannot be achieved locally, some boards recruit respected experts from outside their region to ensure that the board maintains the right skills in its oversight obligations and ability to execute on strategy.
5. **The interests of the organization must transcend the interests of the CEO and the medical staff.** Similarly, higher expectations for both clinical and business outcomes must transcend personal loyalty to individual executives or physicians. Too often, healthcare organizations languish because of loyalty that inadvertently undermines the board's higher fiduciary obligations. If individuals cannot effectively contribute to the success of the organization, then relationships must yield to the board's responsibility to ensure committed outcomes that will ensure the ability of the organization to survive in an increasingly competitive global environment.
6. **Quality, safety, and service must transcend finance even as financial health and growth is sustained.** It is known that services drive quality and quality drives financial performance. Thus, the board's primary responsibility should be to ensure clinical outcomes that drive financial performance. This is not to say that the financial success of the organization is not essential; it merely reflects the hierarchical relationship between clinical and business outcomes and the values that the community and stakeholders expect the board to adopt and champion.
7. **Decisions of the board should be increasingly driven by clinical/business data and analytics with strict adherence to proper benchmarks.** Clinical and business analytics and decision tools now enable healthcare organizations to oversee

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Key Board Takeaways

As boards work to become accountable governing bodies, they should consider the following questions:

- How is the board currently held accountable for business and clinical outcomes?
- Are conflicts of interest properly identified and eliminated, or does this process need to be revamped?
- What additional competencies does the board need to effectively govern the organization?
- How does the board use clinical/business data and analytics to make decisions?
- Does the board perform rigorous board and individual self-assessments on a yearly basis?
- What does the board do to continually raise the bar?

The Board's Role in Capital Resource Allocation

By Jason H. Sussman, Kaufman, Hall & Associates, LLC

High-performing organizations typically have clear delineation and balance between governance and management responsibilities and accountabilities, thereby enabling both parties to focus on the challenging work at hand in the rapidly changing healthcare environment.

For more than a decade, board members of hospitals and health systems nationwide have consistently placed "financial oversight" at the top of the list of board fiduciary duties and core responsibilities (see **Exhibit 1**). More than 96 percent of board members surveyed in The Governance Institute's Biennial Survey of Hospitals and Healthcare Systems cite within this duty adoption of four recommended financial oversight practices related to capital allocation and management at the organization:

1. The board approves the organization's strategic capital and financial plans.
2. The board reviews information at least quarterly as to the organization's financial performance against the approved plans.
3. The board demands corrective actions in response to under-performance on capital and financial plans.
4. The board requires that the organization's strategic and financial plans be aligned.

Despite clarity provided by use of the words *the board approves* in #1 above, the delineation of responsibilities related to capital decision making often remains murky, misunderstood, or misapplied. This introduces significant risk to the organization given the fact that long-term success in the current dynamic environment depends highly on the quality of today's investment decisions.

Overseer or Decision Maker?

The Governance Institute and Kaufman Hall hold that the capital allocation and management process is a *management* responsibility. The optimal role of the board should be to provide appropriate *oversight* of the process, rather than directly evaluating specific allocation options and making related spending decisions. (See sidebar "The Board's Role in Capital Allocation and Management" for more information on The Governance Institute's position.)

Board oversight of the capital allocation and management process should occur at numerous points as the process intersects with the organization's strategic-financial planning process, as illustrated in **Exhibit 2** on the next page.

But what are these points, and what should a board be looking for at each juncture? What questions should the board ask its management team to ensure that capital allocation and management is fully integrated with the overall planning process, and thereby yielding the best decisions?

Board oversight of management decisions related to capital allocation should begin with quantification of the amount of cash flow available for capital spending, and end with review of the projected performance of approved capital spending plans. This article provides a description of the eight oversight points and the questions[1] boards should be raising at each stage.

Key Board Takeaways

The board's primary responsibility is to ensure alignment of the capital allocation and management process to the long-range strategic, financial, and related operating plans. The board should understand that the capital allocation and management process is a *management* responsibility. The optimal role of the board should be to provide appropriate *oversight* by asking management important questions as the process intersects at various points with the organization's strategic-financial planning process. The board should:

- Ensure that management allocates capital as part of a *single batch* process, viewing capital as a portfolio of investments, whether it is destined for new digital ventures or other traditional types of capital-based initiatives.
- Be alert to, and work to eliminate, management tolerance of "end-arounds" (i.e., project evaluation and spending approvals that occur *outside* of the structured process).
- Ensure that large projects, particularly those with associated debt, divestitures of material assets, and creation of a new corporation or joint venture, require board approval before they are initiated based on business-case revalidation.
- Have and foster an understanding that not all projects for which capital is allocated will be successful. As such, all individual project proposals should incorporate exit strategies.

Exhibit 1. Overall Performance Ranked by Average Score

Duties/Responsibilities	2003	2005	2007	2009	2011	2013	2015*
Financial Oversight	1	1	1	1	1	1	1
Duty of Care	2	2	2	2	2	2	2
Duty of Loyalty	3	3	3	3	3	3	3
Quality Oversight	6	6	5	6	4	5	4
Duty of Obedience	7	4	6	5	5	4	5
Management Oversight	5	5	4	4	6	6	6
Strategic Direction	4	7	7	7	7	7	7
Community Benefit & Advocacy	9	9	9	9	8	8	8
Board Development	8	8	8	8	9	9	9

*Most recent year data is available.

Source: The Governance Institute's Biennial Surveys of Hospitals and Healthcare Systems, San Diego, California, 2003–2015.

1 The repetition of questions across multiple sections purposefully guides board members to critical areas of focus related to evaluation of management's decision-making process.

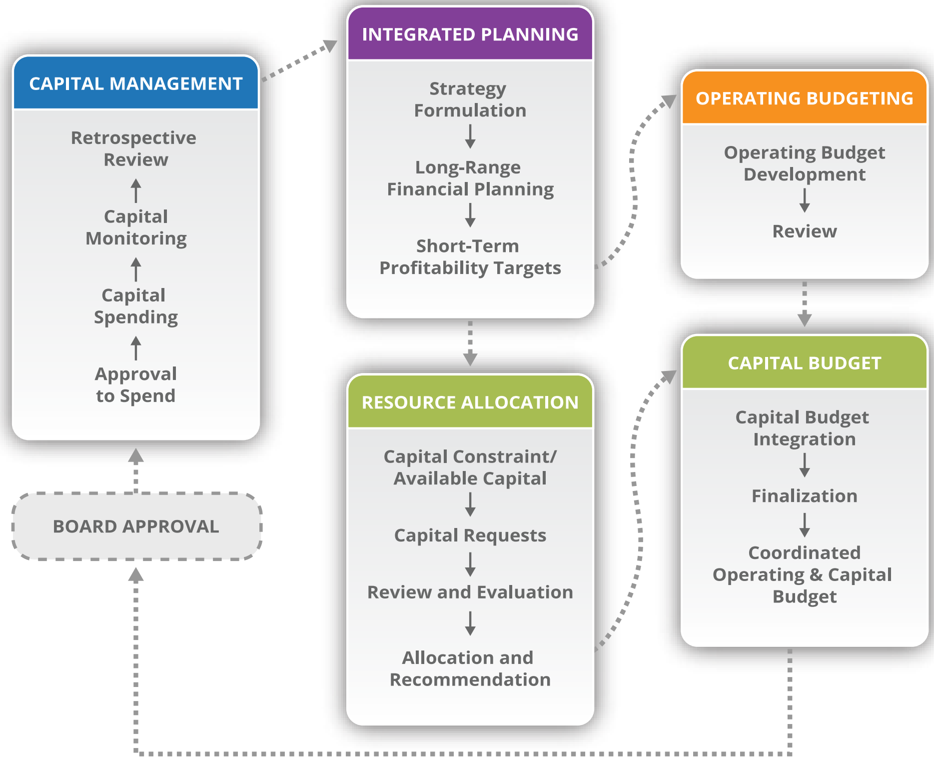
The Board's Role in Capital Allocation and Management

Whether local or system-wide, boards have fiduciary responsibility to protect and enhance their organizations' financial resources. They must provide oversight that ensures that these resources are used for legitimate purposes and in legitimate ways. The Governance Institute has identified specific practices that are part of a board's core strategic and financial responsibilities. Practices that affect capital allocation and management include the following:

- Articulating a vision and mission for the organization
- Overseeing organizational strategy and strategic planning, which involves review, approval, and monitoring of progress toward specified goals
- Ensuring alignment and integration of all plans (financial, capital, operational, quality improvement, and more) with the organization's overall strategic plan/direction
- Establishing key financial objectives that relate to goals and mission
- Overseeing the thorough and timely development and implementation of capital and operating budgets so that resources are allocated and managed effectively across competing uses
- Ensuring levels of financial performance that support strategic investment and meet established credit goals
- Approving the organization's capital and financial plans and reviewing information on the organization's performance against those plans
- Ensuring prudent investment of excess funds and access to debt and other capital sources

Sources: Kathryn C. Peisert, *Governing the Value Journey: A Profile of Structure, Culture, and Practices of Boards in Transition,* The Governance Institute's 2013 Biennial Survey of Hospitals and Healthcare Systems; and Kathryn C. Peisert, *21st-Century Care Delivery: Governing in the New Healthcare Industry,* The Governance Institute's 2015 Biennial Survey of Hospitals and Healthcare Systems.

Exhibit 2. The Integrated Planning Process



Source: Kaufman, Hall & Associates, LLC

Oversight Point 1: Definition of the Capital Constraint

The *capital constraint* defines the cash flow an organization can afford to spend on capital. It represents net cash flow available for project and annual capital spending in the context of a multi-year period, typically three to five years, as defined by the organization's strategic financial plan. In defining the capital constraint, management should answer the question:

- What amount of capital capacity, generated both by internal operations and through external sources, will be available to support the organization's growth and development over the defined period of time?

The capital constraint calculation should account for all sources and uses of cash (see **Exhibit 3** on the next page). The formula adds all sources of cash on the left side of the graphic, and then subtracts all uses of cash on the right side of the graphic, to determine *total cash available for capital spending.* Contingencies are subtracted from this sum to yield *net cash available for capital allocation,* or the *capital constraint.*

The board's oversight responsibility should focus on whether management's capital constraint calculation is tied directly to the short- and long-term performance targets in the long-range financial plan. The board's key questions, therefore, are:

- Does capital availability, as defined by management, reflect comprehensive organizational cash flows (i.e., cash sources)?
- Is the level of capital spending (i.e., the capital constraint) appropriate, given the organization's strategic financial plan?
- Is the calculated capital constraint consistent with the planned performance in year one of the financial plan?
- What is the process for ensuring that major acquisitions/initiatives are included in both the capital allocation process and the organization's long-range strategic and financial plan?

Without a multi-year strategic financial plan, an organization will be unable to establish objective levels of capital spending for the upcoming years and to assess the impacts of its decisions on future years.

Exhibit 3. Sources and Uses Portion of the Capital Constraint

Source: Kaufman, Hall & Associates, LLC

Management should allocate capital as part of a *single batch* process, whether the capital is destined for new digital ventures or other traditional types of capital-based initiatives (see sidebar "Investment Types That Should Be Covered by the Capital Allocation and Management Process"). All proposed expenditures that meet the broad definition of threshold capital dollar levels, as described next, should be subject to the capital constraint and included in the management review process.

Investment Types That Should Be Covered by the Capital Allocation and Management Process

Given the evolving nature of healthcare strategies, a current, best-practice capital allocation and management process should include the following types of capital:

- Facilities, property, and equipment, including information technology
- Business acquisitions and partnerships
- Divestitures and asset monetization
- Equity investments
- Network development
- Managed care (health plan) investments
- Digital/telehealth investments
- Leases for ambulatory and other facilities
- New operating entities, programs, and services (e.g., ambulatory and post-acute services and facilities)
- Program start-up/expansion subsidies
- Physician practice acquisition investments and integration subsidies

Source: Kaufman, Hall & Associates, LLC

The board should be alert to management tolerance of "end-arounds" (i.e., project evaluation and spending approvals that occur *outside* of the structured process). A simple question will illuminate the commitment of the management team to the discipline of a controlled allocation process:

- How does management handle requests for capital made to individual executives or departments?

The answer should be: No requests are permitted other than as part of the centralized, structured decision-making process.

Oversight Point 2: Resource Allocation Objectives and a Portfolio Approach

The board must be assured that the allocation process is structured with unambiguous objectives—meaning they are specific, measurable, and closely intertwined with the integrated decision-making framework.

At the highest level, an organization's objectives for the process design should be to achieve consistency, standardization, reliance on analytics, known timing, accountability, integration with the integrated planning process, and transparency of management decision making.

The board's primary responsibility is to ensure alignment of the capital allocation and management process to the long-range strategic, financial, and related operating plans, as described in detail in Oversight Point 6. Key questions are:

- Is the process structured—as in Exhibit 2—to support such alignment?
- How are investment priorities determined and related to the strategic plan?
- How are allocation decisions integrated with the multi-year financial plan and annual budget?

Board members should look for best-practice structures in their organizations' capital allocation and management process. Among these, a portfolio approach to allocation should be a primary focus. To be effective in its governance of the decision-making process, the board should be reviewing for approval, on an annual basis, the complete portfolio of investments proposed by management for the coming year. So the question is:

- Is a portfolio approach to spending occurring in the organization?

As part of the portfolio view, the board should be able to determine how the portfolio and the individual initiatives within that portfolio will add measurable financial and strategic value to the organization. The alternative, reviewing individual projects throughout the year, does *not* provide the board with a sense for how each project is advancing organizational strategy, or how all projects come together to create an optimal investment portfolio with an overall positive return.

Oversight Point 3: Use of Capital Pools

Following a definition of capital available for spending and a commitment to a portfolio approach to allocation, the next point of board contact is oversight of the management team's use of investment pools to differentiate types of spending. The key question boards can raise is:

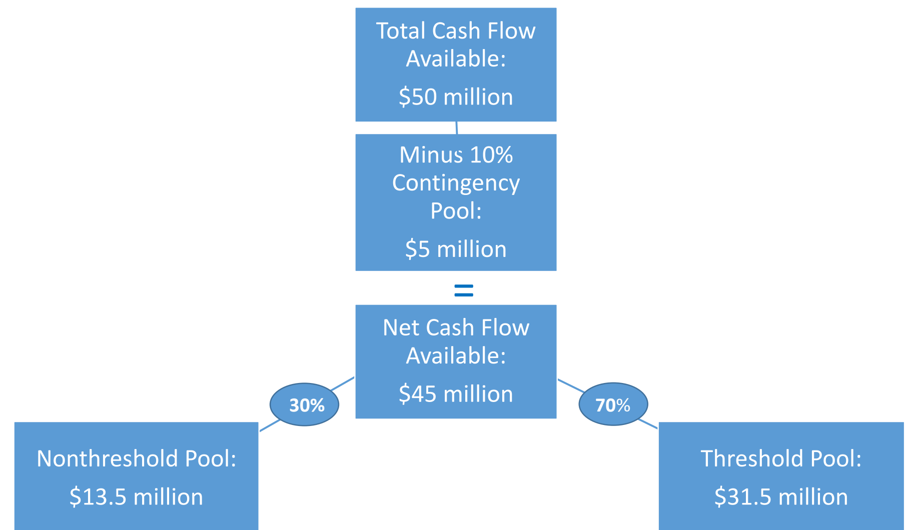
- Are there capital allocation pools and if so, how are these pools defined, accessed, and managed?

Capital pool designations vary widely among healthcare organizations, but should be present in all organizations. Pools are *not* predefined buckets of defined dollars for various purposes. Rather, a well-designed capital allocation and management process has three investment pools defined as follows:

- The *nonthreshold capital pool* consists of requests that fall *under a threshold* dollar amount, explicitly defined, and therefore do not require detailed

business planning or central review and management. Boards should not be involved in the approval of items in this pool or the pool as a whole.
- The *threshold capital pool* consists of requests that are *at or above* the specific threshold dollar amount defined by an organization. Comprehensive business planning analysis and central review are required for these requests, which typically comprise 70–80 percent of net cash flow available capital for spending.
- The *contingency capital pool* is intended to support threshold capital needs and should be managed centrally as a safety valve to cover cost overruns, emergency needs, and preplanning costs. It typically is set to be about 10 percent of total capital available for spending.

Exhibit 4. Funding the Threshold and Nonthreshold Pools



Source: Kaufman, Hall & Associates, LLC

For example, a two-hospital health system with a capital constraint of $50 million might set the *threshold* dollar amount at $250,000 based on the fact that 68 percent of current and past requests have been for $250,000 or more. After allocating 10 percent to a contingency pool, the threshold pool receives 70 percent of net cash flow available capital and the nonthreshold pool receives 30 percent. Therefore, the pool available to high-dollar threshold initiatives is $31.5 million (see **Exhibit 4**).

Each threshold capital initiative should have been evaluated by management based on an associated business plan that describes the business or investment concept and its financial effect in significant detail. The plan must provide the basic documentation and analysis necessary for management to make a valid capital decision. The sidebar "Core Elements of Comprehensive Business Planning" outlines the elements vital to business planning.

Oversight Point 4: Evaluation of High-Dollar Requests

Management of threshold capital should be under the aegis of a central capital management council or team (hereafter "council"), whose members represent key management team members and organizational constituencies (see **Exhibit 5**).

As mentioned, the threshold level is set at a dollar level that generally reflects a dollar level that will cover 70 to 80 percent of the current capital constraint, based on historical proportions and current requests. Because these are high-dollar spending requests, each will require consistent, transparent, and rigorous quantitative analysis that enables comparative evaluation and assessment of the initiatives individually and of the portfolio of requests as a whole.

While the specifics of threshold capital evaluation are part of the management-defined allocation process, board members can use the following questions to assess the appropriateness of the threshold capital evaluation/allocation process vis-à-vis the organization's broader strategic and financial requirements:
- What process does management use to review and evaluate high-dollar capital requests?
- What details are expected in a business plan for these threshold capital initiatives?
- What hurdle rate is required for return on investment?
- How does the decision-making process assess the risk of not meeting targeted performance rates?

With high-dollar, threshold requests, the board needs to know that management is applying uniform criteria in a formal *single batch review process* for investment opportunities that are consistent with organizational strategy. Use of standardized business plans and capital project review forms and templates facilitate informed decision making. Information required of all proposed threshold capital initiatives should have the following components:
- Description of the initiative and its alignment with the organization's mission and strategic plan
- Details supporting the level of investment required to start and complete the initiative, including the amount and timing of required capital investment, and projections of initial and ongoing operating requirements
- Detailed quantitative analysis to identify potential return on

Core Elements of Comprehensive Business Planning

- Definition of the proposed business/investment and the specific strategic objectives it will address
- Quantification of the capital resources required to initiate, complete, and maintain the proposed investment
- Delineation of the potential population to be served and the means by which that population's health or care needs will be enhanced by the investment
- Projection of the initial and ongoing operating requirements associated with the proposed investment
- Calculation of the potential return on investment, including analysis and quantification of key risks associated with the investment
- Identification of potential exit strategies and related performance measures

Exhibit 5. Sample Capital Management Council Structure

Voting Members	Nonvoting Staff Support
Chief executive officer	Finance staff
Chief operating officer	Strategic planning staff
Chief financial officer	Information systems staff
Chief nursing officer	Physician or other provider network development and management staff
Chief information/technology officer	Managed care contracting staff
Chief medical officer	Business development staff
Operational representatives (2–3 members)	Quality or patient experience staff
Physician or clinical representatives (2–3 members)	

Source: Kaufman, Hall & Associates, LLC

investment and key financial risks associated with the investment, including projected financial impact at least two years beyond full operationalization, projected cash flow, net present value and risk-adjusted net present value, and other information
- Qualitative factors, such as mission, growth, safety and quality, customer value, and more
- Sensitivity and risk analyses related to qualitative and quantitative measures
- Identification of performance measures and related potential exit strategies should the investment not meet performance objectives

Large projects may require "way points" for allocation decision making with multiphase planning, review, and approval.

Tried-and-true corporate finance techniques continue to provide the best basis for quantitatively based comprehensive decisions: net present value and risk-adjusted net present value, internal rate of return, and multi-year cash flow projections. While description of these techniques is beyond this article's scope and available elsewhere,[2] boards should be assured that the management process employs quantitative measures to evaluate individual projects and the financial returns of a portfolio of projects. Risk and sensitivity analyses are required as well to assess the likelihood of not meeting individual or portfolio targets.

Qualitative analysis, including criteria such as mission, impact on critical stakeholder groups, safety and quality, competitive position, operating efficiency, infrastructure, and other factors, should complement quantitative analysis to enable complete assessment of portfolio priorities. Criteria should reflect the organization's qualitative priorities and be applied as an alternative screen related to the initiatives once they are ranked based on quantitative analyses.

Oversight Point 5: Approval of Portfolio Recommendations

The capital management council (the centralized management function) should identify priority threshold initiatives for the defined period that collectively fall within the defined capital constraint. If reflecting best practices, this process will involve ranking of projects according to their return on investment using net present value or expected net present value (which incorporates risk), along with several other financial return criteria as the basis for allocation decisions. These quantitative measures should be combined with more qualitative analyses to capture a composite value encompassing mission, strategy, and financial return.

The meeting at which the capital management council allocates funding to threshold capital projects is often viewed as the apex of the executive decision-making process. Council members must be equipped to make effective decisions across the portfolio of potential threshold capital projects.

The board must be confident that the allocation process used by management for this meeting:
- Includes the necessary breadth of quantitative and qualitative information in a format that is consistent and comparable across the variety of potential projects
- Allows sufficient time (at least one week) for review of the materials before the meeting
- Structures the meeting to move at an efficient pace and withholds no critical information

Following capital management council allocation of a portfolio of threshold initiatives, it is typical for the board finance committee to review the recommended portfolio and if satisfied, bring the portfolio to the full board for approval as part of the budget approval process.

The full board has fiduciary responsibility for ensuring that the capital created by the organization and available for spending is reinvested appropriately. The board is *not* expected to review and approve each item in the portfolio. Rather, the board needs to receive a list of the proposed threshold initiatives described in high-level detail, understand the evaluation criteria applied to each item in the list and the list as a whole, and validate the portfolio's connection to the organization's strategy as described in oversight points 4 and 6.

The most important questions for the board at this point are:
- Is the board provided with a specific portfolio of threshold capital projects in which management plans to invest? The key word is *portfolio*. If the answer is "no," the board will not have the big-picture view of investment strategy that will enable the board to fulfill its fiduciary responsibility.
- What is the evidence that the proposed portfolio connects closely and appropriately to organizational strategy?
- What is the portfolio's overall short- and long-term return on financial

2 Jason H. Sussman, *Strategic Allocation and Management of Capital in Healthcare: A Guide to Decision Making (2nd Edition),* Chicago, IL: American College of Healthcare Executives, 2017.

investment and how was this number calculated?

A direct connection to organizational strategy and a positive return for the overall portfolio assure board members that the selected initiatives will collectively create positive momentum for the organization.

Unfortunately, in all too many organizations, the board never receives the list of high-dollar initiatives, but just the total dollar amount of the portfolio. Following approval of this portfolio, the board may first hear about a proposed project when it requires funding, or when the dollars required for the project have increased significantly from initial projections. Having never been aware, for example, that the initial cost estimate for the project was $2.5 million, board members are not equipped to ask why the approval for funding is now $3.5 million. This poses the risk of serious financial shortfalls for the organization.

At a minimum, the board should be receiving from its finance committee or the management team a financial package that provides summary information on the portfolio of threshold investments, and specific pages with standardized details on the status of individual projects, with the supporting calculations and analytics for each.

Oversight Point 6: Integration of Capital Allocation with Broader Organizational Plans

Prior to board approval of the management-recommended portfolio of threshold investments, the rubber must meet the road. The board must confirm that it has received definitive and appropriate answers to the many questions it has asked along the way about how capital spending plans are integrated with the organization's overall strategic, financial, and capital plans, with each step described as follows:

- The *strategic plan* has identified the market- and mission-based strategies that require funding.
- The *financial plan* has quantified potential capital and operating requirements of such strategies and established the annual financial performance targets needed to generate appropriate funding for the proposed strategies.
- The *capital allocation process* has balanced strategic opportunities with financial capabilities, ensuring that capital is deployed to meet the organization's strategic imperatives while enhancing the organization's financial integrity through a portfolio of investment strategies.
- The *annual operating budgeting process* has created a current-year implementation and operating plan, integrating the targets of the strategic and financial plans with the specific investment decisions resulting from the capital allocation process.

The full capital budget, consisting of threshold, nonthreshold, and contingency capital, along with the operating budget, typically are brought by the management team to the board for approval as a package at the same time. The annual operating budget should reflect the first year of the multi-year strategic financial plan and, therefore, becomes a strategic implementation tool. The operating budget should have two parts:

- "Same store" operations, meaning those that are ongoing year-to-year
- Incremental initiatives that are additive to the ongoing budgeted costs of operations

Components of the initiatives that comprise a recommended capital budget will likely impact the operating budget.

An integrated planning cycle requires a highly structured planning calendar, with the sequence of planning activities shown in Exhibit 2. Typically, strategic planning occurs during the first three to five months of the fiscal cycle. Quantification of identified initiatives and their integration into the financial planning process occurs during the next two to three months. This leaves four to seven months to complete the annual operating budget and capital allocation processes. The latter should be scheduled to conclude approximately one month before finalizing the annual operating budget so that management can incorporate amounts allocated and the related operating impacts of selected projects into the appropriate departmental operating budget for implementation.

Capital allocation and management thus is integrally linked with the organization's multi-year strategic, financial, and capital planning processes, as well as its annual budgeting process. To assess the best practice nature of its organization's decision-making

processes, the board should ask the following questions:

- How is the organization's capital allocation and management process connected to its long-range strategic and financial planning?
- Does the capital allocation and management process incorporate the key components described in this section?
- Where and how does the capital budget link to the operating budget?
- Is the planning process calendar-structured and fully integrated?

With satisfactory responses to these questions, the board can feel confident that it has fulfilled its fiduciary responsibilities when approving the capital allocation recommendations of management.

However, the capital allocation and management process does not end when allocation decisions are approved in the capital budget. A *post-allocation process* commences. This process, driven by management and evaluated by the board, includes review and revalidation of projects before their actual funding (i.e., release of funds), decision making regarding the timing of capital spending, handling of any budget deficits or surpluses that occur, ongoing monitoring of capital spending, and determining the appropriate course of action based on performance results.

The board plays an oversight role in the post-allocation process as well, particularly with funding review and revalidation and performance review, as described next.

Oversight Point 7: Project Funding

Most organizations require some form of revalidation of project parameters by the management team before funding is approved by the board for allocated threshold capital. This ensures that new data or information obtained following approval of the capital budget can be taken into account, integrated appropriately, and evaluated according to previous quantitative and qualitative criteria.

In many organizations, project sponsors are required to update business plans when actual funding is required for approved threshold capital projects. This revalidation of the original business plan should rely on the same data and analyses that substantiated the original allocation decision (e.g., projected cash flows and financial ROI). In the time that has elapsed between the allocation decision and the need for funding, some of the project parameters will have changed (some perhaps materially).

The revalidation process captures these changes and their impacts on project quality, thereby improving the board's ability to perform its fiduciary duties. When a specific capital project is brought to the board for funding, the board has the assurance that the project has been thoroughly and consistently analyzed by the sponsoring and management teams, has been established as a priority strategic investment for the organization, and has been vetted for any material changes that would affect the direction of the original allocation/budgeting decision.

The board, of course, should have previously seen the project as part of the recommended capital budget and should be aware already of its imminent funding requirement. The board also should have a complete understanding of the sources of funding for the project, including whether or not the project will require external debt or will need to access the contingency pool.

Most organizations have established levels of authority relative to funding approval for high-dollar projects included in the capital budget (the "Authority Matrix"). For example, depending upon the size of capital budgets, organizational bylaws may stipulate that:

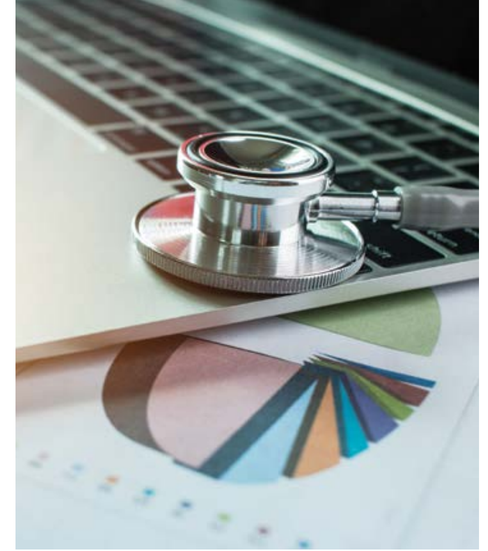
- Prior to funding, the board must review and approve projects approved for $X million or more of threshold capital
- Funding approval for projects under this sum remain under the aegis of the management team

As the size of the organization and its capital spending increase, the approval sums typically should rise as well. Large projects, particularly those with associated debt, divestitures of material assets, and creation of a new corporation or joint venture, typically should require board approval prior to funding.

It is important that definition of the Authority Matrix for each organization be structured to reflect its size, complexity, and risk culture, but not create barriers to efficient and effective decision making and strategic implementation. To ensure this is the case, the board should have answers to the following questions:

- Are levels of authority for funding approval established in the organization?
- How frequently are such levels evaluated based on the size and complexity of the organization?
- What analyses does management provide the board for review and approval of project funding?
- Are these analyses consistent with those originally provided at the allocation decision-making point?

Consider an unfortunately not-infrequent example of a $2 million project originally approved by the board as part of the capital budget based on solid analytics. Sometime later in the fiscal year, but prior to full implementation of the capital budget, the project is presented to the board for funding approval at a cost of $3 million.



The board should ask the following questions and expect appropriate answers at the time of the funding request:

- Why has the cost of the project increased so materially?
- Does the project still meet the strategic goals and financial ROI targets of the organization?
- Where is funding for the increased capital going to come from?
- Will another or other projects need to be deferred or can the contingency pool cover this cost overrun?

- If we approve funding, what are the implications to the long-term financial plan?

Analyses required for the board to approve this project include strategic and financial projections, ROI/net present value studies, and additional sensitivities around risk factors. The higher investment-funding request may, or may not, undermine the economics of the project.

The revalidation process should not be viewed as another chance to question the project's legitimacy. Rather, revalidation should verify that the project's original premise remains solid, that the key assumptions continue to be supported, and, most important, that the project's investment requirements remain consistent with the original request or can be supported by the financial plan.

Oversight Point 8: Performance Review

Post-approval performance review and monitoring is vital to the integrity of the capital allocation and management process. Management teams in successful organizations define quantifiable indicators of project success as part of the initial project analytics, measure performance against these indicators, and devise and implement plans to respond to less-than-anticipated performance.

Management should define the post-allocation monitoring timeframe for review of every approved threshold capital project. For example, one organization established guidelines that indicate the following: Threshold capital projects, including projects in which operations begin in the first investment year and multi-year projects in which operations do not begin in the first investment year, will be reviewed annually as part of the management component of the capital process until after the project has completed one full year of operations post completion. In this organization, projects with a long build-out or start-up periods could be required to undergo annual reviews for several years.

Post-allocation, retrospective analysis should mirror the prospective, business planning analysis prepared in support of the original allocation decision. Benchmarks and metrics related to both qualitative and quantitative aspects of the project should be based on the benchmarks and metrics used in the project's business plan.

Both management and the board must have and foster an understanding that not all projects for which capital is allocated will be successful. Because this is an axiom of business planning, it is vital that each project request include specific metrics that define the point at which the "plug should be pulled" on an underperforming investment. In addition, the business plan should include a defined, specific exit strategy that will be implemented in such an instance. Many healthcare organizations wait far too long to either modify or terminate bad capital investment decisions.

Boards must ensure consistent development and successful implementation of corrective strategies, not simply

effective performance monitoring. The practice of demanding corrective action plans in response to underperformance on capital and financial plans is critical.

Board questions at this final point of oversight include:

- What process is used for evaluating project progress following post-allocation and funding?
- What is required of management when a project is not meeting expected performance targets?
- How are steps to address underperformance implemented?

Resources Going Forward

In an environment of scarce resources, increasing competition, and significant requirements for capital investment, healthcare management teams must allocate available capital to initiatives that will best meet the strategic objectives of their organizations while enhancing financial performance. In almost all healthcare organizations, capital appetites routinely exceed capital constraints. Choices will need to be made. Use of a disciplined capital allocation and management process is critical. The oversight provided by boards at the eight touch points described here will better ensure the effectiveness of such a process for the organization as a foundation for its success going forward.

The Governance Institute thanks Jason H. Sussman, Managing Director of Kaufman Hall and a leader with the firm's Strategic and Financial Planning practice, for contributing this article. He can be reached at jsussman@kaufmanhall.com.

Leading for High Reliability

By Kate Goonan, M.D., Navigant Consulting, Inc.

Healthcare providers nationwide are pursuing a journey to high reliability to ensure the communities they serve trust them to deliver the right care at the right time in the right way.

The attributes of highly reliable organizations (HRO) are well known,[1] and much has been written about how to integrate HRO principles and practices into an organization's culture and operations. Yet, while leaders have attempted to transfer them into our industry for more than 15 years, barriers exist to the adoption of HRO practices in healthcare.

Healthcare boards need to know how to oversee executives building highly reliable healthcare delivery while simultaneously addressing such issues as declining operating margins, transitioning to value-based payments, and clinician burnout. Doing so requires boards to consider such questions as: What needs to change in governance and executive leadership performance to ensure multi-dimensional performance improvement is possible? How can we accelerate progress in high reliability and link it to all other strategic priorities?

The Board's Role in Accelerating Progress in High Reliability

Following are eight key dimensions that require scrutiny and transformation, and critical questions boards need to ask to ensure accelerated progress is made on all fronts:

1. **How are HRO principles translated into measurable behavioral expectations of leaders at all levels?** High-reliability science provides a wealth of evidence for required leadership and managerial behaviors. It defines the cultural attributes such as "preoccupation with failure" and "reluctance to simplify" that must be in place to be an HRO. Translating this information into concrete tactics and tools is where we fall short. Measuring their effectiveness is similarly vague. Healthcare boards should ask for specific accountability on leadership activities and their results.
2. **How are diverse strategic priorities (HRO, margin enhancement, population health, etc.) integrated and aligned to ensure they're effectively cascaded to the entire workforce?** What tactics are in place to ensure all the worthy initiatives an executive team undertakes are simplified and integrated to be manageable at the sharp end? We commonly see an alphabet soup of legacy and recent "silver bullets" that get piled onto managers with the expectation that they somehow figure out how to implement all of them. Business-savvy, sensible board members can lend tremendous insight and direction by raising thoughtful questions, helping executives move beyond great concepts to measurable implementation.

3. **How are patients and their families leveraged to support a culture of HRO?** Many of the effective tactics in high reliability depend upon listening to the people most attuned and knowledgeable about the situation. This includes the patient and those who know them best. Patients and their families can be encouraged to be observant and attentive to potential failure and actively speak up. Boards should ask management: How are caregivers at our hospital/health system encouraged to take advantage of patient and family participation in care?
4. **What executive dashboards and scorecards are reviewed regularly**? How are these tools prioritized to ensure leaders and measures at all levels have focus and direction? Again, governance and executive leadership need to help overcome the tendency to treat a longer list as a better list. They key is focus and transparency around true progress toward the goal, and this takes actionable data that has meaning. If it doesn't make sense to you, it probably won't make sense to the people who need to act on it.
5. **How are leaders and managers developed and supported so they can offer the workforce what they need to implement strategic goals and action plans?** The problem of burnout has many causes. One important cause is the overwhelming number of complex expectations coming at managers and the workforce. Often, HRO is just one more thing coming at the medical staff and employees. It's up to senior leadership to simplify demands. Creative leaders find ways to integrate and streamline expectations to ensure they are manageable.
6. **What approaches are used to manage key operational processes and how do operational leaders measure and improve them?** Today, healthcare delivery is a multidisciplinary team sport. Operational leaders need to have tools and techniques to work across professional disciplines to increase reliability and patient engagement, reduce variation, and maintain vigilance to prevent error. Doing so requires significant skill and

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Key Board Takeaways

Growing numbers of hospitals and health systems are adopting the practices of high reliability to ensure the care they deliver is safe. To instill the required behavioral and cultural norms, boards must adopt key expectations to include:

- Participate in ongoing learning about the high reliability sciences applied to healthcare.
- Expand preparation for meetings to address safety practices and analytics more broadly than in the past.
- Evaluate the organization's culture and progression toward higher reliability by subjective and objective measures.

1 Karl E. Weick and Kathleen Sutcliffe, *Managing the Unexpected: Resilient Performance in an Age of Uncertainty*, San Francisco: Jossey-Bass, 2007.

The Power of One Idea

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a medical device that fell outside of our group purchasing contract—cochlear implants. The small department that provides audiology services knew its ongoing financial losses threatened the sustainability of the program. In response, staff members suggested that rather than continue to lose money on each procedure, team members should approach a couple of the device manufacturers for further price negotiation. Frontline technicians coordinated their idea with the director of rehabilitative services and an audiologist. The result: The purchasing representative successfully negotiated a cost that would ensure enough revenue to keep the program going, not only enabling continued provision of this important service, but also saving the system nearly $500,000 annually.

Other ideas came from pharmacy staff, who identified significant savings for heparin management and medicines used in "sinus cocktails;" the IT department, which identified opportunities for printer cartridge savings; and the surgical team, which formulated a new cost-saving process for OR drapes. While a couple of suggestions have each yielded more than $1 million in cost reductions—the largest was $1.7 million—the average benefit per idea is around $125,000 in annual savings.

Getting the Word Out

The Power of One Idea program is promoted through a variety of communication vehicles, including informational posters and announcements on our intranet. Success stories are recognized in our weekly corporate newsletter.

The importance of the program—and incentive opportunities for associates—is reinforced at each quarterly town hall meeting. Despite these efforts to promote the program, only 2.2 percent of associates have been participating, which is considerably lower than our goal of having 10 percent of the workforce submitting ideas. The program has been successful in keeping the focus on the quality versus quantity of the suggestions received, with about a 34 percent approval rate.

The cost-saving advantages to MLH have been a welcome benefit. Since the program's inception in 2014, the ideas submitted so far have generated more than $8.11 million in system savings—money that we can use to continue to provide exceptional care to our patients and their families. The 264 associates who submitted those ideas have shared nearly $1 million in return.

Beyond the tangible benefits around the cost savings we've experienced, and perhaps more important, are the intangible and cultural advantages. Associates at each level of the organization now share responsibility for sustainability, and their insight has expanded leadership's perspective in spotting waste within our system.

The Governance Institute thanks Michael O. Ugwueke, D.H.A., FACHE, President and CEO of Methodist Le Bonheur Healthcare, for contributing this article. He can be reached at michael.ugwueke@mlh.org.

21st-Century Skills…

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and manage both clinical and financial performance concurrently and even proactively rather than retrospectively. Thus, boards should increasingly require the use of these "tools of accountability" (which the for-profit sector has used for decades) that enable it to fulfill its fiduciary responsibilities to support a high level of clinical and financial performance.

8. **Board members should be held increasingly accountable through rigorous board and individual self-assessment processes.** An accountable board needs to hold its own members accountable through rigorous assessment processes to support ever-increasing expectations. Only individuals who are willing to hold themselves and others accountable should participate in accountable governance in the 21st century, as a deliberative body cannot hold others to a standard that it will not or cannot perform itself.
9. **Consider compensating board members based upon performance that drives measurable outcomes.** The days of the voluntary board member may be nearing an end as the rigor and expectations of accountable governance surpasses the ability of individuals to serve in a casual and less than fully committed way. Just as voluntary physician leaders are now appropriately compensated for driving clinical and business outcomes, consider whether your market situation warrants compensating some or all board members through a fair market value framework that is consistent with the organization's legal and regulatory status. Reasonable compensation represents an investment to achieve outcomes that cannot be achieved through a purely voluntary board alone.
10. **The board needs to continually raise the bar.** Our society no longer tolerates mediocrity and is willing to allow organizations to fail that cannot meet its continually increasing expectations. Thus, governance must now seek ways to oversee the creation of value in an increasingly globalized healthcare industry. Boards that rely on the "effectiveness" models of the past will enable their organizations to languish while those that drive excellence and distinction will create a legacy of which they can be proud.

To succeed in the 21st century and beyond, effective boards must become accountable boards and create rigorous standards for both its membership, those whom it oversees, and those whom it serves.

The Governance Institute thanks Jon Burroughs, M.D., M.B.A., FACHE, FAAPL, President and CEO, The Burroughs Healthcare Consulting Network, Inc., for contributing this article. He can be reached at jburroughs@burroughshealthcare.com.

Leading for High Reliability

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methods to accomplish these goals. Hospitals and health systems need to account for the tools they use to manage the reliability of operations and improve their performance continually.

7. **Given how the organization is led and managed, what results is it achieving?** There is a natural tendency to focus on good news rather than dig deep into the systematic causes of failure and how to redesign operations to overcome them. Where there are the inevitable gaps, what is being done to ensure sustainable performance improvement? How does management track its progress in areas of vulnerability?
8. **What does the board itself need to do to become a high-reliability team?** The board must make a concerted effort to change its leadership role by incorporating high reliability into its approach to governance. All board members must undertake education in high reliability and apply the principles to how they evaluate management's performance. Routine meeting agendas need to prioritize safety concerns. Analysis of operations will change to pursue more fully both anticipation and containment of potential safety hazards.

The best members of governance don't have all the answers, but they do know what questions to ask. As we tackle the broad and complex problems facing healthcare providers today, it's the board members and senior leaders who ask probing questions and demand clear and understandable answers that are doing a huge service to their organization's management teams and the communities they serve.

The Governance Institute thanks Kate Goonan, M.D., Managing Director, Navigant Consulting, Inc., for contributing this article. She can be reached at kate.goonan@navigant.com.

Healthcare Service Lines...

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and job satisfaction—high motivators for engagement. Under the guidance of a well-trained physician leader (or dyad management team), service lines become effective tools for direct, two-way communication with doctors that leaves these practitioners feeling informed, respected, and their input appreciated. Frontline operational concerns are not neglected and their resolution gets linked to important concerns regarding finances, staffing, and marketing.

Many medical staffs have a poor record of carrying out peer review constructively and effectively. Service line approaches are often more effective than historic medical staff structures to address practitioner performance issues for multiple reasons. First, service lines are more commonly led by a physician who is being paid for her/his leadership skill set and provided dedicated administrative time. (Most medical staff leaders are voluntary and transient in their roles.) The service line physician leader is not only responsible for clinical outcomes, but also financial performance, patient satisfaction, patient safety, and personnel matters (typically in collaboration with an administrative partner). This makes it much more compelling for the physician service line leader to address performance problems, rather than letting them linger or making excuses for their continuation.

The potential of service lines is undermined when management does not clearly define their scope, authority, and leadership. Physician leaders for service lines will not be effective without appropriate training and mentoring. The same is true if they are expected to be clinically productive and insufficient administrative time is protected. Often physicians are placed in a dyad relationship to lead a service line, but the nature of the relationship is not clearly articulated. Orientation and onboarding for the role is likewise often neglected. This can lead to situations where a clinically busy physician service line leader functions in a clearly accessory fashion to a hospital administrator dyad "partner." The historic model of a hospital departmental administrator who is given a medical director to "herd the cats" on that administrator's behalf is not the template for a successful service line.

At least annually, the board should review how effectively service lines have been deployed at their institution and challenge both senior administrators and health system physician leaders to demonstrate their efficacy (see "Key Board Takeaways" sidebar for questions the board should ask). In a time of growing physician shortages and practitioner turnover, widespread burnout, and growing physician dissatisfaction with remote senior administrators, the service line model offers a doorway to strong physician engagement. The obvious benefits should lead every board to scrutinize institutional efforts to stand up powerful service lines.

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. He can be reached at tsagin@saginhealthcare.com.

Healthcare Service Lines: A Potent Resource to Promote Physician Engagement

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

Hospitals and health systems are challenged on many fronts to create delivery systems that can achieve lower costs, better outcomes, safer care, greater patient satisfaction, and more engaged workforces (often referred to as the Triple or Quadruple Aim). Most are making only incremental progress towards these goals, rather than achieving transformational breakthroughs. Significant progress requires fully engaged practitioners who are motivated to undertake meaningful redesign of traditional approaches to care.

In recent decades, many hospitals and health systems have moved to adopt a service line approach to care delivery. The use of service lines has been a powerful organizational tool in some institutions, but only achieved moderate success in most. Governing boards seeking to promote transformative change through an engaged clinical workforce should periodically explore whether their service lines are sufficiently organized and led to accomplish these goals.

The Return of Service Lines

The healthcare service line concept replaces a traditional departmental approach to clinical care with a product-line model that follows the patient's path through the care process. The service line approach was imported into healthcare in the late 1980s in response to the financial impact hospitals faced with the implementation of diagnostic related groups (DRGs). At that time, this approach focused on business branding to increase market share and increase volume. This emphasis on marketing was only modestly successful and many established service lines were discontinued during the 1990s as managed care came to dominate in many healthcare markets. As the century turned and organizations continued to face financial pressures, services lines again became a favored tool to control costs, reduce variation, and improve outcomes.

There is no single model for a service line and there is considerable variation across the healthcare industry. Nevertheless, contemporary service lines tend to be multidisciplinary and provide services across the continuum of care. In multi-hospital health systems, the service line often extends across all campuses and health system facilities. There is a strong emphasis on integration of all related services and typically a service line is regarded as a business unit with its own strategic plan, budget, marketing initiatives, operational oversight, quality goals, and workforce strategies.

Key Board Takeaways

Questions boards should ask regarding service lines include:

- Has our organization made use of service lines and if not, should it?
- Is there a clear and consistent definition of what constitutes a "service line" in our hospital/health system? Is this definition well understood by administrators and physicians?
- Does our organization have the "right" number of service lines?
- Is the typical service line in our organization an integrated business unit or chiefly a marketing construct? If not the former, why not?
- Do our service lines adequately cross the continuum of care?
- Are service lines a physician-led initiative?
- Is physician leadership of service lines adequately defined? Are physician leaders adequately trained for this role? Is a dyad leadership model (physician and non-clinical administrator) in use and, if so, is it being adequately deployed? Do physician service line leaders have adequate dedicated administrative time?
- Do our service lines appropriately shift the clinical focus from episodic care to longitudinal interactions with patients?
- Have our service lines worked to effectively encompass both employed *and* non-employed practitioners?

Increasing Physician Engagement

Many well-managed service lines have demonstrated the ability to reduce costs and variation while also increasing volume and patient satisfaction. However, perhaps their most valuable contribution is their potential to increase physician engagement. Many organizations are struggling with physician burnout, practitioner disillusionment with health system leadership, and diminished confidence in historic structures for physician–hospital collaboration (e.g., the organized medical staff). Physicians often express the belief that they are not seen as true partners by health system leaders, complain that management is not transparent, and bemoan their loss of autonomy over clinical operations.

A robust service line model can address many of these physician concerns because it scales down the focus of hospital–physician collaboration to an area of immediate and compelling interest to the doctors who practice within it. While it is the rare medical staff department that still sees good meeting attendance, well-run service line meetings are characterized by robust participation. This is because the issues discussed—clinical protocols, operational decisions, equipment and staffing needs, and service line strategic initiatives—are all highly relevant to the practitioners who are invited. The discussions directly impact physicians' daily practice circumstances, income,

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