BoardRoom Press

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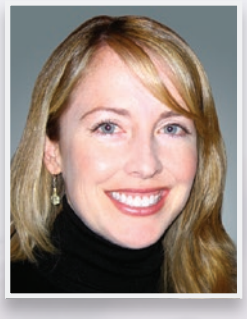

Charting Our Course Forward

We are living and breathing COVID with no end in sight. Healthcare boards have entrusted their leadership with responding to the pandemic by increasing PPE supply, expanding capacity, pivoting to telehealth, and training and educating their workforce and communities. Now it is time for boards to come back to the [virtual] table, look to the future—now, near, and far—and find a way to chart a new course. This course will be strange and new and unlike anything we have charted before.

We chose the articles for this issue very carefully, to address topics that are equally important to boards now as well as going forward. Providers will need to realign purposes and priorities to work together to create a better, stronger healthcare system. The board and management should always ensure that they are regularly communicating and in sync, but this is especially important today. COVID has forced us all to look at financial resilience to find new, imaginative ways to see our organizations through this as well as future challenges. Every organization needs to be taking a critical look at digital health capabilities to expand rapidly for today and for the long term, not for technology's sake but for better consumer experience and outcomes. Finally, achieving greater systemness is ever more essential for multi-hospital healthcare entities to achieve better care, better value, and better patient experience. Let us not lose sight of the future, and start now to create one that is better than we have ever imagined.

Kathryn C. Peisert,
Managing Editor

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Working with Leadership to Ensure Success

By Mike Milburn, Benefis Health System

Mike Milburn
Chairman, Board of Directors
Benefis Health System

Good communication is an essential element in any professional relationship, but particularly so between the chairman of the board of an organization and its CEO. Board education also is critical to ensuring a strong relationship between management and the board; as board members' understanding of issues increases, so will the quality of their advice and assistance.

Benefis Health System in Great Falls, Montana, is a not-for-profit community health system that serves nearly 230,000 residents across a 15-county region. As chairman of the system's board of directors, I am fortunate to have an excellent working relationship with CEO John H. Goodnow, FACHE. Our relationship is characterized by communicativeness and a commitment to board education as we work together to ensure value and organizational financial success.

The system's 11-member board of directors is responsible for approving the strategic goals of the organization and evaluating the CEO's performance in achieving organizational results, whereas the daily operations of the organization are the responsibility of the CEO and his management team. It is important that these responsibilities remain distinctly delineated between the board and management or the working relationships between the board and the CEO can become strained.

In addition, the board oversees and/or coordinates eight subsidiary and advisory boards. At least one individual from the health system board acts as either a voting member or liaison for most of these boards, ensuring that system board members understand the perspectives of these various boards. There are four system board committees as well.

Focus on the Value Equation

Although numerous issues vie for the board's attention, Benefis places significant emphasis on its value equation: good outcomes at lower-than-expected costs.

Key Board Takeaways

A strong relationship between the board chair and CEO relies on:

- Ensuring management and board leadership place a significant emphasis on the organization's value equation.
- Good communication between management and the board.
- Board education to help board members better understand current national and local issues and possible strategic solutions.

Board and Management Alignment during a Crisis

The board and management should always ensure that they are regularly communicating and in sync, but this is especially important today as healthcare leaders navigate the COVID-19 crisis. Some tips for ensuring board and management alignment include:

- **Communicate consistently.** It's critical for there to be regular communication between the board and leadership. Things can change quickly, so the board needs to know how and when they will be kept informed during a crisis. The board and CEO can work together to create a communication plan that includes how often they will connect and what types of communication channels work best. Consistent communication will help build trust, ensure transparency and alignment, and keep the board engaged.
- **Be clear about the roles of management vs. governance.** Have a conversation about who does what and who has the final say on various issues during a crisis. For example, ensure the board understands who should or should not speak on behalf of the organization in an official capacity. In these unique circumstances, the rules may change so even if you have had the conversation several times before, it's time to revisit this discussion so there is no confusion.
- **Work as a team.** These situations create an opportunity to build the relationship between the board and management. Consider it a joint effort to navigate the challenges, unknowns, and stressors that come with a crisis. Ensure the board and leadership are always in sync and lines of communication are open for sharing insights and asking questions.

When it comes to ensuring organizational financial success, management is responsible for the health system's financials. However, it's the responsibility of the board and the finance committee to bring forth questions if they notice something isn't progressing as expected based on the organization's budget.

Related to quality, the board outcomes committee is responsible for reviewing the health system's patient satisfaction, clinical quality and outcomes performance, as well as the development and recommendation of policies and standards concerning quality improvement.

To effectively address concerns, the board tries to match the expertise of its members to the various boards and committees on which they serve. For instance, the chairman of the outcomes committee is a physician and a director on the system board, so he is very knowledgeable about the various quality controls that the board is monitoring. Alternatively, board members with financial backgrounds instead serve on the finance committee.

Communication Is Key

Regardless of what issues our system is facing, good communication with and from our CEO is key, and in that respect, Benefis has been fortunate to have a strong CEO who values communication. Recently, the national COVID-19 outbreak reinforced the value of communication, particularly during a crisis. Regular communication with the board regarding the status of the health

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COVID-19 and a New Financial Perspective for Hospitals

By Kate Guelich and Dan Majka, Kaufman, Hall & Associates, LLC

The COVID-19 pandemic has significantly disrupted the operational and financial landscape of hospitals and health systems nationwide. Historically, most hospitals have relied on a flow of elective, non-urgent procedures reimbursed by commercial payers to maintain financial health, as margins for medical patients and from government payers are either narrow or negative.

The COVID-19 pandemic has shown what happens when this lifeblood of hospitals' financial health goes away for a significant time. As a consequence of the pandemic, many healthcare organizations have decreased or stopped elective, non-urgent procedures for extended periods. The central financial planning challenge for hospitals now is to deal with any continued immediate threats to their financial viability, and to adapt for the new revenue, cost, and operational picture of a recessionary, post-COVID environment.

Organizations have faced serious revenue erosion and expense increases in recent months. Many have had to make hard decisions to contain costs, including reducing hours, scaling back benefits, and cutting staff. In the midst of the surge, executives shifted all focus to ensure they had the capacity, staff, and equipment to test and treat COVID-19 patients. For the most part, organizations found that the virus hit them more quickly than they ever could have imagined, and the impact was more profound than they ever could have envisioned.

Boards and senior leaders must work together to continue to address the major financial consequences of this misbalance of revenue and expenses. Doing so requires ensuring their organizations have a clear and full picture of the pandemic's impacts—both since its start and moving forward. **Exhibit 1** lists key metrics that senior leaders and directors should be monitoring to inform their current financial position, and to help them prepare for immediate and longer-term next steps.

Adapting for a New World

Hospitals will find themselves in a very different recessionary and post-recessionary world. The rebound in elective and non-elective procedures is proving unpredictable.

Organizations typically fit into two broad categories in how they think about the immediate and longer-term financial implications. One category comprises organizations that, before the virus, were operating with marginal profitability and relatively weak balance sheets. For these hospitals, the immediate concern is how to continue to navigate the virus and recessionary pressures in the short term. They need an understanding of exactly what financial damage has been done and is expected in the coming months in order to make precise financial decisions that will best serve the hospitals and their communities in the short and long run.

If they have not already, this group needs to start as quickly as possible to determine changes to their cost structures in order to weather a potential longer-term decrease in volumes. For some independent organizations, partnership options may need to be assessed.

Organizations that are stronger financially, many of which are larger systems, have a somewhat different financial planning perspective. For these organizations, the longer-term financial issues have to do with how to remain financially sound when the major source of margin is dramatically reduced for a significant period of time. Such organizations need to look at costs through a new lens. They may look for substantial capital budget reductions, cancel certain large initiatives, and take a hard look at their hospital portfolios, overhead costs, and labor. The level of cost reduction is likely to be meaningful in every respect, and the cultural and political adjustments could be significant.

In general, larger organizations need to continue to plan for unexpected

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Key Board Takeaways

As COVID-19 continues to disrupt the traditional foundations of U.S. hospitals and health systems, boards and senior leaders must be diligent in monitoring the pandemic's continued repercussions, and in planning to close financial gaps. Questions to ask include:

- What is the organization's payer mix and how has it changed due to COVID-19?
- How is management addressing continued COVID-related demands and costs?
- What performance metrics is the organization tracking to assess the impacts of the pandemic?
- What type of budgeting processes are senior leaders using to ensure flexibility?
- What steps is management taking to plan for the new revenue, cost, and operational picture of a post-COVID environment?

Continuing to navigate the pandemic's short- and long-term impacts requires timely data, sophisticated analysis, and flexible forecasting and budgeting methodologies for an unpredictable future.

Exhibit 1: Key Metrics for Tracking the Impacts of COVID-19

Volume and Revenue	Expenses	Balance Sheet and Cash Flow
• Elective volumes • COVID-19 volumes • ED visits • Service mix • Payer mix • Intensive care • Bad debt • Physician visits • Telehealth • Governmental support • Philanthropy	• Workforce • Supply chain • Physician productivity and compensation • Emergency preparedness • Capacity implications • Interest expense	• Collections of receivables • Accounts payable management • Invested asset portfolio/ investment income • Near-term liquidity requirements and capital access • Capital structure disruption • Pension funding • Debt capacity • Swap collateral posting requirements

Source: Kaufman, Hall & Associates, LLC

Medicare Direct Contracting and the Impact of COVID-19 on Value-Based Payment Strategy

By Allen Miller and Cindy Ehnes, COPE Health Solutions

The Chinese saying, "Crisis equals opportunity," may seem callous with relation to the COVID-19 pandemic; however, it is definitely apt. By most indications, the next several quarters, if not years, will be daunting for senior leaders, boards, and the health systems and hospitals they run, while at the same time creating new opportunities for those nimble enough to move quickly. There will be unique opportunities amid the challenges for boards to assess and provide counsel to management but also to take on longer-term strategic planning work.

There has been much written recently on the havoc COVID-19 treatment and prevention efforts have inflicted on physicians and hospitals. Both are rethinking their partners and payment models in order to minimize the financial impact of the massive reductions in office visits and elective services. Amidst this increasingly complex and strategic reimbursement environment, the reimbursement landscape post-COVID-19 will continue the trend toward health systems and physicians assuming greater financial risk.

Therefore, one of the most pivotal strategic decisions is the assessment of opportunities to adopt and implement a value-based payment (VBP) (or premium risk-based) reimbursement strategy as a core design element. An increasing number of providers, particularly physician groups, have embraced VBP with downside risk and its focus on accountability for cost and quality. VBP models can incentivize hospitals and healthcare providers to work in a more coordinated manner, focusing on delivering high-quality care while avoiding unnecessary utilization and costs. There are opportunities to partner closely with payers to develop benefit plans and VBP agreements that can grow market share, access to premium dollars, and accountability for actively managing an attributed or assigned population.

This issue is not on the top of executive leadership or board members' minds as they respond to the crisis; however, advancing value-based care has been a priority for Congress, multiple administrations, and large self-insured employers for some time. Given crushing fiscal constraints, it is likely that the pressure to engage will only increase.

One VBP model that became available for participation during 2020 is the Centers for Medicare and Medicaid Services (CMS) Medicare Direct Contracting Model ("Direct Contracting"), which encourages health providers to assume increased financial risk for greater reimbursement returns.[1]

Medicare Direct Contracting envisions allowing providers and risk-bearing entities such as independent physician associations to "directly contract" with CMS and receive monthly capitated payments for the care of their patients. It is a voluntary, risk-based initiative to transform the Medicare program's reimbursement of primary care services from a fee-for-service payment system to a value-based system that rewards physicians who keep patients healthy and reduce total cost of care.

Regrettably, CMS maintained the close date of May 1, 2020, for applying to participate in Direct Contracting for the 2021 performance year. This was an unfortunate decision that compelled potential applicants to design a risk-based direct contracting program in the middle of a crisis. Failure to have submitted an application during the allowed timeframe resulted in many organizations now ineligible to complete an application and plan. As well, to further muddy the strategic waters, it is unclear whether there will be additional application windows for future performance years through 2025 when the program is currently slated to end.

Despite this uncertainty, CMS is the "lead dog" in fostering reimbursement and contracting relationships, whether with health plans or providers. Collectively, Medicare patients offer the largest opportunity to reduce healthcare spending for the federal government. It is unquestionable that the devastating financial landscape post-COVID will create far greater pressures to flatten healthcare costs and therefore a continued focus on VBP.

Key Board Takeaways

- Post-COVID providers are seeing the unique opportunities to achieve consistent financial sustainability through value-based payment arrangements; Medicare Direct Contracting, if not a good fit or if your organization missed the letter of intent, provides an excellent roadmap in its application for what is required for success in value-based contracting.
- Additional value-based payment options include the MSSP ACO model through CMS, Medicaid managed care, commercial health plans, and direct-to-employer relationships.
- It is imperative that physicians, hospitals, and health systems build competencies to succeed with value-based contracting, foster alliances between providers, and engage with patients as affiliated "members" in order to create more stable sources of revenue.
- New rules, regulations, funding, and waivers that have resulted from COVID-19 will allow hospitals and health systems to jump-start the development or expansion of high-performing physician and other provider networks that will be foundational for success in VBP contracts.

1 For more information, see CMS, "Direct Contracting Model Options" (available at https://innovation.cms.gov/innovation-models/direct-contracting-model-options).

Direct Contracting does not replace the Medicare Shared Savings Program (MSSP), which is also a VBP opportunity for Medicare beneficiaries who have not selected to participate in Medicare Advantage. For those who may have missed the Direct Contracting application window, the notice of intent to apply for the Medicare Shared Savings Program (MSSP) was due May 8 and the final application for 2021 opened on May 14 and closes on June 11. Once again, failure to submit a letter of intent during the allowed timeframe will result in the organization being ineligible to apply during the application period.

It is important to keep in mind that, in addition to the VBP opportunities for Medicare represented by Direct Contracting and MSSP, enrollment in Medicare Advantage is steadily increasing across the country. Thus, any VBP strategy needs to include engagement with Medicare Advantage health plans to develop VBP agreements for their populations.

Many systems that have not had experience with Medicare Advantage VBP agreements now have an opportunity, even if not participating, to learn from and leverage the Medicare Direct Contracting application and contracting model as a starting point for understanding how these agreements with health plans should be structured. Planning for the launch of a Medicare Advantage plan network and contracts must begin now for 2022.

In addition to VBP opportunities with Medicare, many hospitals and health systems are developing VBP models through direct-to-employer relationships and with Medicaid managed care and commercial health plans.

Key Questions for the Board around Risk-Based Reimbursement

The following questions help frame longer-term strategic planning around risk-based reimbursement such as CMS Direct Contracting participation. These questions can guide board members in striking a respectful balance between the next unknown months and the future.

Has the board and management team established key indicators for continuously monitoring operational and financial impacts, as well as the effectiveness of efforts to mitigate risk?

The first order of business must be to monitor business stability. This includes evaluation of potentially devastating short-term financial impacts from many areas, including reduction or elimination of elective services and non-COVID admissions. It is essential to future planning to have a sense of where the bottom is. The board must receive information that identifies the sources of disruptions caused by COVID-19 that are most likely to affect the short- and longer-term finances and operations. There are second- and third-order effects in the broader community that could influence these areas, as well.

It is essential to future planning to have a sense of where the bottom is. The board must receive information that identifies the sources of disruptions caused by COVID-19 that are most likely to affect the short- and longer-term finances and operations.

Pulling back from crisis, what has been our organization's larger strategy?

Over the last few years, the ongoing trend all hospitals and health systems were identifying was the flattening or marked decline of hospital admissions. As healthcare has shifted from inpatient to ambulatory and home health sites of care, reductions in per capita admissions now affect entire market areas. While there is a small offset by an aging population in some areas, the trend for admissions per 1,000 overall continues to push downward.

Longer term, the market and financial realities portend grim additional trials. Healthcare boards must plan on continued lower overall inpatient and even ambulatory volume as patients

are wary of hospitals and other potentially unsafe environments.

Further, particularly in states that failed to expand Medicaid under the Affordable Care Act (ACA) in good financial times, providers will be caring for many patients who have lost coverage through unemployment or can no longer afford their premiums. Entire communities surrounding hospitals, particularly in safety net communities, will have raw socioeconomic needs that will foster population health risks in the community.

Additionally, prior to COVID-19, the telehealth market had not just struggled to penetrate; it had struggled to exist because of privacy and security restrictions, broadband capabilities, and arcane reimbursement rules and rates. A 2019 study found that 66 percent of patients had never used a virtual platform for health services and 63 percent of patients did not understand their telemedicine insurance coverage.[2] As of 2017, only 30 percent of physicians reported telemedicine usage.

Health systems must develop robust capabilities in delivering services through telehealth and engage physician networks to ensure they have the tools and training necessary. Telehealth may over time reduce in-office and outpatient visits but can also expand the reach of the physical plant of the hospital and its ambulatory network. Remote consultations can improve access to timely care and patient compliance, while helping to reduce costs and thereby improve performance on value-based payment contracts.

In response to COVID-19, in March 2020, CMS issued a sweeping array of new rules and waivers of federal requirements to expand care capacity as hospitals and health systems act as coordinators of healthcare delivery in their areas.[3] CMS expanded access to telehealth services for people with Medicare through changes in what devices may be used, remote monitoring, and increased reimbursement. After crisis conditions ease, most experts believe that CMS cannot retreat on this relaxation of some privacy restrictions in the name of greater access, as well as its increased reimbursement for telehealth visits.

What are the questions to ask of management to assess and weigh in on new opportunities in a value-based payment strategy?

Obviously, the short-term daily crises weigh heavily on management and all staff members, and the board must respect the need not to divert important resources to producing informational presentations. However, it continues to be essential for board members to monitor the following issues:

- Where do we stand with regard to projected declining inpatient and, at least temporarily, ambulatory volumes and revenue?
- What is our plan to differentiate ourselves relative to our competitors in the eyes of payers and patients?
- Where are we on the transition continuum from fee-for-service to VBP models?
- What is the anticipated pace of change?
- What strategies do we have to protect and increase patient volume and revenues as the shift occurs?

How should we assess and prepare for success in risk-based or value-based reimbursement strategies? What is the "COVID impact," including regulatory relief, on related options and strategies?

Pre-existing and now further COVID-19 impacted squeezes on reimbursement require a forward-thinking strategy. This strategy must acknowledge that the organization is already "taking risk" when it serves patients that come in the door uninsured, underinsured, or with a highly constrained payment, such as Medicaid or even Medicare. With high revenue-generating hospitalizations trending down now for years and with the COVID-19 pandemic creating unparalleled shifts in ambulatory care, telemedicine, remote care, and monitoring at home, as well as historic rates of attrition of commercially insured patients, hospitals and health systems will need to adapt.

Optum-owned medical groups, entrepreneurial medical groups, telehealth medical groups, ambulatory surgery centers, and home care models have already been a game-changer for hospitals and health systems pre-COVID-19. For better or worse, they will be coming out of this crisis firing on all cylinders.

2 Lisa Hedges, "Should You Offer Telemedicine Services? Patients Weigh In," Software Advice, August 5, 2019 (available at www.softwareadvice.com/resources/should-you-offer-telemedicine-services).

3 CMS, Center for Consumer Information and Insurance Oversight, "FAQs on Availability and Usage of Telehealth Services through Private Health Insurance Coverage in Response to Coronavirus Disease 2019 (COVID-19)," March 24, 2020 (available at www.cms.gov/files/document/faqs-telehealth-Covid-19.pdf).

Every board must make critical decisions as to the role its hospital or hospitals will play in their communities. Is it a "must have" provider, virtually guaranteeing network inclusion and some flexibility to command premium rates? That is increasingly wishful thinking as lucrative commercial markets rapidly compress in the face of record unemployment.

The status of most hospitals, particularly those without large and well-aligned physician networks, will be less lofty. They will fall into a category of "important" in their communities as medical safety nets, employers, and potentially centers of population health, but not irreplaceable network "assets" for contracting payers. It is imperative that physicians, hospitals, and health systems build competencies in risk-based contracts, foster alliances between providers, and engage with patients as affiliated "members" in order to create more stable sources of revenue. This means that board members must be proactive in raising the value that the hospital or system can bring to the bargaining table. In turn, proactive and aggressive engagement with community physicians and other key providers will be required.

The ability to develop a high-performing network and to assume financial risk for discrete populations can be a game-changer. COVID-19 has not only produced a significant impact on hospitalizations and other health system utilization; it has also presented unique opportunities for hospitals and health systems to jump-start the development or expansion of high-performing physician and other provider networks that will be foundational for success in VBP contracts. Regulatory relief, including blanket waivers of Stark and antitrust rules, actually encourage the type of physician, hospital, federally qualified health center, and other provider engagement and investment required to develop a high-performing clinically integrated network. This is also an opportunity to access funding and build high-value, integrated telehealth and remote home-based monitoring and care management models.

With high revenue-generating hospitalizations trending down now for years and with the COVID-19 pandemic creating unparalleled shifts in ambulatory care, telemedicine, remote care, and monitoring at home, as well as historic rates of attrition of commercially insured patients, hospitals and health systems will need to adapt.

Is it likely that CMS will continue its push to move financial risk to providers?

CMS has given clear indications that it expects healthcare providers to assume greater financial risk in the delivery of its services. CMS in the Trump administration continued the emphasis of the prior administration in introducing risk to providers through the various Medicare VBP programs mentioned above. There is notable uncertainty on how the pandemic will affect these programs, such as changes to acuity or risk scores and diminished opportunities to meet quality requirements related to preventive care, and which patients the ACO will be accountable for this year.

What is the background of CMS Medicare Direct Contracting?

Direct Contracting evolves elements of legacy shared-savings programs and inherits some best practices from industry payers. The Direct Contracting's capitation options clearly build on experience in markets with long histories of capitation and global risk such as California, Massachusetts, downstate New York, and Florida. It also builds on lessons learned from the NextGen ACO program, which is currently the highest risk-sharing (upside/downside) program available from CMS. These two programs potentially coordinate well with the fact that better attention to care integration for seniors, and particularly for those eligible for both Medicare and Medicaid, can generate significant savings.

Who can participate?

Participants are called Direct Contracting Entities (DCEs). A DCE can differentiate based on length of experience in serving Medicare fee-for-service members, a focus on high-needs beneficiaries, and/or experience in taking financial risk.

A DCE must have a legal entity that contracts with Direct Contracting Medicare-enrolled Participant Providers. State rules will vary; the entity must demonstrate compliance with all applicable state licensure requirements regarding risk-bearing entities. The role of a board member is to validate that applicable state and federal laws are met in the process.

How might Medicare Direct Contracting fit in with our larger strategy towards taking on financial risk with payers?

Consideration of the move to take risk, perhaps contracting for Medicare patients, is in many ways a "lesser of

two evils" analysis of which strategies offer the best chance of longer-term financial survival. There is increasing likelihood federal and state policymakers will look to providers to assume greater financial risk to reduce healthcare costs; it is further likely that other payers will follow suit. The decision to delay building infrastructure capacity to assume financial risk will increase the likelihood that health systems will need to cobble together component system pieces under extreme pressures downstream. If successful, Direct Contracting can help health systems build competencies in risk-based contracting, generate stronger alliances between providers, build affiliation with patients, and create a new source of revenues.

What are critical success factors?

Medicare Direct Contracting requires adequate capital and reserves, a thorough contracted provider network, and capabilities to manage risk (patient engagement, population health analytics, care management, provider relations, capitation management, etc.). An assessment of the organization's ability to take on and manage risk requires an understanding of the strength of the provider network, the gaps in the capabilities of the network, and the financial modeling of likely costs and revenue projections. The financial model is essential; it will reveal operational and financial strengths and weaknesses of the proposed new contracting model. The complexity and the high stakes of this program make it that much more important for precise information to drive decision making. Further, health systems looking to take on financial risk must ensure that they meet all licensing and reporting requirements imposed by the state or states in which the activities will be conducted.

How should the board monitor progress in Direct Contracting and measure successes?

In the post-COVID-19 environment, characterized by unprecedented challenges, risks, and uncertainty, hospitals and health system CEOs face daily fire drills, new challenges, and more complex responsibilities. However, continuous feedback is critical to effective board and CEO alignment related to strategy, performance, results, and the need for continuous improvement.

Boards must add goals related to population health and value-based care to their strategic and financial plans. It is important to keep in mind that different payers will have different metrics and methodologies for determining shared savings and quality bonus earnings thresholds. Boards must partner with their executive team to reconcile these varying metrics—to define a set of VBP metrics that are consistently applicable across numerous payers and VBP arrangements. Increasingly, the focus will be on total cost of care (utilization and pricing), patient satisfaction, and clinical outcomes. The selected strategic VBP metrics should be reported on regularly that "tell the story" as to the key critical aspects of successful Direct Contracting or other VBP program participation.

The reality is that board discussions about population health and value-based care can be difficult not only because of the need for background knowledge, but also because of a central concern: profit. As the industry erodes fee-for-service reimbursement, it means that hospitals beginning the shift to value-based care today will see a further and frightening dip in revenue. Boards need to understand this, because if the board does not appreciate the goals and mileposts, and inevitable financial hits, they are not going to be able to support the strategy long-term.

Conclusion

Amid all of the pressures of the current crisis, board members must not lose sight of their longer-term strategic oversight responsibilities. Boards, together with senior leadership, must traverse the delicate balancing act of thinking both long term and short term. Returning to the original premise that "Crisis can equal opportunity," crises can offer rare opportunities for innovation to not only defend the core business, but also to plan for a vibrant future post-COVID-19. Among the options are strategies to assume financial risk for discrete populations, such as Medicare members. Participation in the Medicare Direct Contracting program should be evaluated within a larger construct of moving to risk- or value-based reimbursement.

The Governance Institute thanks Allen Miller, Principal, and Cindy Ehnes, Principal, COPE Health Solutions, for contributing this article. They can be reached at amiller@copehealthsolutions.com and cehnes@copehealthsolutions.com.

Provider Realignment Post-Pandemic

By Brian Fuller, PYA, P.C., and Jordan Shields, Juniper Advisory

COVID-19 delivered a shock to the U.S. healthcare system that will change it forever. The array of disruptions has been staggering, including:

- Non-essential procedure suspensions
- Global medical supply chain disruptions
- Local, regional, and national equipment shortages
- Market-specific patient volume surges
- An overnight switch to telehealth care delivery

As a result, the U.S. healthcare economy ground to a halt. As we approach a restart, it is important to understand how the effects of the shock—shocks, actually—will impact what was already a changing healthcare industry structure and potential implications for merger and acquisition activity in the provider sector.

Examining Shocks: Why COVID-19 Is So Disruptive to the Healthcare Industry

Shocks are not new to modern economies. Most often driven by unforeseen, overlapping macroeconomic factors, they can reverberate globally, impacting multiple industries for varying durations. Conversely, they can be regional/national, and impact single industry sectors.

As shown in **Exhibit 1**, the COVID-19 pandemic triggered four economic shocks (supply, demand, financial, and policy) and evolved over an abbreviated timeline, which intensified its impact. At this point, the prospect of a quick recovery remains uncertain.

Post-Pandemic Provider Realignment

The crisis exposed the high "cost of fragmentation" within the healthcare industry and, we believe, will serve as the seminal event that ushers in an era of greater provider integration and concentration. We anticipate three phases in the industry's path forward:

- A **turbulent restart** through the remainder of 2020, marked by initially sluggish M&A activity as at-risk providers seeking shelter are courted by cautious buyers assessing their positions and plotting strategies.
- In the ensuing two years, a **shake-out** will follow, characterized by some of the surviving providers and hospitals, risk tolerances battered, seeking safety and security; strong regional systems, insurers, and private equity-backed disruptors will seize the opportunity and be hyper-active in pursuing scale.
- In a final phase, **rise of the titans**, national mega-systems, possessing regional market essentiality, may emerge, dwarfing today's largest systems. These behemoths would compete directly with scaled, non-traditional, ambulatory-centric networks (e.g., integrated insurance companies) in a marketplace that no longer adheres to traditional delivery vs. financing distinctions. These organizations will vie to deliver on the promise of population health and achieve growth and stability through quality and efficiency.

Key Board Takeaways

COVID-19 will accelerate U.S. healthcare's transformation toward a future characterized by the blurring of traditional lines between care delivery and financing. Integrated, scaled, regional, and national organizations that compete aggressively on quality and cost will lead. Increased merger and acquisition activity will be a hallmark of the transition. To help their organizations navigate these changes, board members should:

- Conduct a forthright evaluation of their organization's go-forward strategic and financial position.
- Revisit growth plans to determine their continued validity.
- Scenario plan to identify key assumptions or market events that could materially impair organizational performance.
- Chart a course forward that reflects the realities of operating in a post-COVID-19 world, including partnership models of all stripes.

Exhibit 1: Four Economic Shocks from COVID-19

Type of Shock	Defining Characteristics	Historic Example	COVID-19 Example
Supply	• Inputs become scarce, expensive • Supply chain disruption	• OPEC oil embargo	• PPE price spikes, scarcity • Hot spot clinical staff shortages
Demand	• Sudden drop in consumer or business spending	• Great Depression	• Elective procedures suspension • Fewer patients seeking care
Financial	• Lack of liquidity; frozen credit markets • Falling financial asset values	• 2008–2009 Global Financial Crisis	• 50–70 percent revenue drops; resultant provider balance sheet impairment, capital access challenges
Policy	• Unforeseen government policy shifts • Often tied to central banks	• 1997 Asian Currency Crisis	• Shelter-in-place • The CARES Act (and others)

Hospitals

Hospitals had already experienced a decade of disruptive change pre-pandemic. Post-pandemic circumstances will act as a catalyst to advance the most stubborn of the changes yet to be widely adopted and will drastically accelerate the pace of many others.

Physicians

COVID-19 underscored the inherent risk of small independent and group practice amid economic crises. With high fixed overhead and limited, if any, reserves or credit, some groups failed only days after elective procedures were suspended and well-care visits dried up.

Non-Acute Providers (Senior Living, Home Health, Behavioral, Other)
Each non-acute sector has faced unique COVID-19 challenges, but their paths out of the pandemic will share similarities shaped by industry forces. Market consolidators will hedge against the cost of fragmentation by building comprehensive well care, sick care, and recovery care networks, while private equity continues to consolidate holdings to eventually exit or, in rare and high-growth situations, take public.

The Road Ahead

The COVID-19 crisis laid bare the fragility of U.S. healthcare. We paid a heavy price for fragmentation.

Looking forward, boards and executive teams will need to take several actions to keep their organizations relevant and healthy: 1) evaluate the degree to which local markets are integrating to compete on quality and efficiency; 2) identify COVID-19-era competitive differentiators and revisit strategic plans to incorporate; and 3) identify partnerships and structures that will leverage differentiation and support the organization's long-term success.

There will be no *going back* to the industry as it existed, only a *going through* to a stronger, more hardened, and, in some cases and in some geographies, a materially scaled healthcare system. Successfully approaching and navigating such an uncertain future will require healthcare leaders to ask a number of existential questions, including:

- Do we have the financial wherewithal to survive the crisis and a potentially slow recovery?
- Can we articulate a credible path to future practice or system growth?
- Can we continue to successfully compete in a marketplace that advantages integration and scale?

Different organizations will have different answers to these questions. All should proceed based on their answers to them, and others that may be dictated by their markets.

The Governance Institute thanks Brian Fuller, Principal, PYA, P.C. and leader of the firm's strategy consulting practice, and Jordan Shields, Managing Director, Juniper Advisory, for contributing this article. They can be reached at bfuller@pyapc.com and jshields@juniperadvisory.com.

Hospitals

Turbulent Restart *6–9 months*	• "Have vs. have not" phenomenon is exacerbated • The financially distressed seek lifelines • Well-capitalized regional systems pursue opportunistic growth • Turnaround-focused, private, for-profit operators enter aggressively • Publicly traded health systems pursue only the most attractive scale opportunities
Industry Shake-Out *1–2 years*	• Some, perhaps many, distressed sellers (especially rural), unable to find geographically proximate buyers, close • Strong sellers seek partners with high quality and operational depth • Regional systems aggressively seek scale consolidation opportunities
Rise of the Titans *3+ years*	• Declining governmental and commercial reimbursement • Large systems leverage scale for clinical and operational advantage and aggressively move to assume insurance risk • A select few integrated national mega-systems (~$75B+ in net revenue) emerge

Physicians

Turbulent Restart *6–9 months*	• Practices reopen; pace of activity ramp-up highly variable • Hospitals and insurance companies that weathered the crisis with capital develop opportunistic physician growth strategies • Private equity active, but at lower multiples; some opportunities lost to strategic buyers
Industry Shake-Out *1–2 years*	• Pre-crisis "physician land rush" escalates, beyond previous levels • Fierce competition for physician services across health systems, insurers, and private equity investors; primary care and procedural subspecialists represent hottest commodities
Rise of the Titans *3+ years*	• Over three-quarters of physicians employed by large group practices, management companies, insurance companies, or hospitals • Private equity investments shift from practice consolidation towards innovation to support operational and clinical efficiencies • Integrated physician enterprises lead health systems toward displacing acute care's traditional position at center of delivery industry

Non-Acute Providers (Senior Living, Home Health, Behavioral, Other)

Turbulent Restart *6–9 months*	• Post-acute sector hit hard given fewer hospital discharges • Relatively quiet rebuilding period as businesses stabilize • Some activity with select investor-backed and healthy system buyers
Industry Shake-Out *1–2 years*	• Increasing divide of "have" and "have not" segments within sectors • Sellers will look first for buyers within their sub-industry, then to integrated systems and large insurers; troubled entities will close • Ongoing shift from facility-based providers to lower-cost settings
Rise of the Titans *3+ years*	• Increasingly, integrated mega-systems and insurers will add non-acute business lines and compete within these sectors • Select private equity-driven sector roll-ups will achieve scale and be taken public

Your Digital Front Door Starts Well Before Your Web site

By Andrew Ibbotson, NRC Health

Your digital front door strategy is key to attracting new patients and building the kind of brand awareness and loyalty that keeps them coming back. Having a strong digital presence is especially necessary during this time of growing consumerism in healthcare, and its importance has only been heightened by the COVID-19 pandemic. However, many healthcare providers still don't realize that their digital front door extends well beyond their Web site.

We have to continually remind ourselves that patients are consumers living in an online, on-demand, and reputation-driven economy. Because of the technology we use every day, the patient experience begins long before anyone calls to schedule an appointment or steps into a doctor's office. It usually begins with an online search.

Dr. David Feinberg, who runs Google Health, recently told attendees at a Texas conference that Google receives more than 1 billion health-related questions every day, equivalent to 70,000 searches every minute.[1]

According to our own research at NRC Health, 77 percent of patients begin their healthcare search online, making it critically important for hospitals and health systems to proactively manage and optimize their digital footprint across the four key channels used by consumers: 1) desktop search, 2) mobile search, 3) maps, and 4) voice search. The goals of your digital front door strategy should be:

- To be easily found by consumers
- To effectively engage consumers online
- To convert consumers to patients
- To deliver a frictionless experience
- To grow loyalty

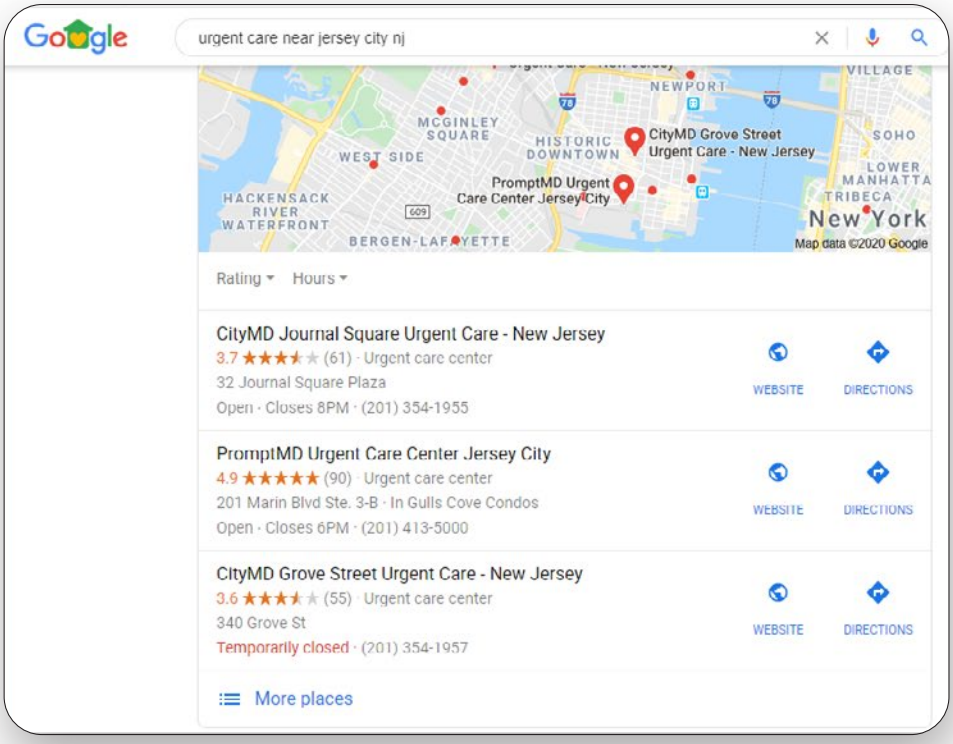
To achieve these goals, many healthcare systems find that transparency is key. Patients are increasingly searching for answers to questions like, "**Best** urgent care **near me** that is **open now** and **accepts** Aetna insurance." Let's break this question down to its key components and explore each one in more detail.

Key Board Takeaways

Board members can hold the organization's marketing executives accountable to achieving the goals laid out in this article by asking and following up on the following questions:

- How are we managing the organization's online reputation?
- What are we doing to manage our business listings (across popular consumer Web sites like Google, Yelp, Facebook, Healthgrades, Vitals, and WebMD)?
- How are we making it easier for consumers to engage with us (i.e., appointment scheduling on our Web site and Google, interactive chat on our Web site and Google, virtual visits through our Web site and third-party directory sites)?
- How transparent is our organization today with consumers and what do you think is achievable in the next 24 months?

Exhibit 1: Example of Strong Local and Organic Search Results



Source: CityMD, NRC Health client example.

Managing Your Online Reputation—Who Has the "Best" Doctors?

When patients begin their healthcare search, it's critically important to come up at the top of both local and organic search results to maximize your visibility and Web traffic. According to data from Google Trends, there's been a more than 400 percent increase in local healthcare searches since 2016. "Near me" and "best" searches now dominate in healthcare.

Even more important is making sure the experience you provide is accurately represented online when patients "Google" your organization, or one of your providers, by name. Today's uncomfortable truth is that 81 percent of patients will read reviews about a provider, even after they have been referred by another doctor.[2]

Owning your online reputation consists of three key initiatives:

1. Publishing verified "first-party" ratings and comments from your patient experience surveys on your own Web site and provider profile pages.
2. Giving every patient the opportunity to leave a review on the third-party Web

1 Margi Murphy, "Dr. Google Will See You Now: Search Giant Wants to Cash in on Your Medical Queries," *The Telegraph*, March 10, 2019.
2 Les Masterson, "Patients Want Providers with Strong Online Presence," *Healthcare Dive*, May 21, 2018.

sites that matter most to healthcare consumers (Google, Yelp, Facebook, Healthgrades, Vitals, WebMD).
3. Proactively managing your business listings and responding to online patient reviews.

It's a little-known fact that, if a Google search contains the word "best," only listings with 4 stars or higher will appear in local search results. The national average for healthcare providers is 3.8 out of 5 stars based on less than 10 total reviews per provider. By contrast, organizations that give patients the opportunity to rate their experience and leave a review have an average rating of 4.6—based on feedback from more than 125 verified patients per provider, per year.

According to Harvard Business School, a one-star increase in your online reputation can translate into a 5 to 9 percent increase in revenue. If you just cross your fingers and leave your reputation to chance, you will be harder to find and less likely to be chosen.[3]

Accessibility—Who Is "Near Me" and "Open Now"?

If you have done a good job of attracting consumers to your Web site and business listings, you need to engage them with the content and information they're looking for in order to convert those consumers to patients.

Some of the most critical factors patients consider when deciding where to seek care include:

- Accurate location data and hours of operation
- Online self-scheduling
- Same-day appointments and virtual visits
- Estimated wait times for emergency and urgent care

Market-leading healthcare providers are rapidly adding these capabilities not just to their own Web sites, but also making them available on their Google My Business (GMB) listings, third-party directory sites, and through voice assistants like Alexa and Siri.

Over the past 12 months, we have seen a steady increase in the use of technologies like online chat to help patients explore symptoms, triage their needs, and navigate them to the appropriate site of care. And since the COVID-19 pandemic began, many of the health systems we work with are reporting a sixfold increase in the use of telehealth services.

Healthcare providers are scrambling to offer virtual visits that allow patients to complete a visit from the safety and comfort of their home without exposing them to crowded and potentially infectious clinical locations. And they are realizing the added benefit of helping to route low-acuity visits away from their emergency departments.

Insurance and Pricing—"How Much Is This Going to Cost"?

To ensure that telehealth services are available to as many people as possible during this crisis, the Federal Communications Commission initiated a $200 million program to fund telehealth services for medical providers. But patients continue to pay more out of their own pocket every year. In fact, patients as a group are now the fastest-growing "payer" in healthcare.

Simply informing patients that you accept their health insurance plan is no longer going to be enough to remain competitive. Patients are increasingly demanding up-front estimates of what they should expect to pay. Mandates like the new hospital price transparency rule are just the next step in a growing movement of increased transparency in healthcare. In addition to being able to read unfiltered patient ratings and reviews on your Web site, patients are looking for price information that's easy to access and understand.

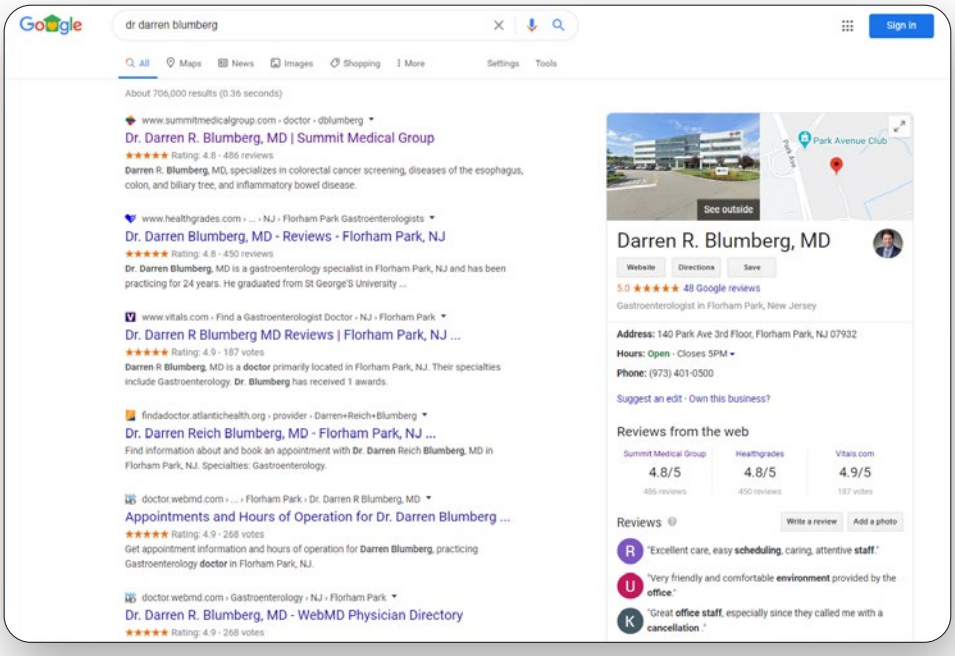
Patients Will Choose Ease

At the end of the day, the overwhelming majority of patients will choose ease. You need to be easy to find, easy to navigate, easy to choose, and easy to work with. Whenever possible, look for ways to engage patients at every major touchpoint of the patient journey using technology they have already adopted for everyday use—search, ratings and reviews, online scheduling, maps, voice, and video.

When implementing new technologies, make sure your digital front door experience complements the in-person interactions patients have with your caregivers and staff. Collect real-time feedback after each in-person and virtual experience so you can more accurately measure whether or not you're living up to your brand promise. And follow up with patients in a timely manner to build trust and inspire loyalty. After all, today's experience is tomorrow's reputation.

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

Exhibit 2: Example of Strong First- and Third-Party Reviews



Source: Summit Medical Group, NRC Health client example.

3 Michael Luca, "Reviews, Reputation, and Revenue: The Case of Yelp.com," Harvard Business School, Revised 2016.

Working with Leadership to Ensure Success

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system's preparations for and responses to the outbreak proved instrumental in helping the board understand the issues the organization was facing throughout the course of the virus's spread.

Benefis' CEO works diligently to ensure members have access to relevant and timely resources. Each month, Goodnow communicates in writing to the board and stakeholders in the community, as well as to all Benefis employees, on various issues in his *CEO Report*. These *CEO Reports* are a great way of being transparent with the board and people in the community and region. Additionally, the CEO sends another monthly report called *Hot Topics* to only the board about more confidential issues being addressed throughout the system. He firmly believes in the principle of no surprises.

Goodnow also informs the board either by email or during open Q&A sessions held at the board's monthly meetings. These face-to-face discussions about hot topics or issues that management is facing allow the CEO and the board to express their concerns about or voice support for various solutions.

The board exists not to make senior management look good; rather, the purpose of the board is to serve the hospital and the community, working in collaboration with management and recognizing that we are all on the same team.

To accomplish the organization's mission, there must be trust between the board and the CEO and vice versa. If the trust isn't there, then that's an issue. Good communication builds and maintains trust.

Board Education

Equally important as good communication is board education. In addition to providing education at each of the board's nine regular annual meetings about ongoing health issues at the national and regional levels, the board holds an annual board education meeting that lasts several days. Past board education trips have included visits to Washington, D.C., to learn more about national health policy as well as a visit to a medical school to learn about graduate medical education, among other trips. The board also holds an annual retreat that provides an opportunity to focus on system strategies.

Board education and the monthly reports help Benefis' board members to better understand current national and local issues in the complex healthcare environment, along with possible strategic solutions to the issues.

Although healthcare leadership face a myriad of challenges today, when equipped with the right knowledge and level of transparency, senior management and the board should be able to work hand in hand to ensure value and organizational financial success.

The Governance Institute thanks Mike Milburn, Chair, Board of Directors, Benefis Health System, for contributing this article, which was adapted from a "Governance Insights" column in the November/December 2017 issue of Healthcare Executive *magazine. He can be reached at mmilburn@mcn.net.*

COVID-19 and a New Financial Perspective…

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stresses on credit ratings, weakened balance sheets, and profitability. Boards must be well educated about the situation and the new state of hospital economics. Executives will have some opportunities; for example, new competitive positions and partnership options might exist compared with the pre-COVID environment. In general, however, these organizations will need to develop a new mental model accompanied by a new and more sophisticated financial plan.

Boards will need to stay in close communication with their executive teams about the nature and degree of the financial impact of COVID, the gap that impact creates between current and budgeted performance levels, near-term actions to address the gap, and longer-term effects on strategic and capital plans. This information will need to be updated regularly, due to the unpredictable nature of the current and future environments.

A New Hospital Economy and New Planning Paradigm

The financial instability of the nation's healthcare system has been apparent for some time. For hospitals, a critical element of that instability has been reliance on commercial insurers and surgical procedures to maintain margins. The COVID-19 pandemic has revealed that vulnerability in the starkest terms. Lost revenue and higher expenses remain a major problem for many.

The COVID-19 virus has challenged hospitals not just to plan for short-term financial hits, but for a new healthcare economy. This new planning paradigm has exposed the inadequacies of traditional annual operating budget processes.

Annual budgeting by itself simply does not provide the frequency or flexibility to meet the demands of the current planning environment. Hospitals require a process such as rolling forecasting for efficient and timely updates that enable management to assess changes frequently, and adjust quickly to a volatile environment.

Whether tracking for the immediate, continuing needs of the crisis or forecasting for the post-COVID-19 world, healthcare leaders face new demands for timely data, sophisticated analysis, and forecasting and budgeting methodologies suitable for a highly unpredictable future.

The Governance Institute thanks Kate Guelich and Dan Majka, both Managing Directors with Kaufman, Hall & Associates, LLC, for contributing this article. They can be reached at kguelich@kaufmanhall.com and dmajka@kaufmanhall.com.

The Board's Role in Achieving Systemness…

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Exhibit 1 from Premier outlines specific areas to be assessed. Health systems will want to dig deeper into each of these areas to find opportunities to improve systemness. For example, some questions for organizations to consider regarding "organizational culture" under the governance and operational management domain include:

- **Defined core values and behavior expectations**:
  - » Are clearly defined core values in place that promote a system perspective/integration and guide organizational behavior?
  - » To what degree are the values practiced and internalized consistently throughout the system, introduced to all new employees, and routinely celebrated for reinforcement?
- **Culture of continuous improvement, safety, and innovation**:
  - » Are all leadership, providers, and staff members visibly committed to improving safety and innovation, and encouraged to openly share information?
  - » Are consistent tools (e.g., Lean, Six Sigma, Plan-Do-Check-Act, etc.) used throughout the system to drive continuous improvement?
- **Reward system/compensation models**:
  - » Are compensation models, rewards systems, and incentives (i.e., performance appraisals) linked to the system's desired culture and behavior, which are consistent with the organization's core values?
  - » Are additional incentives offered to celebrate and reward operating units/divisions or individuals that exemplify the organization's values and desired culture?

We recommend that boards and senior leaders create a focused roadmap to coordinate integration activities that increase quality, create a culture of excellence and accountability, improve financial and operational results, eliminate duplication and waste, streamline clinical and support services and processes, and improve patient experience.

Board Oversight Responsibilities for Systemness

The process described above is only one example of many methods that a system board can develop and use with its senior management team to identify a roadmap to achieve greater clinical, financial, and operational integration and systemness. Every process should be tailored to meet the specific and unique circumstances associated with the organization, taking into consideration market characteristics, competitive environment, associated physicians and other clinicians, resources, history, culture, mission, vision, and values.

Systemness encompasses the degree of standardization that will be established across the healthcare enterprise. It defines the functional areas of activity that will be assumed at the system level, and those functions that will be retained at the local/individual hospital/business unit levels. While achieving complete systemness may seem like a continual—and even elusive—process, system boards will succeed when they are open to new approaches and practice discipline in oversight and accountability. This mindset and approach will help sustain systemness through a continuous improvement approach.

The Governance Institute thanks Guy M. Masters, M.P.A., Principal at Premier, Inc. and Governance Institute Advisor, for contributing this article. Jeremy Mathis, Director Performance Partner at Premier, Inc., also contributed significantly to this article. They provide systemness performance assessments and governance effectiveness evaluations, as well as keynote presentations on trends, strategies, and governance issues at board retreats and industry conferences. They can be reached at guy_masters@premierinc.com or (818) 416-2166 and jeremy_mathis@premierinc.com or (704) 654-9956.

Exhibit 1: Areas to Assess for Systemness

	Domain	Functional Area
	Governance & Operational Management	1. Organizational Culture 2. Leadership and Operations 3. Policy and advocacy 4. Strategic, Operational, Financial and Facility Planning 5. Performance Improvement
	Physician-System Integration	1. Clinically Integrated Network 2. Physician Services 3. High Value Network Development / Integration 4. Value-based / Payer Contracting
	Clinical Integration & Effective Outcomes	1. Quality measurement 2. Service Line Integration 3. Patient Engagement / Activation 4. Medical and Professional Education
	Functional Alignment and Operational Integration	1. Supply Chain 2. Financial Management / Funds flow 3. Information Technology 4. Human Resources 5. Marketing / Branding 6. Research 7. Legal and Compliance 8. Provider owned health plan

Source: Premier, Inc.

The Board's Role in Achieving Systemness: How to Measure, Monitor, and Improve It

By Guy M. Masters, M.P.A., Premier, Inc.

Has your organization recently been involved in a merger, alliance, affiliation, or other organization-altering transaction? Such events can take months (or in some cases, years) of planning, analysis, due diligence, stakeholder meetings, negotiations, legal and regulatory filings and approvals, creating and signing of definitive agreements, and other activities. Once the transaction portion is complete, then the more difficult work of ensuring success of the new entity begins. Such success can be dependent upon achieving a high level of "systemness."

What Is Systemness?

Hospitals and health systems that have been involved in mergers, alignments, consolidations, and the pursuit of horizontal and vertical integration strategies all seek the benefits and advantages that come from greater "systemness." This includes making measurable improvements in quality, expanding access, lowering total cost of care, achieving economies of scale, streamlining processes of care delivery, and eliminating duplication, variation, and waste across service lines, departments, clinical areas, and administrative support functions. It also embraces creating a common culture around mission, vision, and values, as well as improving patient experience and perception through coordinated uniformity across all the system entities.

Measuring Degrees of Systemness: How and Why It Matters

An assessment of the components of system integration is an essential process for boards to embark on and oversee. Doing so enables boards to understand and monitor the degree to which management is executing on elements of strategic and operational plans to achieve greater systemness. Pairing this assessment with financial and clinical data and other performance information allows boards and management teams to determine status, progress, and the rate of change across the organization. Feedback from the assessment will validate if system-wide processes and policies are being followed and implemented consistently and uniformly across all entities in the organization (or at least reaching minimum acceptable performance thresholds). It will also highlight where best performance practices exist, allowing those to be shared across sites as appropriate.

Decision support capabilities can be used to augment the qualitative inquiry that an assessment provides to conduct a diagnostic review of the degree of horizontal and vertical system integration and systemness by key functional areas. This exercise can be most beneficial to organizations with the following circumstances and/or characteristics:

- New health systems created due to mergers or acquisitions
- Health systems that have expanded in the last three years
- Organizations in competitive marketplaces that compete with other fully integrated systems
- Integrated health systems that are looking for new opportunities to further integrate, reduce costs, and enhance quality and effectiveness, and/or tear down organizational silos

Key Board Takeaways

Achieving greater systemness is essential for multi-hospital healthcare entities to reach optimal mission-driven and patient-focused outcomes of better care, better value, and better patient experience. Questions for the board to consider include:

- What are the highest priority functional areas that should be standardized across the system's entities? What degree of standardization currently exists for each of these functions?
- What are the quantitative (e.g., ROI, economies of scale, productivity, efficiencies) and qualitative (e.g., culture impact, patient satisfaction, employee engagement) benefits of sustaining and pursing a greater degree of uniformity in each of the priority areas?
- Do the board and management team have a systemness roadmap that can be used as a template for new organizations joining the system to accelerate efficiencies and adoption of best practices for key governance as well as operational areas?
- Is the system's governance model well-defined and implemented consistently across system entities? Is it aligned with the organization's mission, vision, and goals?
- Does the system board use an authority matrix that specifies the roles, responsibilities, and authority attributed to the system board and local subsidiary/member boards? If so, is it being adhered to consistently?

Determining an Assessment Approach

System boards are responsible for working with senior management to define the desired essential elements of systemness, and oversee their implementation through effective execution of strategic, financial, and operational plans. In doing so, they can measure progress by reviewing the degree of horizontal and vertical integration in specific functional areas across a healthcare delivery system including the following four domains:

- Governance and operational management
- Clinical integration and effective outcomes
- Physician-system integration
- Functional alignment and operational integration

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