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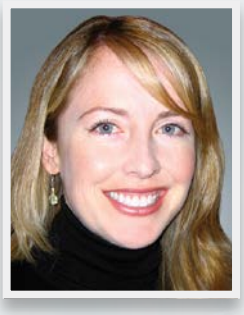

Keep Sight of Our Core Mission

What do we believe will most affect the future of our healthcare organizations? As boards, senior leaders, and physicians traverse critical current issues such as how to prepare for more financial risk, implications of the community health needs assessment, debating whether to publish quality and physician ratings, and determining the organization's strategic risk capacity, we must not lose sight of the most important job of healthcare providers, and therefore, the board: providing (the right) quality care for every patient, every time.

The articles in this issue provide information, perspectives, frameworks, and tools to address the critical issues above. Boards must be strategic. Boards must be innovative. Boards must be constantly thinking of ways to cut costs and become more competitive. Boards must jockey, maneuver, reconsider, and redirect. It is essential to focus on these business-focused, strategic-level issues. But in order to reach any of these goals, quality care must remain front and center at all times. How do these strategic decisions impact quality? Conversely, how does the organization's ability to provide the highest-quality care to every patient better position and enable the organization to reach its strategic goals? The bedrock of the governing board and senior leadership team is to unify the entire organization behind the core mission. Let's not lose sight of the main business we are in.

Kathryn C. Peisert, *Managing Editor*

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Improving Community Health and Rediscovering Organizational Identity

By Elaine C. Thompson, Ph.D., FACHE, and Jennifer Audette, Lakeland Regional Health

American College of Healthcare Executives
for leaders who care®

The field of community health has evolved dramatically over the last decade. Because of the Affordable Care Act, hospitals have come a long way from simply offering free blood pressure readings, blood sugar checks, support groups, and vision screenings. We now devote more research and time to understanding the impact of prevention programs, self-management of health conditions, proper allocation of community resources, and educational marketing. We also are continually learning better ways to use the analytical data regarding the health of our city or town.

As healthcare leaders, we all work in some capacity to improve community health, but do our efforts make sense and are we going about our work the right way?

Six years ago, Lakeland Regional Health, a not-for-profit health system and hospital in central Florida that includes the busiest single-site ED in the nation, decided to dig deep and discover our identity in relation to the community we serve. Although our triennial community health needs assessment played a huge role in how, where, and to whom we delivered care, we found we needed more resources (who doesn't?), data, and better programs and policies.

Branding

The chance to rediscover our organization in relation to our community came at the perfect time. We had recently expanded beyond the walls of our hospital to encompass ambulatory care (including comprehensive primary and preventive care) and had become more than just a place to come when extremely ill.

We were able to sit back and ask, "Who are we? Who do we want to be?" and found that an identity crisis can be a wonderful opportunity for reassessment and revitalization.

We are fortunate to have dedicated and knowledgeable board members who are champions of innovation and transformation. They encouraged us to look at ways we could rebrand ourselves and realign our organization.

We started our examination by reconsidering the name of our organization. Lakeland Regional Medical Center no longer aptly described who we were. Instead, Lakeland Regional Health encompasses the robust continuum of care we provide. Our mission and vision statements also now reflected our focus on health and wellness, including the assertion that "We improve lives every day by promoting wellness, education, and discovery."

From this powerful branding transformation, a positive and crucial shift in our workplace culture gradually ensued.

Understanding Our Community

Once we were well on the path of rebranding, Lakeland Regional Health moved our focus to better understanding the community.

We already were armed with important data on mortality, obesity, chronic diseases, births, economic status, and demographics, and we already knew we were the seventh poorest suburban county in the United States. What we were lacking was qualitative data. We needed to hear from pastors, patients, community members, government leaders, and educators. What were they hearing and seeing? Our board encouraged us to understand the "why" behind the data. Why are children not being immunized for HPV? Why are people with diabetes not being properly diagnosed? Why are children showing up hungry for school and how does that affect their learning?

By having these discussions, hospital leaders and board members (many of whom also serve on the boards of community service organizations and neighborhood churches) learned so much more about lifestyles, habits, and values; the cycles of abuse and poverty; the fears, misinformation, and distrust of medical establishments; and the heart-wrenching reality of lack of access to care.

This information helped us to create programs that meet the needs of community members, including:

- **Congregational Health Partnership:** Outreach to local congregations providing them with resources to improve the health of their members.
- **FitChurch Challenge:** A 12-week wellness challenge that encourages friendly competition among individuals, families, and congregations.
- **Promise Run:** More than 1,300 walkers and runners gather in beautiful downtown Lakeland for 5K, 10K, and children's races.

Advocacy

As hard as Lakeland Regional Health works to create community health programs, if elected leaders and government workers do not understand the health needs of our community, real change will be hard to come by. Our board wholeheartedly believes strong policies and programs supporting equitable access to care are absolutely vital. Board members are passionate in their advocacy work, including connecting with legislators to share this message.

This includes Medicaid payments, funding of hospitals and healthcare programs, and support for graduate medical education. Shortages of physicians and advanced practitioners are not problems unique to our city or state, and our national leaders must partner with us to figure out how to solve this crisis.

Resources and Collaboration

We continue to find immense strength in the people around us. We collaborate

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Key Board Takeaways

Boards at healthcare organizations undergoing innovation and transformation should take the following steps to support efforts to change:

- Examine how the community health needs assessments fit in with the organization's mission and vision. Do they align? If not, this may be an opportunity to reassess your brand and what the organization represents.
- Urge leaders to dig deeper on the vital statistics of your community. Encourage them to understand the "whys" behind the data. Work alongside your organization's leaders to meet with neighbors and civic leaders to gather qualitative insight.
- Understand that your organization cannot conquer all of the community's health needs alone. Embolden leadership to create a network among key organizations to pool resources and work together.
- Lobby, advocate, and vote for programs, people, and policies that will make your town stronger and healthier.

Physician Transparency: An Urgent Priority for Today's Boards

By Andrew Ibbotson, NRC Health

To gauge the importance of patient experience transparency in healthcare, consider how consumers approach buying decisions. Most wouldn't dream of making any large purchase before they consulted online ratings and reviews. In many cases, the absence of word-of-mouth from their fellow consumers is an immediate mark of suspicion. No reviews means no trust, which ultimately means no transaction. Such is the hold that transparency has on the economy.

Healthcare decisions are no exception. As their share of the healthcare cost burden has reached new all-time highs,[1] patients have become savvier at shopping for providers. Above all else, patients want to be certain that they will receive high-quality care and a high-caliber customer experience before they will select a provider. And what they find most compelling are first-hand reports from patients like them.[2]

While quality transparency is equally important, beginning with patient experience transparency is the easiest first step toward embracing full healthcare transparency. This article reviews central considerations for boards, including 1) the benefits of transparency, 2) the obstacles that hold healthcare transparency back, and 3) the characteristics that help ensure the success of a transparency initiative.

Why Healthcare Organizations Should Adopt Transparency

The Centers for Medicare and Medicaid Services (CMS) has famously begun to demand more transparency from healthcare organizations.[3] The agency has identified public-facing data, such as star ratings for hospitals, as an effective way to empower patient choice.

But setting aside regulatory obligations, being forthright about the type of care patients can expect to receive is also strategically valuable. Whether by fiscal or clinical measures, the benefits accrued to transparent hospitals and health systems include:

- **Influencing patient decisions**: As mentioned above, a lack of reviews makes consumers mistrustful. The converse is also true: a surplus of reviews earns their trust. In fact, some research is showing that patients now trust online reviews as much or more than they trust referrals from their doctors.[4] In crowded marketplaces where patients struggle with their options, glowing, credible, and numerous reviews are perhaps the strongest way to differentiate one provider from another.
- **Driving better patient engagement**: Better still, transparently visible data builds a sense of authenticity between the patient and provider. When patients feel empowered to make an informed selection, they feel better about the provider they've chosen. This inspires trust, which in turn makes them more likely to follow their provider's advice,[5] and to be proactive about future healthcare needs.
- **Spurring healthy workforce competition**: Finally, it helps to remember that what patients can see, providers can see as well. Online databases of ratings and reviews reveal to clinicians just where they stand among their colleagues. For a physician, seeing that they have fallen behind their peers in patient satisfaction can be a humbling experience, but it can also be inspiring. More often than not, physicians want to serve their patients to the best of their ability. Through transparency, they can observe exactly how they're underperforming, and turn to their high-performing peers for mentorship and advice.[6]

Key Board Takeaways

- **Walk in patients' shoes.** On their own, board members should try to find patient experience data on providers in their hospital/health system. Was it easy? Accessible? Accurate? This is a good indication of how far along the organization is on the transparency adoption curve.
- **Open the dialogue.** Discuss transparency initiatives with the executive team. Gauge their attitudes. How do they feel about it? How do their reports feel about it? Are there areas of resistance or hesitation among leaders or frontline staff? Explore these. Try to build consensus around an ethic of openness.
- **Design a pilot.** With executives, designate a department that could benefit from increased transparency. Find a qualified vendor to furnish a transparency solution and observe results. If it's successful, generalize out to other parts of the organization.

Where Transparency Falls Short

However, not every effort at transparency produces these successes. Third-party quality transparency platforms struggle to attract a meaningful patient userbase. Just 18 percent of patients managed to research care quality, according to McKinsey.[7] That's a surprising figure, considering that 72 percent of consumers report that quality information is important to them.[8]

The disconnect stems from usability problems. While patients value the data available from these third-party solutions, they have trouble making sense of what they see. The Agency for Healthcare Research and Quality found that 42 percent of patients believe quality databases to be poorly presented and confusing.[9] Small wonder that they should feel discouraged

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Managing Strategic Risk Effectively Requires Shared Beliefs

By Daniel K. Zismer, Ph.D., Keystone Culture Group, LLC and Castling Partners, LLC

In a recent interview, the CEO of Chevron was asked, "What business are you in?" With no hesitation he remarked, "We are in the business of managing risk." An obvious expectation of the answer might have been, "We are in the oil business." He followed by explaining that Chevron is a global player in the integrated energy business. It deals across geographic, geo-political, and financial and economic lines and is subject to a crowded and competitive marketplace driven by innovation and production efficiencies demanded by the market. The capital requirements are staggering and the costs of leadership decision failures are high. His role as CEO is one tilted to managing the risks of strategic choices, together with the board of directors, on behalf of shareholders.

What does this have to do with U.S. healthcare and, specifically, the role of the CEO and governing board of a hospital—especially in the case of not-for-profit healthcare? To borrow an oft-used and hackneyed phrase, "healthcare is changing." The magnitude and pace of change create the same requirement; i.e., healthcare leaders must manage the risks of strategic choices. While not-for-profit healthcare doesn't have shareholders, it does have community stakeholders that depend upon a CEO and board collaborating to address challenges and opportunities of the times.

This article explores the strategic risks that healthcare CEOs and boards are currently facing and provides a framework for developing a unified belief system that will help leaders work together to create a plan for successfully managing risk.

Strategic Risks for Hospitals and Health Systems

If the Chevron analogy holds, then what are the risks that healthcare CEOs and boards face that, perhaps, require a fresh look at risk and an appropriate definition, including the risk of strategy? First, it is useful to review a list of paraphrased quotes from health system CEOs:[1]

1. "I never thought I'd be this deep into the business of employing physicians."
2. "I don't have the balance sheet strength to take on my larger competitors that can afford to niche my profitable services in my markets."
3. "An increasing proportion of our revenues is coming from out-of-pocket payments and these consumers have become price and value shoppers."
4. "Too much of our financial margin is produced by a small handful of services that are challenged by volume, total cost of care, and competitive pressures."
5. "In excess of two-thirds of the care will be delivered on an outpatient basis and we can't afford the costs of systems, assets, program, and personnel transformations to serve future demand in this arena."

Key Board Takeaways

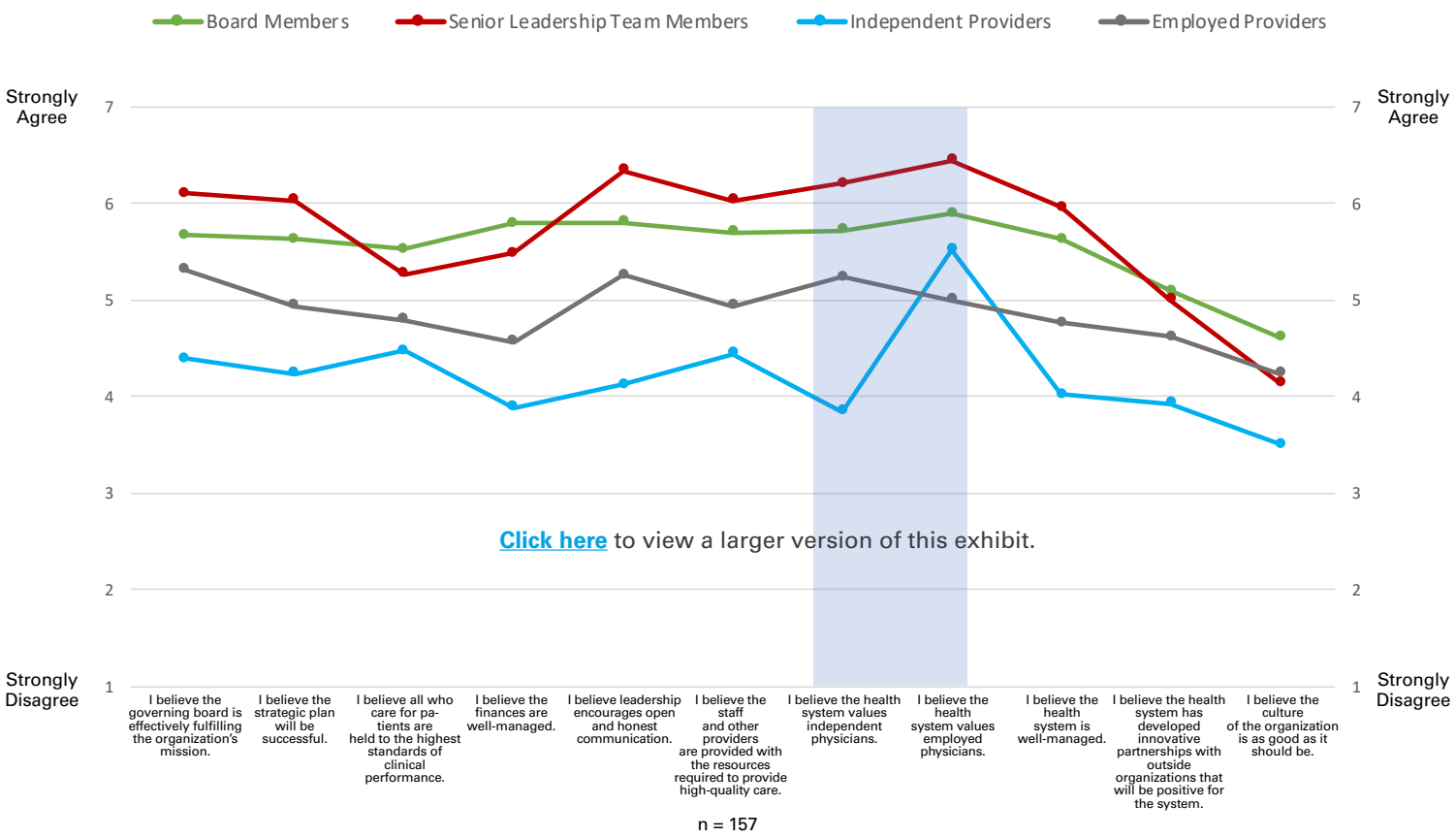
Healthcare market dynamics, and related competitive pressures, will demand that community hospitals and health systems pursue strategy types (at levels of strategic risk) that may be beyond the collective experience of boards and leadership teams. Related risks will emanate from external and internal forces. Boards and senior leadership teams must:

- Identify and understand related risks before they can be managed. Inasmuch as many of the risk categories may be novel, the work required to get the list "on the table" will be new to the working relationship.
- Develop a foundation of "shared beliefs." This is required when building a comprehensive, successful, executive-level program of strategic risk management. Shared beliefs serve to specifically identify and define the risks to be understood and managed. A system of shared beliefs unifies boards and leadership teams by binding them to a strategic risk management plan that they all own. The requirements of such plans dictate the organizational culture required to support the plan execution. The failure of organizational strategic plans can often be traced back to the lack of a system of shared beliefs pertaining to strategic opportunities and related risks.

With these observations in hand, let's dive deeper into the challenges, including the role of governance, starting with the medical staff and the risks for CEOs. In the May issue of E-Briefing, we reported on a "problematic repeating pattern of physician beliefs"[2] in healthcare organizations, based on results from the Stakeholder Alignment Survey.[3] This article addressed how, as community hospitals and health systems add to the ranks of employed physicians, potential risks associated with independent physician affiliates increase, manifesting as the independents believing the employed physicians are "valued higher" by leadership, including governing boards. The risks center on the competitive and affiliation freedoms enjoyed by the independent physicians on the medical staff; they have options of strategy other than as

1 These comments derived from interviews preceding strategic planning efforts at various health systems.
2 Daniel K. Zismer, et al., "A Problematic Repeating Pattern of Physician Beliefs in Community Hospitals and Health Systems," The Governance Institute, E-Briefings, May 2019.
3 The "Stakeholder Alignment Survey" is a proprietary organizational performance evaluation instrument developed, owned, and applied by Castling Partners, LLC (www.castlingpartners.com) and Keystone Culture Group, LLC (www.keystoneculturegroup.com).

Exhibit 1: Stakeholder Alignment Survey—Average Score by Respondent Category



The Stakeholder Alignment Survey is a proprietary culture performance evaluation tool provided through Castling Partners, LLC and Keystone Culture Group, LLC.

partners of community hospitals. (See **Exhibit 1**. Where highlighted, stakeholders were asked about their "beliefs" as they relate to how "the health system values independent physicians" and how "the health system values employed physicians.")

Community hospitals and health systems that have pursued paths of aggressive acquisitions have, for the past several years, struggled with the economics and financial performance of their strategy. A number of organizations on this path have scaled up "dis-economically."[4] Governing boards of the acquirers haven't always been clear on the strategy for creating accretive acquisitions and those acquired have moved forward with transactions believing that the promised "economies" existed, somehow, in the roll-up of the revenues over multiple acquisitions. Examinations of the results of these roll-ups have, for a significant proportion of larger health systems, demonstrated declining free cash flow productivity[5] and increasing pressures on financial performance of the acquiring health systems, overall. Restoration of these health systems' balance sheets to positions of strength will be a challenge moving forward. Managing balance sheet risk will rise to the top of CEO and board risk management strategies—especially as care models move to outpatient settings at accelerating rates.

Not-for-profit hospitals and health systems in the U.S. are facing financial headwinds while taking on more leverage due to increasing debt levels.[6] At the same time, credit agency downgrades are outpacing upgrades.[7] Stated reasons for credit rating downgrades are attributable to financial headwinds driven by "per unit" operating expense rate trajectories that are on a steeper, upward trend when compared with "per unit" earned revenue rate trajectories, increasing dependence on fixed-price governmental payer contract volumes, declining inpatient bed-day rates, and the mounting costs of amassing increasing numbers of employed physicians. All of this is

4 Daniel K. Zismer and David Schuh, "Clinical Service Line Strategy; Managing the Risks of Geographic Expansion," *HFM,* Healthcare Financial Management Association, July 2016.
5 Daniel K. Zismer and Carsten Beith, "Free Cash Flow Productivity and Its Connections to U.S. Health System Financial Performance and Strategy in Current and Future Markets: A 'Macro View' of a Potentially Systemic Problem," The Governance Institute, 2014.
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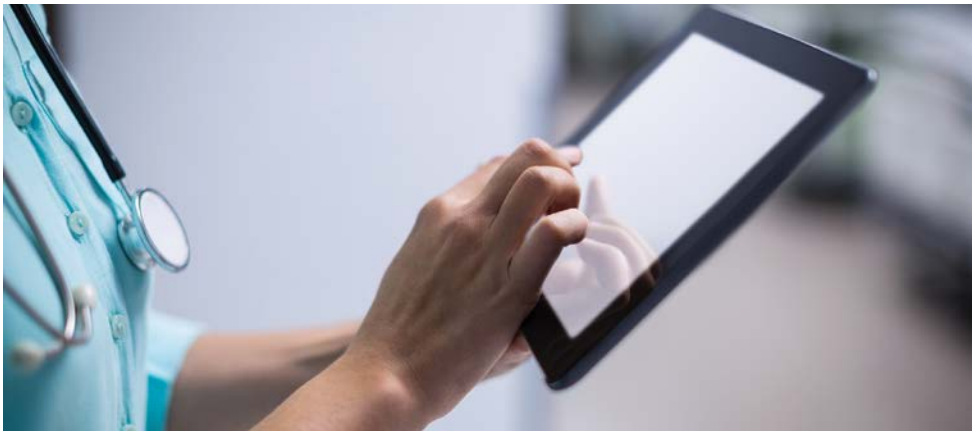

occurring at a time when available balance sheet capacity should be directed to ambulatory care assets and related programming. Moreover, inasmuch as the majority of hospitals in the U.S. are under 200 beds and upwards of a third remain independent, peer group comparisons of relative balance sheet conditions are of little practical use when the real question for any one hospital or health system is, "Can we afford what we need to do to reposition our organization for success in an uncertain future?"

Developing a Unified Belief System

So, let's return to the going-in proposition that not-for-profit community hospital and health system CEOs and governing boards need to shift emphasis to comprehensive, corporate, financial, and strategic risk management for their organizations. What are the areas of "deep thought" that may lead to more effective management of risk as a component of organizational transformations? More specifically, it's important to look at what issues must be addressed through the lens of leaders' unified "belief system." This includes addressing the question, "What do we believe to be true about our organization's future performance in a changing marketplace?" Boards and senior leadership teams, together, must develop a unified belief system to successfully pursue any strategic path.[8] A sample framework for the development of a unified belief system follows:

1. **The movement of physicians from independent practice to hospital/health system employment platforms**. By the end of 2016, more than 40 percent of all physicians in the U.S. reported being employed by organized health systems—a 60 percent increase from mid-2012. All geographic regions in the U.S participated in this trend.[9]
2. **Physician specialties and/or independent groups in our market that will be encouraged to mount strategies that are competitive with community hospitals/health systems**. While it is true that an increasing number of physicians will seek employment, opportunities for entrepreneurial pursuits will remain for certain clinical specialties—specialties that will remain important to the mission, strategy, and financial performance of community hospitals and health systems (such as orthopedics, GI, ENT, cancer care, urology, ophthalmology, and other procedural services that lend well to larger-scale ambulatory strategies). Private equity investors are aggressively pursuing these specialties for partnerships.
3. **Ambulatory strategy investment requirements, including facilities, will require significant investments over a short timeframe**. For many healthcare organizations, in excess of 70 percent of all care will be delivered from sophisticated, high-tech ambulatory facilities, staffed by highly specialized providers and support staff. Many community hospitals and health systems do not have the balance sheet capacity to create such "platforms" while they invest sufficiently in required inpatient and related care system upgrades and asset replacement investments.[10]
4. **Information technology investments will be required in parallel with other large-scale strategic investments**. Integrated information strategies, including electronic healthcare records, can consume extraordinary proportions of available investment capital capacity. While essential to the cause, most hospitals and health systems experience declines in financial productivity during implementation of an EHR, and for the first few years thereafter. Few have experienced enhanced financial productivity beyond the baseline.
5. **Workforce challenges will increase**. All healthcare providers will experience a shortage of highly trained and skilled staff, especially those with technical skill sets that are transferable across industries. The risk is that the "best and brightest" will not be attracted to healthcare at all, much less community healthcare delivery where the speed of innovation often lags behind other healthcare market sectors and other industries.
6. **Likely competitor strategies and effects on our future success**. As noted here, private equity is chasing key clinical specialties in service areas where hospitals are less important to care models. Likewise, physicians will find less traditional partners to pursue their visions for their future world. Community hospitals and health systems need to take stock of who their competitors might be. They may not be the hospital in the adjacent county.
7. **Our real balance sheet capacity framed in a context of the most likely strategic investment spending requirement profiles**. This includes the costs related to the funding of the community hospital/health

8 Daniel K. Zismer and Ben Utecht, "Culture Alignment, High-Performing Healthcare Organizations, and the Role of the Governing Board: Part One: Culture and Culture Alignment—The Foundation of a Board's Culture Game Plan," The Governance Institute, E-Briefings, March 2018.

9 Daniel K. Zismer and Ben Utecht, "Culture Alignment, High-Performing Healthcare Organizations, and the Role of the Governing Board: Part Two: Setting a Culture of High Performance and the Responsibility of Governing Boards," The Governance Institute, E-Briefings, May 2018.

10 Daniel K. Zismer, "How Might a Reforming U.S. Marketplace Threaten Balance Sheet Liquidity for Community Health Systems?," Integrated Health Systems, *Journal of Healthcare Management,* May/June 2013.

system. The "real story" of the balance sheet is not told by the balance sheet. The balance sheets of community health systems and hospitals never reflect an accurate and reliable picture of the future investment needs of the organization. "Old school" formulae used to forecast future capital asset spending requirements are no longer helpful.

8. **An in-depth analysis of the historic and existing mission spend and its sustainability**. "Mission" is defined variously across community hospitals and health systems. Consequently, the related cost structures differ, as do the expected methods of funding mission plans. Mission plans that are dependent upon cost-shifting (i.e., increasing costs of health services to a handful of commercial insurance or managed care plans) are not sustainable. An informal survey of community health system CFOs indicated that the net profit margin performance on commercial payer reimbursements was required at a 36–42 percent level to offset the operating losses realized from governmental reimbursements. Missions requiring such a cost shift are, undeniably, non-sustainable.
9. **The sensitivities of the organization's financial model as it relates to existing clinical programming** (i.e., where and how the financial performance is sensitive to the organization's clinical portfolio composition). The majority of free cash flow productivity for hospitals and health systems is often concentrated with a small handful of clinical programs (e.g., cardiovascular services, orthopedics, and a few surgical and procedural specialties).[11] When aggregate operating margin is sensitive to a small number of clinical specialties, the overall financial performance structure of the organization is at risk.
10. **The organization's real value as perceived by payers, employers, and other influential stakeholders**. The most sophisticated commercial payers and self-insured employers, along with governmental payers, will turn a substantial amount of their attention to total costs of care performance of contracted providers—meaning, the cost profiles of community health centers, related specifically to the management of chronic conditions by affiliated providers. One multi-state provider of community health services recognized that when depression is a secondary diagnosis for any patient with a chronic condition, total costs of care, over time, were on average 25 percent higher than that same condition without this concomitant diagnosis. All payers will have more data on a health system's total cost of care profiles than the large majority of all health systems. Healthcare organizations with high total cost of care profiles for expensive chronic conditions will become targets for cost-reduction strategies, including the diversion of patients to lower-cost providers.

The position presented here can be summarized as CEOs and boards of hospitals and health systems will need to shift an increasing proportion of time, energies, and resources to "strategic risk management"—the definition of which must be developed beyond that familiar to most healthcare boards. The way to begin is the development of a "shared belief system" built from the framework provided. This shared belief system answers the important question relating to "What, together, do we believe will most affect the future of the organization we lead and how are we going to pursue an effective strategy, while managing the risks that pertain?" The answer lies with the corresponding strategy. A unified and shared belief system and a culture of shared performance accountability[12] becomes the bedrock of the governing board and senior leadership team partnership for hospitals and health systems in today's world of community healthcare.

The Governance Institute thanks Daniel K. Zismer, Ph.D., Co-Founder and Managing Director of Keystone Culture Group, LLC, Co-Chair and CEO of Associated Eye Care Partners, LLC, Co-Founder and Managing Partner of Castling Partners, LLC, and Professor Emeritus and Chair, Healthcare Administration, School of Public Health, University of Minnesota. He can be reached at daniel.zismer@castlingpartners.com.

11 Daniel K. Zismer and Donald Wegmiller, "Clinical Service Lines: Mapping the Future of Community Health," C-Suite Resources Report, July 2012.
12 Daniel K. Zismer and Ben Utecht, "Belief Systems and Healthcare Strategy," Keystone Culture Group, The Keystone Way, Vol. 1, Issue 2, November 2018.

A New Conflicts of Interest Primer

By Michael W. Peregrine, McDermott Will & Emery

Key Board Takeaways

- Does the board have a modern approach to identifying conflicts that takes into account the evolution and diversification of the healthcare industry?
- Is the board's conflicts policy sufficient to monitor emerging conflicts?
- Do board members monitor the facts associated with major health system conflicts controversies?
- Does the board have an effective process for evaluating conflicts disclosures?

The hospital and health system sector has experienced several important and widely publicized conflicts-of-interest controversies in the last several months. They have resulted in resignations of officers and directors, implicated matters of individual and organizational reputation, and suggested collateral self-dealing concerns. In so doing, they have heightened the concern about board member conflicts with legislatures, regulators, and the media.

These controversies provide a useful opportunity to refresh board members' awareness of proper conflict-of-interest management—i.e., to review "what it's all about." This includes, but is not limited to, the types of arrangements that give rise to conflicts of interest, the continued adequacy of the board's conflicts policies, and appreciation by officers and directors of their relevant fiduciary obligations.

This article provides a "primer" from which hospital and health system boards can pursue their "conflicts refreshment."

Focus on loyalty. Director obligations concerning conflicts of interest arise within the context of the bedrock fiduciary duty of loyalty. This duty obligates the director to exercise his/her corporate authority in good faith and in the best interests of the organization—as opposed to the director's own interests or the interest of another entity (e.g., the constituency that may have selected the director or who the director may otherwise represent). As it relates to conflicts of interest, the duty of loyalty incorporates responsibilities with respect to disclosure, evaluation, and management of potential and actual conflicts of interest.

It's a matter of law. The duty of loyalty (and its provisions regarding conflicts of interest) isn't some "warm and fuzzy" concept of governance best practices. It is a legal obligation. Fiduciary duties such as those pertaining to care and loyalty arise under principles of common law, and in certain states within specific provisions of the corporation code (some of which contain specific "presumption-shifting" exceptions grounded in reasonableness). Similar prohibitions against self-dealing also arise under state and federal regulation. Thus, it is that state courts, the state attorney general (as to non-profit organizations), and federal courts and regulators have authority to evaluate conflicts-laced transactions.

The fundamental analysis. The goal of conflicts and anti-self-dealing laws and policies is to ensure that directors don't use their position—including voting rights (and any special influence within the boardroom)—for their personal advantage. To achieve this goal, directors must be vigilant to arrangements that create the potential for conflicts, and try to avoid them when possible. And when they do arise, the following analysis should be applied: Is the nature of the director's interest in the arrangement of such personal significance that it could reasonably be expected to exert an influence on the director's judgment when voting on the arrangement?

Why we care. Violations of conflicts-of-interest-related obligations can have serious consequences for the organization, and for the individual director. For example, courts will harshly judge breaches of loyalty, especially in the context of non-profit corporation board service. Third parties (e.g., a regulator, a corporate member, or constituents in a derivative action) may be able to challenge the validity of a business arrangement that is the byproduct of conflict. Conflicts of interest can lead to significant reputational damage to individual directors and to the organization. The presence of conflicts can also be a "red flag" to regulators of the potential for other legal violations.

Disclosure is the key. Having a conflict of interest does not, in and of itself, violate the duty of loyalty (except perhaps where a director pursues an arrangement knowing it to create a potential conflict for the organization). Rather, the greatest risk of breach arises when the director fails to timely and adequately disclose the existence of the arrangement to the board. Such failure frustrates the board's right to be made aware of the arrangement, to determine whether indeed it creates a conflict of interest, and to identify whether the conflict can be managed. The board has a right to know when a director may be acting under dual loyalties.

What's different now? The seismic change enveloping the healthcare industry is having an enormous impact on the conflict-of-interest process of hospital and health system boards. For example, there are new concepts of who—or what—is a competitor. There's a much broader scope of investment interests that could potentially influence a fiduciary's decision making. Dualities of interest once considered non-threatening may now present significant conflict concerns. The personal relationships of fiduciaries are now fair game for conflicts consideration. And the public, media, and regulators are much more aware of conflicts than before. These prompt a more expansive approach to disclosure.

Process counts. The fiduciary duty focus on conflicts is not entirely related to the duty of loyalty. Even the most precise loyalty compliance can't support the effectiveness of a conflict-of-interest policy if the manner in which the board/committee evaluates individual disclosures is not consistent with the duty of care. Key factors include the delegation of board authority to a committee responsible for addressing conflicts, composing the committee with independent directors, staffing the work of the committee with key officers (e.g., general counsel, chief compliance officer), setting standards by which disclosures will be analyzed, and applying the statutory rebuttable presumption where available.

More than once per year. The completion of the annual conflicts disclosure questionnaire should not be the "sum and substance" of the conflicts review process. There needs to be a mindset amongst directors that prompts them to periodically update their disclosures as circumstances arise in the year

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Improving Community Health…

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with such organizations as the YMCA of West Central Florida, Volunteers in Service to the Elderly, local colleges, Healthy Start Coalition, homeless ministries, literacy organizations, and the local United Way. Together, we have found so many innovative ways to strengthen the health of our community.

These partners agree that health literacy, transportation, and lack of insurance are extenuating barriers to healthcare access, and we pool resources to come up with pragmatic and feasible solutions. These include:

- **Get active:** Our relationship with local YMCAs allows us to offer an eight-month program aimed at getting people moving with free Zumba, yoga, and strength-training classes.
- **Early intervention:** We work closely with Nemours Children's Health System and the Early Learning Coalition of Polk County to ensure children enter school healthy and are able to benefit from ongoing health education in supportive and engaging environments.
- **Food pantry:** We collaborate with Feeding Tampa Bay and a local church with a robust health ministry program to provide a monthly neighborhood food pantry.

With the guidance of our board, we also determined that we needed a dedicated professional fully devoted to community health programming and education. These issues were too important and were now too ingrained in our organizational strategy to not have someone whose main mission was to strengthen the health of our community. We hired a community health manager, who is helping us to gradually move the needle, one person at a time.

As one FitChurch Challenge participant wrote to tell us, "I am a surviving terminal cancer patient. This has been so good for me physically, mentally, and spiritually. I have not always been so active. I've joined the YMCA to take swimming lessons, which is something I've always wanted to do…The FitChurch Challenge has encouraged me to get up, get out there, and keep living."

The Governance Institute thanks Elaine C. Thompson, Ph.D., FACHE, President and CEO, and Jennifer Audette, Manager of Marketing Events and Public Relations, Lakeland Regional Health, for contributing this article. Dr. Thompson can be reached at elaine.thompson@myLRH.org.

Physician Transparency…

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from using these tools to inform their healthcare choices.

What Effective Transparency Looks Like

By publishing independently verified provider ratings and reviews on their Web sites, healthcare organizations can give consumers the information they want, in a format they can digest. To succeed, however, transparency initiatives must embody four traits:

- **Accessible**: Reducing friction is a guiding light in Web design. So should it be for transparency. It's critical that consumers encounter minimal obstacles on the way to the information they want. Quality and satisfaction data need to be easy to find and should not require any logins or form-fills.
- **Relevant**: Ratings and reviews should not overwhelm patients. Rather, transparency solutions must offer sort and filter functions to make it easy for patients to consider their options. This way, they can find providers who can help them with their specific health concerns. Further, according to *Health Affairs*, transparency solutions should also combine quality ratings with consumer reviews.[10]
- **Intuitive**: When it comes to transparency, design matters. The number of providers to appear on screen, the scale of quality to use, or even color choices can dramatically affect usability. The wrong choices could leave 20 percent fewer people understanding the data in front of them.[11] Any transparency solution, therefore, must emphasize clarity and concision.
- **Trustworthy**: Finally, and most importantly, transparency solutions must be credible. This means that, while libelous or abusive comments can (and should) be deleted, negative comments must be allowed to let stand (so long as they've been verified). There's a reason that few people trust perfect five-star reviews on Amazon—they recognize that what seems too good to be true probably is.[12]

It Begins in the Boardroom

Healthcare transparency isn't just a strategic initiative or a software-based solution. It's an ethic, a mindset, an approach to patient communication that's premised on openness and mutual respect. Adopting transparency means adopting a culture of clarity. And that cultural shift begins in the boardroom.

As consumers continue to exert their influence in the healthcare market, heeding their demands and desires becomes essential for hospitals and health systems to thrive. Part of upholding the board's fiduciary duty, then, is guiding organizations to embrace what consumers are asking for. Patients have made it clear that they want transparency from their providers. Strategically—and ethically—minded boards will strive to give it to them.

The Governance Institute thanks Andrew Ibbotson, General Manager, NRC Health, for contributing this article. He can be reached at aibbotson@nrchealth.com.

10 Steven D. Findlay, "Consumers' Interest in Provider Ratings Grows, and Improved Report Cards and Other Steps Could Accelerate Their Use," *Health Affairs*, April 2016.
11 Olga C. Damman, et al., "Making Comparative Performance Information More Comprehensible: An Experimental Evaluation of the Impact of Formats on Consumer Understanding," *BMJ Quality & Safety,* 2016.
12 Beth Moellers, "Spiegel Research Reveals 4.5 Stars Are Better Than 5," The Medill IMC Spiegel Research Center, August 4, 2015.

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(conferring as necessary with the general counsel or compliance officer). More particularly, the board should distribute supplemental conflicts disclosure questionnaires to address conflicts issues arising from critical proposed business transactions or arrangements, such as a merger/acquisition or a major investment. A conflicts policy that is not updated throughout the year may be insufficient to protect the organization's interests.

Management plans sometimes work. Many boards may reasonably move forward with conflict-of-interest-related arrangements under the supervision of specially crafted conflicts management plans. This approach is typically applied when non-conflicted board members are satisfied with the reasonableness of the terms and conditions of the arrangement (conflict notwithstanding) and believe that the arrangement offers substantial (e.g., "compelling") benefit to the organization and its mission. Management plans are written documents that provide for close monitoring of the arrangement post approval to make sure the perceived benefits are achieved without inappropriate personal benefit. The plans also provide for termination of the arrangement under specific circumstances.

Appearances count. Arrangements that only create the appearance of a conflict (as determined by the conflicts committee) may nevertheless create two significant risks for the organization and the individual director: 1) the risk of reputational harm arising from media reporting on the arrangement (reporting may apply a more superficial, "common sense" analysis), and 2) the potential for regulatory inquiry based on such media or whistleblower reporting of the arrangement—and the significant legal costs that can be incurred in responding to such an inquiry. Thus, the conflicts committee should also monitor the impact of director interests that only create the appearance of a conflict.

The Governance Institute thanks Michael W. Peregrine, Partner at McDermott Will & Emery LLP, for contributing this article. He can be reached at mperegrine@mwe.com.

Shifting Financial Risk…

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boards and their management teams will need to analyze their markets, determine the potential for competitors or disruptors to enter and accept risk, and develop a holistic, all-payer strategy as part of their planning and financial oversight responsibilities.

Managing Resources for Optimal Outcomes

As part of moving to risk-based models, payers are more frequently providing organizations with claims, utilization, and other data. For example, Medicare ACOs receive full Parts A, B, and D claims data on their assigned beneficiary population to manage the population and drive performance improvement. This tsunami of data allows providers to develop the capabilities to fully take advantage of the information available. (These functions often may best be developed and managed through the structure of, and in conjunction with, an ACO or clinically integrated network.) Leveraging data analytics and providing transparent physician-level reports in real-time is critical. Likewise, using technology for predictive modeling and risk stratification allows for greater focus of resources on opportunity areas to improve total cost of care and quality outcomes.

The processes and activities described provide the basis for developing robust care coordination and cost management programs. Leveraging an advanced primary care model and a multi-disciplinary care team to focus on managing high-cost populations is essential for success in two-sided and global risk models. These resources can be utilized to manage patients with chronic disease and high-utilizers, and provides for seamless transitions of care and readmissions reduction.

Board Next Steps

Payers are moving rapidly to shift financial risk to providers. This creates opportunities for those that are prepared for risk and potentially serious threats for those that are not. To ensure success in risk contracting, boards and their management teams must work together to ensure a clear understanding of the organization's tolerance for financial risk, correlated to the contracting models that will be considered. With the acceptable levels of risk identified, the board can appropriately oversee strategies that management develops and implements.

Boards will increasingly face policy decisions regarding strategic, financial, operational, and clinical implications of moving from FFS to value- and risk-based reimbursement arrangements. Boards and their management teams will need to analyze what additional strategic investments will be essential in information technology, data analytics, decision support actuarial, and other resources as they work to minimize the variation in measures and design of the models they choose to join.

The Governance Institute thanks Guy M. Masters, M.P.A., Principal, Premier, Inc., and Governance Institute Advisor, and Seth Edwards, M.H.A., Vice President in Population Health, Premier Performance Partners, for contributing this article. They can be reached at guy_masters@premierinc.com and (818) 416-2166, and seth_edwards@premierinc.com and (704) 309-3645.

Shifting Financial Risk to Hospitals and Health Systems

By Guy M. Masters, M.P.A., and Seth Edwards, M.H.A., Premier, Inc.

The Centers for Medicare & Medicaid Services (CMS) is leading a national movement to reduce total costs of care and improve the quality of healthcare services. CMS is requiring hospitals, health systems, and other providers to increasingly take two-sided financial risk particularly through accountable care organizations (ACOs), bundled payment agreements, and other managed care contract arrangements. As more financial risk is shifted to care providers, there are opportunities, challenges, and potential liabilities that boards must assess and consider as part of their oversight responsibilities for financial management and strategic planning.

Critical Success Factors for Risk Contracting

Boards must ensure that management develops a holistic all-payer strategy for assessing and potentially assuming risk. An effective strategy should be built upon a clear understanding of the market and competition, and the potential for non-traditional healthcare organizations to enter and disrupt traditional patient and consumer access behaviors and loyalties. Hospitals and health systems will also need to have staff with appropriate skills and experience, as well as the decision support and information technology resources necessary to be successful in two-sided risk agreements.

In most markets, the predominant model of reimbursement is still fee-for-service (FFS), which incents volume over value. Many healthcare organizations' strategies are built around this approach. As organizations transition from FFS to value-based care, they may face erosion of inpatient utilization as well as additional expenses associated with developing and implementing new coordinating care models for patients. Often at this stage, there is a need to rationalize services provided across the health system.

To ensure alignment across multiple reimbursement models, health systems will need to develop a system-wide strategy to address value-based payment and care delivery models. This transition will require alignment of incentives across all aspects of healthcare finance and service delivery. Leaders should work toward the goal of ensuring patients are seen at the right place and time by the appropriately skilled and resourced clinician. The changing landscape will require health systems to analyze the financial, operational, and clinical effects from two-sided risk agreements to determine those appropriate to accept.

Reducing the Total Cost of Care and Improving Clinical Outcomes

An essential element for success under two-sided, risk-sharing arrangements is reducing costs while maintaining or improving patient outcomes. If hospitals and health systems experience reduced utilization of high-cost services, particularly in the inpatient and post-acute settings, boards need to be kept apprised of these shifts and plan for the impacts of changes in utilization patterns. Their role is to align and monitor the movement to risk with strategic initiatives designed to ensure optimal clinical and financial performance.

CMS announced intentions to develop additional models in order to speed the movement to Advanced Alternative Payment Models for the Quality Payment Program (QPP).[1] At the best of circumstances, these models work well with each other; however, at the worst of times, the models conflict and have unintended consequences for overlapping participants.

Some payers have more attractive mechanisms for managing a population than others. For example, in Medicare FFS ACOs there is an inability to keep beneficiaries within a narrow network. However, Medicare Advantage (MA) plans require that beneficiaries remain in their selected MA plan network and stay within it for a specified period of time. These nuances could play a significant role in the success or failure of participating organizations.

Market Characteristics, Disruptors, and Other Trends

As more payers move toward two-sided and global risk models, non-participation may become a competitive disadvantage for healthcare organizations. Hospitals and health systems that do not participate in these new models leave open the potential that another organization will accept the risk, thus placing them in the position of being a cost center for their competitors' savings.

There are a large number of disrupting organizations entering the healthcare industry. Groups that leverage venture capital investment are working to organize clinicians (largely primary care providers) to form entities with the ability to accept risk. Commercial payers are also entering into the provider space, leveraging primary care to coordinate care for patients with the goal of keeping them out of the most expensive sites of service.

Organizations offering Advanced Alternative Payment Model status (most two-sided risk models) are attractive for clinicians due to the potential for a guaranteed bonus under the QPP. To this end, a strategic imperative for hospitals and health systems is to ensure they are offering independent clinicians the greatest support possible for the QPP. In many instances, this strategy may include taking downside risk if there is a potential for a competitor or disruptor in the market who is willing to take it and potentially attract clinicians. In order to be successful,

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Key Board Takeaways

Board oversight strategies include:

- Create patient-centric, physician-aligned, multi-disciplinary care management teams to focus on managing complex patients and high-cost populations (e.g., social determinants, chronic disease patients, behavioral health, and high service utilizers).
- Align payment models with care management and quality improvement initiatives.
- Ensure the ability to integrate and analyze clinical, financial, claims, and other data into useful provider information with real-time access.
- Establish a strong primary care network of aligned, incentivized, value-focused physicians with care management interest and experience.

1 CMS, "Innovation Models."