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Welcome New Members to Editorial Boards

The Governance Institute relies on two groups of engaged members from different types of organizations to help us learn about governance challenges and how organizations handle similar issues. The feedback we receive makes a deep impact on our board education planning. We would like to thank everyone who has served on these boards over the years and welcome several new members (indicated with an asterisk below).

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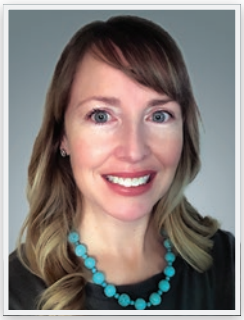
The Reversal of Roe v. Wade: Implications for Healthcare Boards

By Kathryn C. Peisert, Todd Sagin, M.D., J.D., and Kimberly A. Russel, FACHE



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The U.S. Supreme Court has effectively removed the constitutional right to an abortion and returned the issue to the states, creating a complex and shifting patchwork legal system as states redefine legal healthcare. The ramifications for healthcare providers are significant in every state. Boards will need to think quickly about any need to take action and plan for both the intended and unintended impacts on their institutions. The turmoil in the provider community has already begun. State and local policies are being adopted and proposed that tread (or potentially tread) on patient and provider privacy. The Supreme Court ruling and subsequent state actions will impact practices regarding a range of clinical conditions, from family planning to the treatment of some medical emergencies. Hospitals will need to consider the changed landscape on a multitude of additional fronts including: approaches to patient communication and information sharing, patient counseling, a changed liability environment, new patient and practitioner safety concerns, workforce stress and burnout, as well as impacts on practitioner recruitment and retention, service line offerings, and hospital finances. There are also implications for hospitals that train medical students, residents, fellows, and/or advanced practice practitioners, or that sponsor other specialized programs. Additionally, this decision impacts the hospital's role in population health as it will adversely impact the health of communities, especially those with poor and/or high-risk populations.

The task for healthcare boards now is to look proactively at all of the potential implications from this dramatic ruling, which upends half a century of established law and practice. Most members of the general public have yet to understand the depth and scope of the impacts on women's health, family health, and community health.

Some states have already enacted legislation as a result of this decision and many others will follow, compelling boards to begin exploring these issues promptly. The time is now to partner with your senior executives, legal counsel, and most importantly, your medical staff to fully understand the options that need consideration. This article presents some of the issues that we believe need thoughtful deliberation by hospital directors. We recognize that the environment in which these discussions occur will differ significantly depending on factors like a hospital's geographic location, its relationship to a health system, whether it has a religious affiliation or is subject to local governmental oversight, its range of current services, and the makeup of the population it serves. We also acknowledge that many board members will find these conversations uncomfortable. Nevertheless, as fiduciaries for their institutions, board members are responsible for understanding the full scope of issues unleashed by *Dobbs v. Jackson Women's Health Organization* and must plan accordingly.

State Laws Are Different and Nuanced

First and foremost, your board must be well briefed on the legislative changes and legal updates particular to your state. Health systems operating in multiple states will need to determine how to track and operate within regions that have different restrictions and exceptions. Understanding how your state's laws are written and how they will be enforced will be critical to planning and decision making. Furthermore, many state restrictions will be challenged in court and hospitals will need to track such litigation.

While the Dobbs ruling may appear straightforward, it has created a morass of legal questions around numerous concerns,[1,2] and these will take years of litigation to reach clarity. Therefore, boards will require regular updating from counsel as the legal landscape continues to change.

In many states, a growing number of providers are choosing to no longer provide a full range of reproductive healthcare.[3] They consider this approach safer than trying to determine what will be considered legal under shifting or unclear legislative initiatives or changing court rulings. Many patients will choose to receive care in states other than their own for similar reasons. Providing as much clarity as possible from legal resources will help providers and patients make informed choices.

Privacy and Law Enforcement's Access to Data

Boards must learn how HIPAA will play a role in law enforcement activities.[4] Since HIPAA permits providers to disclose PHI where "required by law" and to law enforcement, women seeking an abortion cannot be assured that their "private" health information will remain out of reach of prosecutors or the public. In states where abortion is criminalized, providers may face conflicting obligations; for example, a responsibility to maintain the

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1 For example, will federal laws preempt some state restrictions on abortion? Does FDA authorization for physicians to prescribe medication to induce abortions override state bans? Can states ban out-of-state travel for an abortion? Can a state ban self-insured employer health plans (covered under ERISA) from paying for out-of-state abortions? Can professional liability carriers refuse to cover a provider who performs an abortion to save a woman's life or well-being if this action is considered illegal in the state performed?

2 Centers for Medicare & Medicaid Services (CMS), "Reinforcement of EMTALA Obligations Specific to Patients Who Are Pregnant or Are Experiencing Pregnancy Loss (Updated July 2022)," July 11, 2022.

3 KQED Forum, "How Abortion Care Is Adapting to a Post-Roe America," National Public Radio, July 7, 2022.

4 Jessica Kim Cohen, "HHS Issues HIPAA Guidance After Abortion Ruling," *Modern Healthcare,* June 30, 2022.

Governance Practices that Support Systemness

By Pamela R. Knecht, **ACCORD** *LIMITED*

Over two-thirds of community hospitals in the United States are in systems, according to an American Hospital Association 2022 survey.[1] Therefore, much has been written about the various *governance structures* utilized by healthcare systems. Those articles address corporate and governance structures as well as the number, type, size, and composition of boards and committees.[2] By contrast, this article describes key *governance practices* used to increase "systemness" regardless of the structure.

The Need for Systemness

It may be helpful to review why health systems were created. All system models have one common goal: to function as a more integrated system to provide higher value to those they serve. Over decades, organizations both within and outside of healthcare have improved their "value proposition" by focusing on lowering costs and increasing quality. They began by creating system-wide vision, goals, and processes. Then they targeted ensuring high reliability, reducing redundancies, eliminating variation (as much as possible), and achieving economies of scale. Through these and other means, health systems are more able to consistently provide the right care at the right time in the right place at the right cost.

Alignment between Operations and Governance

Healthcare executives have been increasing systemness *operationally*. However, they are often limited in their ability to fully optimize systemness because governance is not sufficiently aligned with the vision. Too often, the practices used by boards and committees are more aligned with being independent than being part of an integrated system.

Practices for Systemness

There are many actions that system, regional, and local boards can take to function in a more integrated manner regardless of their governance structure.

Starting Out

Common Board Portal

A first step is to utilize a common, secure portal that is easily accessible by all board and committee members across the system. This tool enables all serving in governance to access information on the system (e.g., history, strategy, services, and finances) and its governance (e.g., structure, rosters, bylaws, policies, and meeting materials). In addition, it can become a rich repository of shared educational information (e.g., articles and videos).

System-wide Orientation

Ideally, there is *one* annual, in-person orientation session for all new board members to help them have a common understanding of the organization, its governance, and their role. An added benefit to this approach is that individuals meet and learn from colleagues; this increases their sense of being part of the system.

Clear Governance Authority Matrix

A critical part of orientation is clarifying the role, responsibility, and authority of each board and committee. According to The Governance Institute's 2021 Biennial Survey, only 31 percent of system respondents stated that "the assignment of responsibility and authority is widely understood and accepted by both local and system-level leaders."[3] Therefore, orientation should include a clear explanation of the system's governance authority matrix.

The matrix should use consistent language to describe decision involvement and authority (e.g., develop, provide input, recommend, or approve) for each governance responsibility (e.g., finance, quality, and strategy). Only one

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Key Board Takeaways

There are many governance practices that support systemness regardless of the board and committee structures utilized. The following practices should be overseen by the system governance committee, aided by a full-time governance support professional.

Starting out:
- Common board portal
- System-wide orientation
- Clear governance authority matrix

Getting together:
- Shared continuing education
- Joint committee meetings
- All-boards retreat

Next steps:
- Integrated annual board topic calendar
- Coordinated meeting timing
- Standardized documents

Increasing effectiveness:
- Regular communication
- Consistent reporting expectations
- Common evaluation and goal setting

1 *AHA Hospital Statistics, 2022 Edition*, American Hospital Association.

2 For example, see these resources from The Governance Institute: Pamela Knecht, "Remind Me: Why Do We Need Systemness?," System Focus, June 2018; Pamela Knecht, "Linking Governance Structure to Strategy," *BoardRoom Press*, August 2015; Guy Masters, "The Board's Role in Achieving Systemness: How to Measure, Monitor, and Improve It," *BoardRoom Press*, June 2020; *Restructuring Governance for the New Healthcare Environment: The Evolution of System Governance and Development of Best Practices*, Winter 2020.

3 Kathryn Peisert and Kayla Wagner, *Advancing Governance for a New Future of Healthcare*, 2021 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute.

Key Considerations before Starting a Medicare Advantage Plan

By Yomi Ajao and Allen Miller, COPE Health Solutions

Health systems are continuously looking for ways to capture a greater share of the healthcare premium dollar and become more independent from payers. Some systems are considering the development of their own health plans—often starting with a Medicare Advantage line of business. Systems have long felt that they can do a better job servicing their patients based on their knowledge of the community and ability to manage resources more efficiently. The alignment and ownership of physician practices and other healthcare providers allows a certain degree of discretion at the direction of payments and incentives when it comes to achieving the Quadruple Aim, through improved provider experience, patient experience, improved quality, and efficient cost of care.

This article highlights several issues health system boards and senior leaders should take into account when determining whether starting a Medicare Advantage plan now is the right thing to do for the organization and those it serves.

1. Who Else Is in the Game?

Boards and senior leaders need to take a good look around the area where they are considering providing coverage for members of the plan and ask the following questions:

- What payers will be competitors for the plan?
  - » Are these local, regional, or national plans?
  - » What products are offered (HMO/PPO/National Networks)?
  - » Can we match/support these products and be competitive?
  - » Is our provider network able to meet access, quality, and total cost of care needs?
  - » How will these competitor plans react to the provider-owned health plan as a competitor and how may this impact the health system's relationship with those payers?
- How are these competitors received in the community?
  - » Are they growing?
  - » Have they managed costs of care well?
  - » Are their quality scores good?
  - » Are physicians and other providers satisfied?
  - » Are members satisfied?

Health systems as potential launchers of a new health plan have a unique aspect that they need to consider, and that is whether they are a dominant player in the area they service and whether there is a risk with relation to other health plans in the market that are important to the health system. In some cases, such as that seen in the area serviced by Geisinger Health System, there is a dominant system that captures a majority of the services provided for members and has much more leverage. In other areas, such as within Pittsburgh, there are two dominant systems (UPMC and Allegheny Health Network), creating a more competitive situation. In other communities, there may be multiple health system options for health plans to contract with. In this case, starting a new health plan may be more challenging and should be carefully considered versus other options, such as aligning with priority health plans in value-based payment arrangements and working together to grow profitable market share.

2. What Are the Complexities of Starting a Medicare Advantage Plan?

It is not the purpose of this article to delineate all the rules and requirements that each state and CMS list as required for licensure (state) and certification (CMS) to start a plan, but to highlight some key strategic, financial, and cultural considerations.

Requirements, resources, and functions that must be provided and well-documented for a new health plan include, but are not limited to:

- Adequate risk-based capital, sometimes called tangible net equity
- Product development
- Network adequacy, development, and contracting
- Marketing materials (approved by CMS)
- Member marketing/sales teams
- Broker relations teams
- Member enrollment and provision of ID cards
- Member services department
- Health plan operations, with policies and procedures manuals
- Claims operations and payment
- Utilization management/care management, with appropriate policies and procedures
- Quality programs, including all appropriate documents making up the infrastructure of a program
- Compliance
- Appeals and grievances
- Adaptation or delegation of the credentialing process for physicians and other providers, along with all criteria, policies, and procedures
- Provider services department
- IT and third-party administrator (TPA) systems, such as utilization management (UM)/claims, configuration management (CM), quality, enrollment, etc.

Each of these areas is a separate project, with subject matter experts or consultants participating in every step of development, and at the same time they are highly interdependent. For example, member enrollment software and operations provide information required for claims processing, UM/CM, and quality programs, as well as nearly every other function within the plan. Thus, proper enrollment of a member into the plan, including collection and reporting of the related data, impacts the successful operation of many other systems and processes.

3. Is the Culture Aligned with Evolving from Solely a Provider of Care to Also Being a Payer for Care

The move from being solely a provider to taking on the additional role as the payer—responsible for all costs and outcomes for enrolled members—can create unintended operational and financial conflict without careful planning, consideration, and management coupled with proactive governance. The common view of the payer by the provider is one of the "overseer," saying no to providers who just want to take care of patients. In many cases, the system does not see the payer as trying to manage a limited amount of dollars to get the best outcomes, but rather as the barrier to getting things done for their patients. For hospitals that are part of health systems, payers have rarely been "partners." They contract for services, seek prior authorizations for procedures, and redirect care to less expensive facilities.

Payers on the other hand, often see hospitals as simply trying to put "heads in beds" and maximize revenue through chargemaster game-play. From the health plan perspective, they may see little initiative shown by hospitals to move care to intermediate levels of

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Bridging Health Inequity through Health System Partnerships

By Rex Burgdorfer and Brent McDonald, Juniper Advisory

As hospitals and health systems emerge from the COVID-19 pandemic, they are confronting a new medical and economic world order. With government relief mostly ending, leaders are confronting a challenging set of circumstances—both new and old. Headwinds exist across the industry but are particularly acute for sub-scale providers, which most define as companies with less than $1 billion in patient net revenue.

This article explores the most pressing issues confronting boards today: 1) patient access to complex care delivery systems, 2) cost structure inflation, and 3) clinical quality issues. We describe how these factors, and others, have contributed to runaway disparities and inequities in the health of certain populations.[1] Lastly, we illustrate how some health systems, notably public hospitals sponsored by local-government entities, are using strategic partnerships or mergers and acquisitions as a tool to narrow the divide between the haves and the have-nots.

1. Patient Access to Complex Care Delivery Systems

"The U.S. healthcare market is the least customer-centric of any customer service industry…we are so numb to the pain that we rarely object or complain," said Bill Gurley of Benchmark.[2] In fact, across the U.S. economy, it is hard to find any business that compares to the malaise patients feel in the medical system—adrift from point of entry through recovery and payment.

One culprit may be the fragmented ownership structure of America's uniquely individualistic approach to care delivery and coordination. Reinventing or duplicating overhead in thousands of smaller communities, each attempting to individually raise capital, recruit and retain providers, and harness the power of complex health information technologies is, in aggregate, ineffective.

This fragmentation and inefficiency contribute to general patient confusion and uncertainty around care navigation and opaque billing practices. Obtaining care at the right place and right time through this fog is difficult for educated and insured patients. For vulnerable populations, preventive care for chronic disease may be an unreachable ideal, and the system may only be accessed at inappropriate settings like the emergency room where costs to the local system are high and individual care coordination and integration are not available.

These factors place stress on many local systems as patient expectations, fully met in other retail or service settings (i.e., Amazon or Trader Joe's), are not met. Dissatisfaction with the status quo is one of the leading reasons behind the growth in concierge medicine, which, in turn, perpetuates inequality.

Another trend, work-from-home employment, has enabled many to relocate from high-cost, high-tax urban centers to more lifestyle-oriented geographies—often rural, on water or in mountains. Patients accustomed to receiving care at academic trauma centers and who expect an EPIC record to seamlessly follow them are placing higher demands on local hospital leadership. Local hospitals are expected to have fellowship-trained specialists practicing in modern facilities with the most advanced technologies, and the reality is that costly upgrades and recruitment of specialists is difficult, if not impossible, for many community hospitals to provide on their own.

2. Cost Structure Inflation

Inflation, supply chain disruptions, and higher costs of staff and employees is a common refrain from the many health systems we visit. Specifically, these systems, both large and small, have had their cost structure upended by the trend of traveling employees, especially nurses.[3] In some cases, the cost structure of the organization has risen by around 20 percent. The impact is not just financial; it will result in less cash flow available for necessary routine infrastructure investments and technology upgrades.

Rating agencies, with a bias towards scale, recognize that larger-scale organizations are generally better able to implement discipline and performance improvement initiatives across the whole system. Smaller organizations may react by discontinuing services or restricting access in ways that disproportionately impact vulnerable populations.

3. Clinical Quality

The reputation, sustainability, and even reimbursement of a local health system are integrally reliant upon the organizational clinical quality. The above referenced development regarding hospitals being forced to hire traveling staff in order to maintain services is not just having an impact on expenses but is also having a significant adverse impact on clinical quality and safety. These temporary staff are often working in unfamiliar departments, with new equipment, and without the muscle memory on a team. As with sports (and most things in life—think 9th grade Algebra), repetition produces better outcomes. Safety and errors have long been correlated with volume. Current research goes further to suggest: "higher-volume hospitals may be better able to create clinical environments that improve the safety of surgical care…such as critical care expertise, as well as technologically

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Key Board Takeaways

- Take into consideration the community needs of all stakeholders, including segments that may be subject to health inequities.
- Focus on partnerships that improve access, patient experience, and clinical quality for all communities served.
- Arm directors with an understanding of the full range of strategic alternatives available to meet the organizational mission.
- Consider spearheading broader solutions that address social determinants that are exacerbating health inequities.
- Challenge historic biases against change.

1 Selwyn Vickers, "Medical Students Need to Learn about Health Disparities to Combat Future Pandemics," AAMC, April 30, 2020.
2 As presented by Tandice Urban, Co-Founder of The Landby, at the All-In Summit in Miami, Florida on June 1, 2022.
3 Lauren Hilgers, "Nurses Have Finally Learned What They're Worth," The New York Times, February 15, 2022.

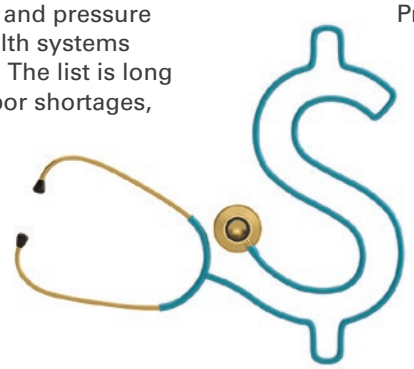
Where Is this Turmoil Leading? It's Heading Toward Value at Scale

By Dave Morlock, Cain Brothers

As a board member of a not-for-profit hospital or health system, you are tasked with multiple important responsibilities. But in the midst of monitoring the performance of your organization, overseeing the CEO, staying connected to the community and their healthcare needs, and thinking about your organization's strategic and budget plans, it can be hard to stay on top of overarching trends happening in the industry.

That said, American healthcare is experiencing changes the likes of which we have not seen in at least a half of a century. Board members must be well versed on those trends and issues. This is especially true when wrestling with trends and issues that impact the core of your organization's traditional business model. Your role is not to do the CEO's and management team's jobs for them. But you certainly need to be attuned to strategic and business model changes and be able to provide guidance and oversight as appropriate.

Entering the third year of the pandemic, the strain and pressure on hospitals and health systems remains unrelenting. The list is long (and depressing): labor shortages, expense inflation, legacy building fixed costs, vaccines, increasing regulatory and compliance burden, reimbursement pressure, physician consolidation, disruptive private equity and public equity investment in patient care, payer consolidation, price transparency, consumer demands, Medicare Advantage (MA) growth and the attendant administrative burdens related to MA, the continuing slow march to value-based care, expensive IT investment, and on and on.



In addition, some health systems are in markets where local socio-economic conditions, payer mix, stagnant population growth, and an over-bedded market exacerbate the already scary overarching industry trends.

Healthcare is a tough business right now. Because of mission dictates, community needs, and the fact that we have the health and well-being of human beings in our hands (literally), it is a business with a soul and a heart. But it is a business nonetheless. Whatever trite phrase you choose to use ("no margin, no mission," etc.), you must be aware of the strategic implications of underlaying business model shifts.

And immediate financial pressures are taking a toll. The first quarter of 2022 has created some exceptionally large losses across the industry, both in terms of the number of hospitals losing money, as well as the size of many of those losses (for example, Kaiser Permanente lost $961 million, CommonSpirit Health posted a $591 million operating loss, and Providence Health recorded an operating loss of $510 million in Q1 2022).

It is no wonder that health system CEO turnover is at some of the highest levels that we have ever seen. According to Challenger, Gray & Christmas, Inc., a healthcare executive placement firm, 29 hospital CEOs exited their roles in Q1 2022, nearly double the amount in the same period of 2021.[1] It certainly begs the question: Where is all this turmoil heading in the future? Because the status quo simply cannot continue.

A Shifting Business Model

We at Cain Brothers believe that future health system survival is all about scale—but not scale in the traditional sense. It's about value-based care at scale. That means scale in attributed lives. Health systems must be the nexus of care for attributed lives in their markets, and those markets must be large enough to be relevant and influential.

Ask yourself: Why are insurance companies acquiring physician practices, management services organizations (MSOs), ambulatory surgery centers, and home care companies? Why does private equity invest so heavily in physicians and physician enablement companies? And why are CVS, Walgreens, and Walmart investing so heavily in the actual delivery of care? They are doing so to become the nexus of care because there is profit in managing care of attributed lives at scale. That's "value at scale."

This competitive pressure is based on Medicare Advantage and value-based care reducing utilization and driving care into the lowest-cost settings. And the key phrase is "at scale."

Key Board Takeaways

Today's health system boards must no longer delay the process to reimagine their organizations in order to create a truly integrated value-based care delivery model that reduces utilization, moves as much care into the lowest-cost settings, and in which the care and payment models work together rather than against each other. The following are some questions for boards to discuss with their senior leadership teams to help move faster towards value at scale:

- How can we expand (further, faster) into full capitation and two-sided risk models?
- What do we need to do in our marketplace to compete for covered lives rather than patient care volumes?
- If we are considering consolidation, how can we ensure that it does not result in a larger, stronger, higher-priced FFS engine?
- What are we doing to increase the size and scale of non-hospital-based care?
- Can we break even at Medicare FFS rates?
- How can we become a platform for potential partners who can bring attributed lives, capital, and know-how to succeed in an MA model?

1 Challenger, Gray & Christmas, Inc., "CEO Exits Hit 119 in March; Q1 Exits up 29% over the Same Period Last Year" (press release), April 21, 2022.

This competitive pressure is based on Medicare Advantage and value-based care reducing utilization and driving care into the lowest-cost settings.

Public equity investment markets provide an interesting view of where they think the healthcare world is heading. The largest publicly traded hospital company in the country is HCA Healthcare. They have a market value of $80 billion as of the end of 2021, and their 2021 annual revenue was $58 billion, making their revenue multiple 1.37x (see **Exhibit 1**). Contrast that with value-based care companies such as Iora Health and Agilon Health. Exhibit 1 shows their market value, annual revenue, and revenue multiple compared to HCA.

So why does the stock market place a much higher value on the revenues of value-based care companies than the leading publicly traded hospital company? It is because the stock market is forward-looking by nature. They believe the future of American healthcare is value-based care. It is similar to the way the investment markets place a higher value on Tesla than on General Motors, Ford, and Toyota, even though the legacy car companies all sell many more cars than Tesla.

The future of cars is moving from gasoline combustion engines toward electric vehicles. And the future of American healthcare is moving from fee-for-service care toward value-based care. As a board member, you must understand this and have a point of view on what your organization needs to do in order to strategically deal with this shift in the fundamental business model.

An element of value-based care is the integration of insurance risk (i.e., the financing of care) with the actual operations of delivering care. Many health systems have struggled with that integration, because providing healthcare and providing health insurance are diametrically opposed business models. That's why many health systems that have tried to tackle value-based care by owning insurance companies have struggled to actually integrate the insurance and care models. One could

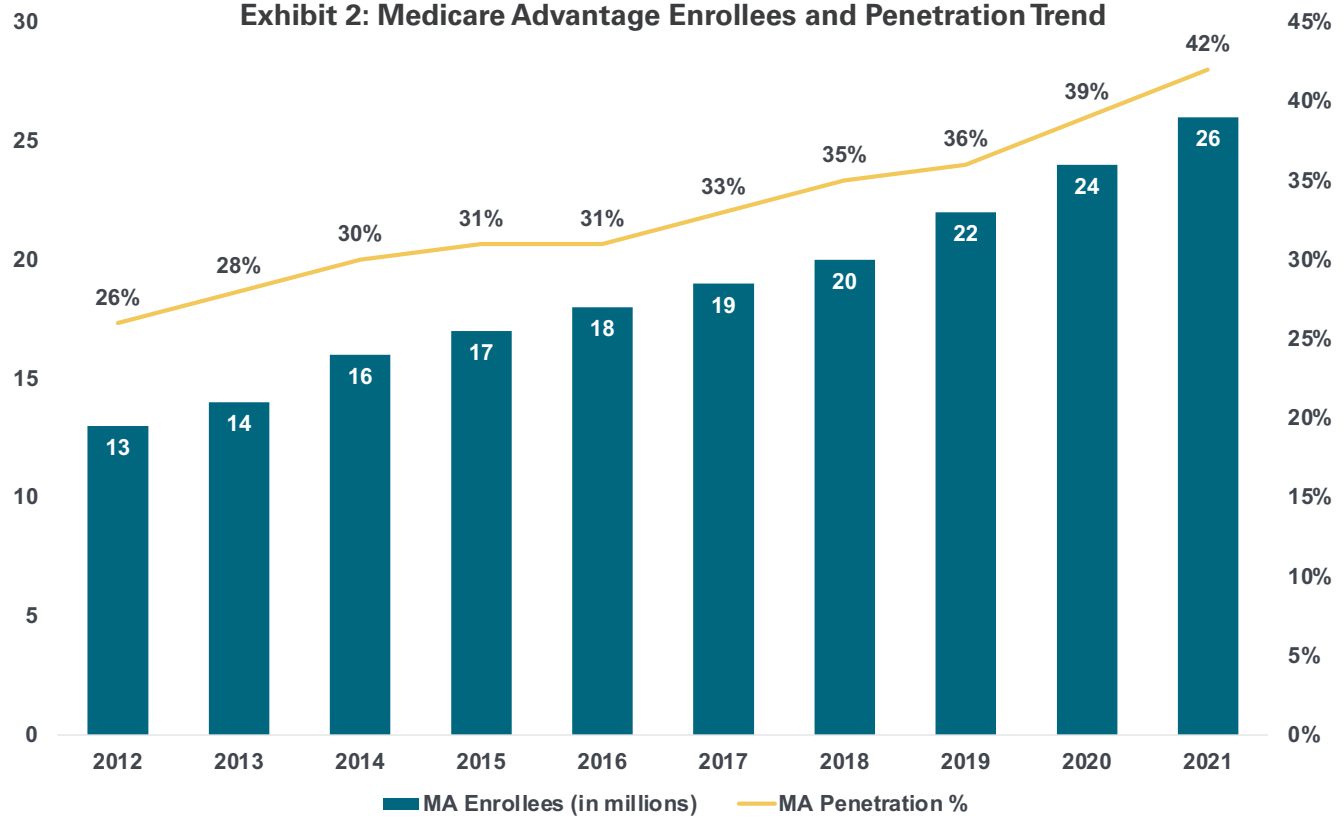
Exhibit 1: Key Financial Information for Publicly Traded Value-Based Care Companies

	Market Cap	Annual Revenue	Revenue Multiple
Iora Health (ONEM)*	$3.4 billion	$623 million	5.46x
Agilon Health (AGL)	$10.6 billion	$653 million	16.23x
HCA Healthcare (HCA)	$80.0 billion	$58 billion	1.37x

*Iora Health was acquired by One Medical on September 1, 2021.

Source: Google Finance, as of December 31, 2021.

Exhibit 2: Medicare Advantage Enrollees and Penetration Trend



Source: Kaiser Family Foundation

argue that Kaiser has managed to pull off this integration. But Kaiser may be a unicorn, providing the one-off exception that proves the rule that diametrically opposed business models can't readily be integrated. Even Kaiser has struggled to successfully export that integrated model outside of the West Coast.

Medicare Advantage has been on a slow and inexorable march toward being a dominant force in American healthcare for many years now. It has broad support across the political aisle. It is actually the privatization of traditional Medicare, though politicians wishing to remain electable generally shy away from that characterization. In the end, Medicare Advantage will have a similar effect on American healthcare that the move from defined benefit pension plans to 401k plans had on American retirement. It provides the vehicle to cap unsustainable growth in costs. While Medicare Advantage growth rates and penetration rates vary by state, the trend is clear (see **Exhibit 2 and 3**).

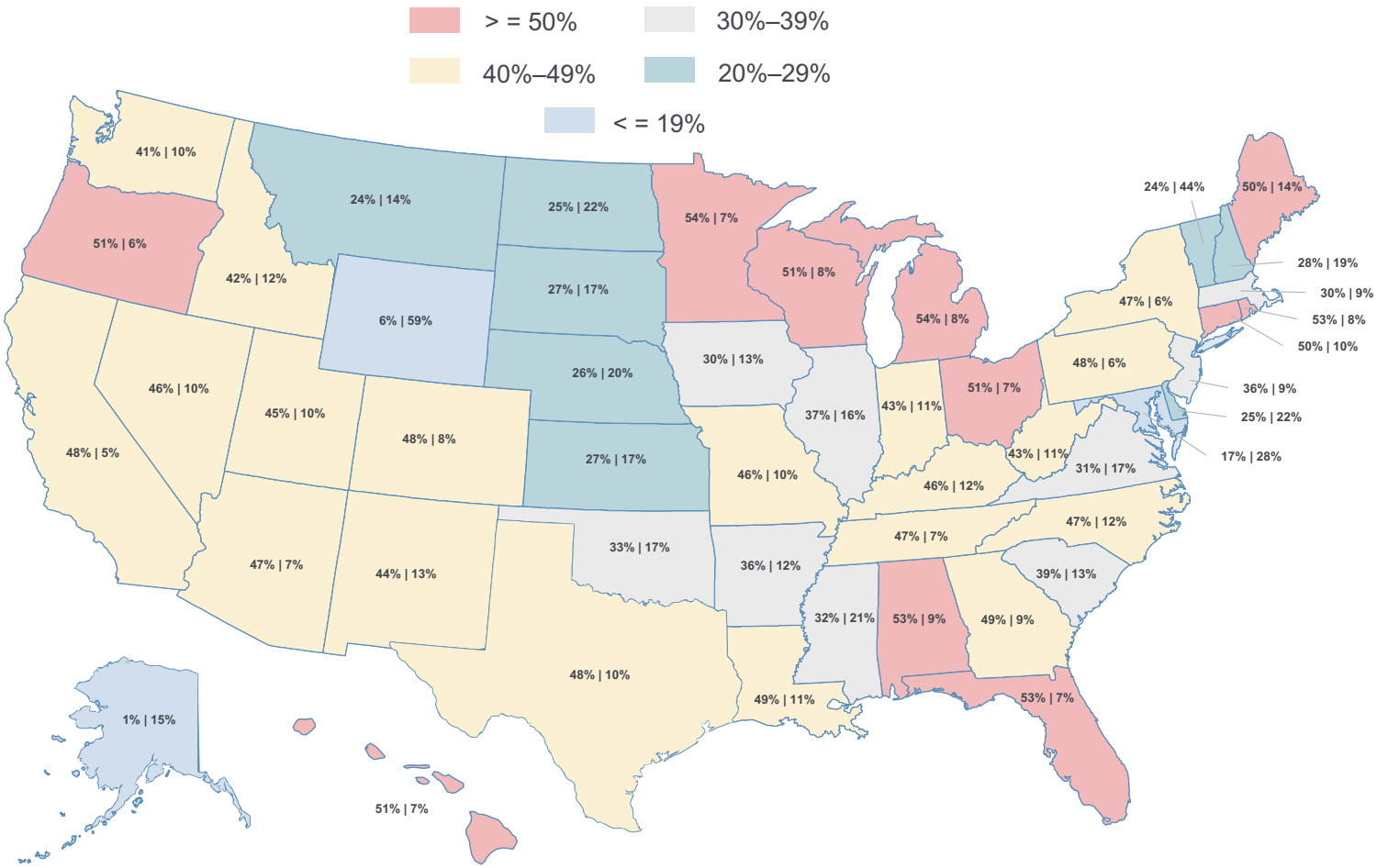
Medicare Advantage will continue to grow. And it will be the main factor that leads to the tipping point where value-based care will supplant fragmented, highly variable fee-for-service care.

The Slow March to Value-Based Care

It has been over a decade since we started the push toward payment mechanisms at the federal level to create value-based care. Organizations have invested significant amounts of money and management bandwidth on the effort. But the march has been very slow. By the end of 2020, less than 10 percent of health system payments were related to either full capitation or two-sided ACO risk. And few markets can be characterized as having true competition between multiple fully integrated health systems competing for covered lives, rather than competing for patient care volumes. What we have experienced instead is markets where consolidation has created large and strong fee-for-service engines, which actually makes healthcare more expensive to people, employers, and payers. And it does so without the element of integration necessarily driving improved quality of care.

An unfortunate outcome of this consolidation without the corresponding connection to competition in large-scale value-based care is the renewed federal push against health system scale. This is a misguided concern. The scale of health systems is not the issue. The real issue is that the

Exhibit 3: Medicare Advantage 2021–2022 Enrollment Growth Rate and Penetration by State



Source: Kaiser Family Foundation, CMS, The Chartis Group

fee-for-service payment mechanism is flawed. What American healthcare needs is more integrated health systems at scale competing with each other for covered lives, under a risk-based reimbursement model. We will never transform healthcare in America until we transform the way we pay for healthcare in America.

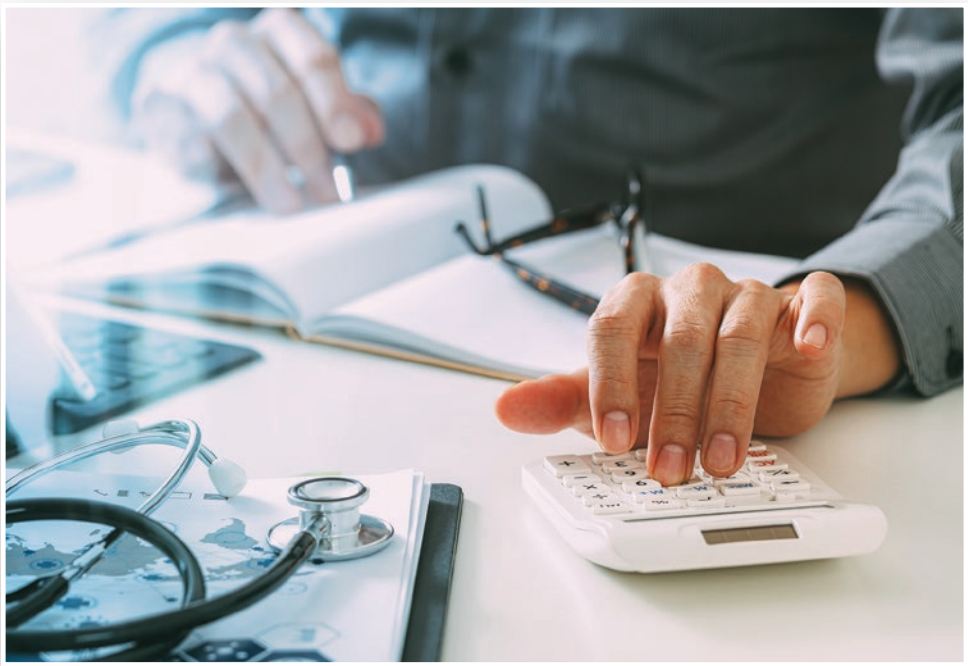
It should be noted that a key reason for the slow march toward value-based care is the significant portion of the healthcare industry's reliance on political lobbying as part of their business model. Almost every congressional district in America has at least one hospital in it. And in virtually all cases, those hospitals and health systems are one of the largest employers in the community. When a disruptive change to their business model is on the table (such as the shift from fee-for-service to value-based care), there is significant political lobbying pushback. A lack of desire, or lack of ability, to compete for covered lives in a value-based care environment could mean financial strain for health systems. At the hint of financial strain, cries of job reductions and reduced access to care for the vulnerable can be heard. And no politician seeks to be seen as a jobs-killer or someone who lacks compassion for the vulnerable (including the vulnerable citizens who vote). Political lobbying is a key tenet of the American healthcare business model. You have to wonder whether lobbying is ultimately a long-term sustainable pillar of an industry business model.

What does this all portend for hospitals and health systems?

Exacerbating this competitive dynamic for health systems is the increasing size and scale of non-health-system-based care giving activities. Large insurance companies are significantly increasing their positions in the provision of care through investment in ambulatory care activities (physician practices, ASCs, ancillaries, and home care). Private equity and public equity also continues to be invested in ambulatory care and physician services at significant levels. And these non-health-system players are doing this at scale. The two largest market participants in this area are United Health Group and CVS-Aetna. Their combined annual revenue is more than a half-trillion dollars (that's "trillion" with a "t").

Achieving Scale in Attributed Lives

Health systems need a Medicare Advantage model that works in both a value-based-care world and a fee-for-service world. In the fee-for-service context, the model means that you can be break-even at Medicare fee-for-service rates. If you continue to rely on the plan of losing money on government-paid business but making up for it with profits on commercial payers, then your strategy will fall apart over time. This fee-for-service context also means that you need to make money in your ambulatory environment, including the employed physician group. In a value-based-care context, the Medicare Advantage model means that you are taking top-line insurance risk, and you are on the hook for population health, quality of care, and economic outcomes for an entire population of attributed lives.



What American healthcare needs is more integrated health systems at scale competing with each other for covered lives, under a risk-based reimbursement model. We will never transform healthcare in America until we transform the way we pay for healthcare in America.

Health systems have multiple ways to achieve scale in attributed lives. Some of these options include:

- Acquire and employ many primary care providers and gate-keeping specialists, in an attempt to control attributed lives. Are you positioned to outcompete major insurance companies, private

equity, and major pharmacy chains in this physician acquisition space?

- Own and operate a Medicare Advantage health plan, at scale. Scale in this context is measured in hundreds of thousands of lives. And the MA health plan business is a retail business. Are you positioned to outcompete major insurers in this space? Currently, nearly 75 percent of the Medicare Advantage lives in this country are controlled by six insurance companies, and they each have covered lives measured in millions. Can you compete with that scale? The number of small health system MA plans with 10,000 to 20,000 covered lives is astounding. The idea that those plans think that they can compete with large-scale health plans in a retail business like MA is even more astounding.
- Sign a large full-risk capitation agreement with a payer, covering a large number of attributed lives. Are there payers in your market signing those deals?
- Merge with another health system, such that the combined entity has sufficient scale and access to attributed lives to permit your system to survive in the future.
- Access attributed lives via partnerships. You could be a convener of partnerships by being a platform, similar to the way an iPhone is a platform for all of those apps. There are many partners to choose from. This would involve running a crisp, controlled process to identify the right partner who can bring not only attributed lives, but capital and know-how, in order to be successful in the Medicare Advantage model.

Partnerships can be used to successfully participate in the value-based care model by delivering high-quality care in lower-cost settings. For a couple of decades, that has often meant the delivery of care in an ambulatory care setting, rather than in the acute inpatient setting. More recently, an important key for the future is the ability to deliver care in more distant settings. This means care delivered in the home.

In this home-based approach to value-based care delivery, we will see the continuing emergence of a new "shadow continuum of care." The traditional continuum of care has been patients seen in a doctor's office, an ambulatory care clinic, an urgent care, or in the emergency department of the local hospital. Then a patient is admitted to the acute hospital setting. Then after discharge, care is often delivered in a post-acute setting such as a skilled nursing facility, long-term acute care hospital, or an inpatient rehab setting. In the "shadow continuum," care is delivered in the home setting via telehealth visits with providers, visits by home health providers, urgent care at home, acute care in the home setting, skilled nursing facility care in the home setting, palliative care, and then home hospice care.

Certainly, patients will move back and forth between these two continuums. But over time, as monitoring infrastructure gets even better, more and more care will be delivered in the virtual continuum of care. This is a lower-cost setting and will contribute to better health outcomes, better cost outcomes, and greater consumer satisfaction.

Very certainly, there will be continued private and public equity money invested in this space. As an example, UnitedHealth Group's Optum recently acquired home care provider LHC for $5.4 billion. As a health system, are you putting your precious capital into the virtual continuum of care, or in the brick-and-mortar continuum? This is a competition between the new healthcare economy vs. the old healthcare economy.

In moving from the old healthcare economy to the new healthcare economy, scale matters. But not from the traditional sense of leverage against payers or suppliers. Scale in attributed lives matters because of actuarial soundness, access to capital, shared operational services, and deploying technology and innovation on a scale where a reasonable return can be achieved.

A new world is emerging for health systems. They can shift paradigms, make partnerships, gain scale, and survive. Or they can hunker down, hope, and then wither away. What will you do?

The Governance Institute thanks Dave Morlock, Managing Director, Head of Health Systems Group, Cain Brothers, for contributing this article. He can be reached at dmorlock@cainbrothers.com. Cain Brothers, a division of KeyBanc Capital Markets, is a trade name of KeyBanc Capital Markets Inc. Member FINRA/SIPC. This article is for general information purposes only and does not consider the specific investment objectives, financial situation, and particular needs of any individual person or entity.

The Reversal of Roe v. Wade…

continued from page 3

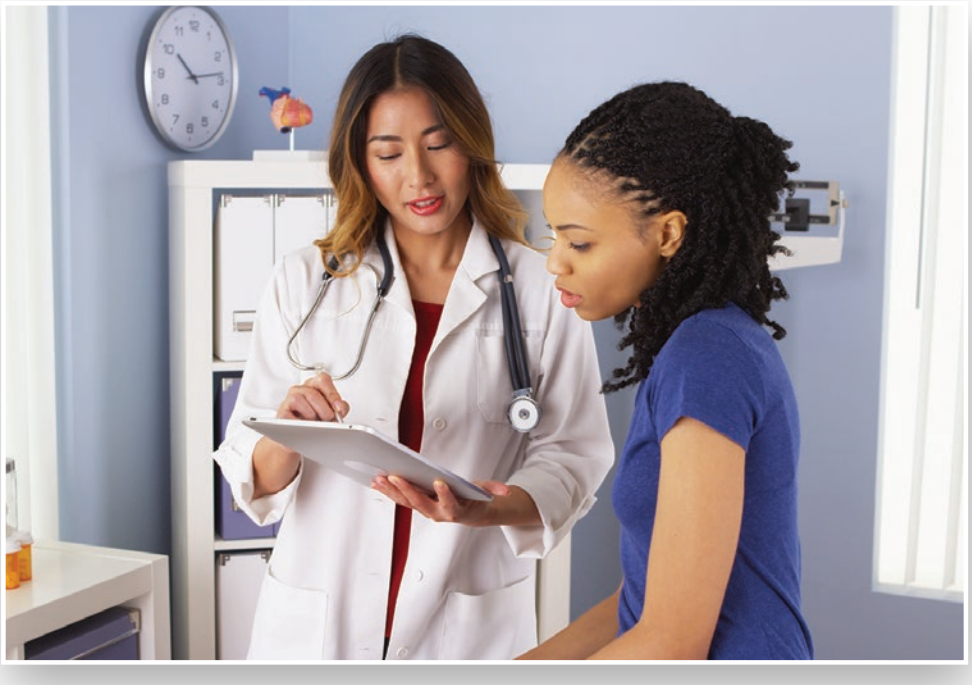
confidentiality of communications with their patients, and a legal requirement to comply with court orders, subpoenas, or other summons. Even in states where abortion remains legal, providers may face challenging privacy issues, such as whether to produce medical records to law enforcement in a patient's home state when a patient has traveled to the physician's state for purposes of obtaining an abortion.

Metadata is everywhere and is not (yet) protected by a federal law. While a House subcommittee is working to advance the American Data Privacy and Protection Act, it may become political currency in the current polarized environment.[5] The majority of data that could be made available to law enforcement is not healthcare data and therefore not protected by HIPAA or by traditional medical ethics practices (e.g., GPS location-tracking data, apps that track purchases including prescriptions, period-tracking apps, data that tracks searches for health information on the Internet, etc.). Many hospital Web sites track patient activity in order to better conduct triage and help patients navigate their system.[6] HIPAA also might not be a limiting factor if law enforcement or individual states determine that patient data regarding abortion is no longer protected under HIPAA.

Hospitals and physicians that may be compelled to provide patient data to law enforcement agencies should work closely with knowledgeable counsel and proactively plan their legal and ethical responses. Some may want to carefully rethink their digital strategies if such data can be used against the interests of patients. (Security and privacy related to digital healthcare overall is currently an area requiring further attention.)

Service Offerings and Financial Impacts

Given the new legal and political risks associated with selected medical practices, the board and management will need to carefully review the services offered and the financial impacts that may result from shifts in medical practice. For example, some institutions may find it no longer feasible to provide services such as infertility treatments,



non-elective or elective abortions, some contraceptive options, or selected telehealth consultations. Other services may need to be cut back if it becomes difficult to recruit or retain providers who don't want to practice reproductive medicine in a hostile state environment. There may also be increased unforeseen demand for some services. For example, since the Supreme Court's ruling many urologists have seen a marked uptick in the number of men seeking vasectomies and ob-gyn physicians have reported increased demand for tubal ligations.[7] In addition, many experts project increased demand for psychiatric and social services as rates of depression, child and spousal abuse, and substance use disorders are expected to increase in the wake of this ruling (see below).

Hospitals will need to plan for consequences that may be both financial and operational. The diminution in volume or elimination of some services may reduce revenue while increases in vasectomies, tubal ligations, and pregnancy-related health problems may increase revenue. The costs of practitioner recruitment and retention may increase. More money may need to be budgeted for legal expenses. In some states, payers may no longer be willing to pay for abortions or other women's healthcare. On the operational side, changes in service offerings or the availability of physicians may necessitate planning to facilitate patient transfers to other institutions for emergency care. Investment in psychiatric and social services may need to be increased as demand grows.

Health Equity

It is largely anticipated that this ruling will have a disparate impact on ethnic minority families and those in lower income brackets. Some are anticipating an increase in domestic violence and see the likelihood of more women and children living in poverty. This new environment will also impact mental health. Boards should be discussing this in the context of their duty of obedience to the charitable mission and integration of new efforts with ongoing population health activities and programs addressing social determinants of health. Boards may wish to consider ramping up SDOH programs with community partners to address poverty, access to affordable mental healthcare, childcare, domestic violence, and so forth.

Workforce Well-Being

With a workforce still in crisis from the impacts of COVID, the Supreme Court's

5 Arent Fox Schiff, "Moving Closer to a Federal Data Privacy Act: House Subcommittee Advances American Data Privacy and Protection Act to Full Committee," July 5, 2022.
6 Xiufen Yu, et al., "Got Sick and Tracked: Privacy Analysis of Hospital Websites," Concordia University, Montreal, Canada.
7 Meena Venkataramanan, "Men Rush to Get Vasectomies After Roe Ruling," *The Washington Post,* June 29, 2022.

Dobbs decision is already having major impacts on the emotional well-being of your workforce. In their roles as both caregivers and patients, members of the hospital workforce are facing new challenges that may undermine their well-being.

Healthcare organizations are themselves diverse communities, and your workforce may be made up of people with drastically different positions on this issue. If your workforce is starkly divided, friction may result that might not have existed previously. Your employees might not understand all of the potential implications of this decision. The board's role is to ensure that its workforce is educated by asking the CEO and senior leadership questions about how this is being handled. Aligning the workforce to the mission and focusing on education and process may help minimize division. Employees may need additional avenues to have safe and candid conversations. Partnering with and supporting the CEO and C-suite to enhance workforce support will be key.

Medical Education

Academic institutions have raised concerns about what will happen to the quality of women's overall healthcare if abortion and related procedures are no longer taught in all ob-gyn residency programs. Evidence shows that physicians who are knowledgeable about abortion care and the various circumstances/treatments for pregnancies that become dangerous to the woman's health provide better care overall.[8]

Influx of Travelers in States Providing Abortion

For states that will continue to make abortion available, boards may need to ask themselves how to handle the anticipated influx of people traveling to these locations to receive abortion services. Beyond having providers available, what are some other unforeseen complications of this that boards need to think about up front and prepare for? Will such travel increase use of the emergency room? Will there be an opportunity to ramp up other reproductive services such as in vitro fertilization or family planning clinics?

Advocacy

Governing boards will have their hospitals take different positions regarding advocacy for women's health needs. Many healthcare organizations have spoken out forcefully expressing their concerns about the Supreme Court's decision to end federal protection for women's health privacy and medical autonomy; others have remained silent. Some boards have more latitude to undertake advocacy than others and many will not wish to be drawn into the political dialogue becoming ubiquitous throughout the country.

At this point, critical discussion needs to happen in the boardroom as boards ask themselves what their role is in the advocacy arena to influence policy, existing laws, and new laws. This should occur as part of a broader task to develop a philosophy about the hospital's role in local and national advocacy.

Communication

Boards need to ask their C-suite and physician leaders what messages, if any, the organization needs to present to the public, their workforce, and other stakeholders. There may be many new areas in which patient education and information needs to be updated. Given the increased role of state and local governments (and in some states, private citizens) in the personal decision making of patients, many hospitals will find it necessary to increase their efforts to communicate with the public. Such communication can be used to clarify for patients how the services the hospital has historically offered may change, how the hospital will treat their health information, and how it will cooperate with local law enforcement. Some hospitals will see an imperative to provide women more education about the impacts of pregnancy on their health and what options are available for family planning.

Addressing Practitioner Concerns

Many of the hospital's privileged practitioners will have serious concerns about their professional well-being in the face of new legal uncertainties. They will want to know if the board and management have their backs if they "do the right thing" to protect the health of their patients. Will the hospital help them with legal costs to defend their actions against prosecutors or "deputized" private citizens? Will it help them fight possible actions by regulators who want to withdraw their license to practice? Will it provide professional liability coverage if private carriers refuse to defend care that could be deemed illegal under a state's statute?

Looking Forward

We can only begin to project the cascade of consequences that will emerge in the wake of *Dobbs v. Jackson Women's Health.* But thinking ahead is a crucial responsibility for boards, many of which already spend too little time deliberating mission and strategy.[9] This may be the time for hospitals with dormant ethics committees to give them new life and purpose. If the Supreme Court makes future rulings that further undermine patient autonomy, privacy, and established medical practice as some of the Justices have advocated, hospitals will need to be prepared.

There is an opportunity for organizations to move quickly through the reaction phase of this Supreme Court decision and fast-forward innovation around community partnerships, ramp up SDOH efforts, improve maternal health, and engage in proactive family planning. We urge our members to set aside significant time, whether at the next several board meetings, or a special retreat, to discuss these issues and ask the hard questions. Whether answers may become clear or not, beginning this process now will better position your organization to make the decisions it will inevitably face.

The Governance Institute thanks Todd Sagin, M.D., J.D., National Medical Director, Sagin Healthcare Consulting, and Kimberly A. Russel, FACHE, CEO, Russel Advisors, for contributing to this article. They can be reached at tsagin@saginhealthcare.com and russelmha@yahoo.com.

8 Ariel Bleicher, "Preparing for a Post-Roe America: What Happens Once Abortion Is Illegal in Half the Country?" *UCSF Magazine,* Summer 2022.

9 Kathryn Peisert and Kayla Wagner, *Advancing Governance for a New Future of Healthcare,* 2021 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute.

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entity should have final approval for each responsibility and each similar entity (e.g., hospital boards) should have the same authority.

Getting Together

Shared Continuing Education

Inviting all who serve in governance to attend the same continuing education session(s) virtually or in-person has multiple advantages. Everyone hears the same information at the same time, relationships are built, and a "one system" culture is emphasized.

Joint Committee Meetings

If hospital boards have committees, invite all serving on similar committees to meet as a group. For instance, convene an annual joint quality committee meeting to discuss system-level quality metrics and share best practices.

All-Boards Retreat

High-performing systems convene an all-boards retreat at least once a year. These events often include education on healthcare trends as well as updates from the CEO on the system's performance vis-à-vis the strategic plan. In-person retreats also solidify cross-system relationships, support systemness, and help provide direction to all boards and committees.

Next Steps

Integrated Annual Board Topic Calendar

Each year, the system CEO and board chair develop a calendar of board topics and approvals. The calendar lists which items will be approved in which system board meeting (e.g., audit, operating budget, executive compensation, strategic plan). This allows subsidiary boards and committees to integrate their workflow appropriately.

Coordinated Meeting Timing

It is easier to function as an integrated system if meeting calendars are synched. Ideally, subsidiary boards meet the same number of times in a year (e.g., quarterly) and their meeting dates are coordinated with each other and with the system board and its committees. This allows sufficient time to prepare agendas and materials that flow into each other.

Standardized Documents

One of the most valuable practices is to ensure all governance documents are consistent across the system. Highly evolved systems have standardized bylaws, board policies, and committee charters. In addition, they have templates for agendas, minutes, dashboards, and other meeting materials.

Increasing Effectiveness

Regular Communication

Almost all boards within systems wish there were better communication. They want to feel sufficiently informed to fulfill their responsibilities to both the system and their community. The best subsidiary board meetings include reports from system management on system strategies, finances, and operations as well as updates from local management. In addition, the system CEO and local management send regular updates to all board and committee members.

Consistent Reporting Expectations

Great systems set clear and consistent expectations regarding how information will flow among management, committees, and boards. For instance, each committee is expected to create an executive summary of its "asks" of the board. Common dashboards for key information (e.g., finance, quality, and strategy) are used. Committees and boards all provide their written minutes in sufficient time to be included in board packets.

Common Evaluation and Goal Setting

Using the same evaluation tools helps ensure that all are rowing in the same direction. If all boards use the same self-assessment instrument (e.g., The Governance Institute's BoardCompass®), the report can identify challenges and best practices in each entity and across the system. That information serves as the foundation for developing annual, system-wide and entity-specific board development goals.

Final Advice

Each governance practice described above has been successfully implemented. However, two critical success factors were: changes were led by the board(s), not by management, and participative processes were utilized. This is especially important if the system is new or if subsidiary boards have/had substantial authority.

Therefore, the sytem governance committee should lead this effort and consider it a change initiative. Subsidiary boards and management should be engaged in education and discussions about how and when to implement which practices. In this way, the system governance committee models both good governance and the vision of systemness.

The Governance Institute thanks Pamela R. Knecht, President and CEO, **ACCORD** *LIMITED, for contributing this article. She can be reached at pknecht@accordlimited.com.*

Key Considerations…

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care, such as observation or, even better, to less expensive non-hospital-based ambulatory and home options.

The development and launch of a health system-owned Medicare Advantage plan requires the health system to adopt more of the payer perspective and role in managing the total cost of care and member outcomes. This can be difficult for some systems to do. Being able to reduce admissions and length of stay at a facility seems counterintuitive until you understand the need to include management to the premium and not just to the hospital revenue as a key part of cost containment, as well as understand the potential enhancement in revenues from the plan premium. Providers need to be brought on board to buy into this concept and be aligned as well as share in potential margins achieved.

Some of the most disruptive aspects of adding a health plan into the health system family are:

- Utilization management, including:
  - » Prior authorization
  - » Management to third-party sourced guidelines (MCGs or InterQual)
  - » Follow outpatient guidelines and manage low-value procedures (medical clearance on low-intensity surgery, such as cataracts, for example)
  - » Hospital inpatient and ED utilization management
  - » Denial management
  - » Steerage when appropriate
  - » Out-of-area and out-of-network management
  - » Appropriateness of care
- Care management from both a plan and provider perspective
- Member engagement
- Contracting with and referrals to providers outside of the health system

The decision to start a new Medicare Advantage plan requires a lot of discussions, inquiries, and significant hiring and culture change, the last being the most difficult sometimes. Including all stakeholders in these discussions, market surveys, an understanding of the competitive environment, and a good comprehension of the key priorities of the system is vital before moving forward.

The Governance Institute thanks Yomi Ajao, Principal and Chief Consulting Officer, and Allen Miller, Principal and CEO, COPE Health Solutions, for contributing this article. They can be reached at yajao@copehealthsolutions.com and amiller@copehealthsolutions.com.

Bridging Health Inequity…

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sophisticated diagnostic and treatment services."[4]

Further, economic inequality today can be seen directly impacting patient access to high-quality, affordable medical care. Netflix's "Operation Varsity Blues" that investigates the college admissions scandal calls this "opportunity hoarding." The breadth and availability of specialty services is commonly (and sadly) tied to the strength of regional demographics.

What Is the Proper Board Response?

Local governments that contain both affluent and poor communities are at a crossroads. Officials are confronted with how best to configure care *for all* constituencies. Many are choosing to explore the merits of partnerships to form more integrated delivery networks across diverse populations to better serve communities in need.

In response to these forces, a unique and interesting trend has emerged in health system mergers and acquisitions recently. Across the country, local government-sponsored health systems are stepping in to aid struggling private hospitals within or adjacent to their market. A principal aim of these business combination transactions is to maintain access, better coordinate population health, and thereby bridge health inequities.

Two recent examples stand out: Monterey County in California and Indian River Health District in Florida. Monterey County contains Carmel and Pebble Beach, with a median home value of $3,900,000. It also includes inland communities like Salinas with a base of largely migrant, undocumented agriculture workers earning a median annual income of $25,200.

A similar story exists in Vero Beach, Florida, whose exclusive John's Island is dominated by well-to-do retirees occupying homes with a median value of $1,300,000. A short distance inland, and within the same district, is the hub of the U.S. citrus industry where workers earn a median income of $28,002. Civic leaders sought to bridge the gap in care opportunities by coordinating under a shared ownership model. Indian River did this through a long-term lease with the Cleveland Clinic. Funds created by the transaction are being used to support educational programming, indigent care, scholarships, primary care development, and research regarding social determinants of health.

As readers undoubtedly feel, inequality is at all-time highs. The Economic Policy Institute measures the CEO-to-worker pay ratio, which shows no sign of narrowing.[5] While the California and Florida examples cited are extreme, they illustrate the ways in which inequality is tricklingly down to primary care and how hospitals are responding by partnering with others in their market.

There are several municipalities whose hospital systems have evaluated partnerships, such as Grant County, New Mexico; Indian River County, Florida; Branch County, Michigan; Hardin County, Kentucky; Hanford, California; Gregg County, Texas; and others. Some had elected officials directly overseeing hospital operations. Others had self-perpetuating 501(c)3 boards overseeing hospital operations separately from the government agency. We believe this is an important theme to monitor in 2022 and beyond.

The Governance Institute thanks Rex Burgdorfer, Partner, and Brent McDonald, Managing Director, Juniper Advisory, for contributing this article. They can be reached at rburgdorfer@juniperadvisory.com and bmcdonald@juniperadvisory.com.

4 Shenae Samuels, et al., "Association of Hospital Characteristics with Outcomes for Pediatric Neurosurgical Trauma Patients," *Journal of Neurosurgery,* June 2021.
5 Economic Policy Institute CEO Compensation Report, August 2019.

CEO Retention: Beyond the Compensation Package

By Kimberly A. Russel, FACHE, Russel Advisors

As the pandemic shifts into endemic status, CEO retirement announcements are appearing in healthcare news feeds almost daily. The American College of Healthcare Executives recently announced a 2021 CEO turnover rate of 16 percent, which matched the rate in 2020. Notably, there is significant state-level variation ranging from 3–33 percent.[1] Healthcare executive search experts informally predict even higher CEO turnover in the future due to a combination of baby-boomer demographics and pandemic-related burnout.[2]

CEO retention is a primary focus of boards and their compensation committees. As expected, compensation committees concentrate on the CEO's total compensation package: salary, benefits, and incentives. Without doubt, the total compensation package is vital to successful CEO recruitment and retention. However, the non-financial aspects of CEO retention can significantly impact the decision of a CEO to engage (or not engage) in a search for a new position. Along with the compensation package, boards should also consider the non-financial aspects that mitigate the risk of CEO turnover. Fortunately, these elements are all within the control of the board.

Non-Economic Retention Considerations

CEOs are often reluctant to leave a situation in which the overall board culture is positive and forward-thinking. This means the board focuses on governance-level work, including devoting the majority of board meeting time to strategic pathway discussions and deliberations. Such boards feature engaged directors who are committed to sound governance practices. Boards that desire a lengthy tenure from their CEO should consider these non-monetary retention points:

- Boards that are deliberate in defining the roles and responsibilities of governance (especially in relationship to the CEO's role) have created the foundation for strategic (or generative) governance. When a board by design does not become involved in operational matters, it signals confidence in its chief executive and respect for the CEO position. A board that devotes its agendas to strategic challenges, questions about the future, and governance oversight is an attractive partner for a CEO.
- Are directors prepared for meetings? Is there robust participation in the boardroom? Is attendance generally very good at board meetings and board events such as retreats? It can certainly be discouraging to the chief executive if the answer to any of these questions is a consistent "no." The answers to these questions are direct indicators of board culture.
- Boards with a disruptive director must remember their self-governance responsibilities and "take care of business." Disruptive board members who are not addressed by board leadership will create an unappealing environment for the CEO (and other directors too).
- A conflict-of-interest policy that is clear, robust, and respected by all directors is essential to CEO retention. When a known conflict is not addressed by the board, the CEO can find him or herself in an untenable situation.
- A strong partnership between the board chair and chief executive is also an attractive scenario for a CEO. As boards select officers, one consideration should be the potential to develop a high-quality partnership with the CEO. Boards should seek confidential input from the CEO as one of many considerations in board leadership selection.
- CEOs aspire to work with top board talent. Boards with a history of attracting directors from diverse backgrounds, industries, and perspectives create an enticing boardroom environment for the CEO.
- CEOs need performance feedback on a regular (usually, annual) basis. Especially when a CEO is generally acknowledged to be high-performing, it can be tempting for boards to skip this step. Instead, boards should commit to conducting an annual CEO performance review. The dialog surrounding the review—along with associated insights—are beneficial to the CEO.
- Boards should both encourage and support the CEO to be active in professional development activities at the local, state, and perhaps even the national level. CEOs learn from involvement in these external activities and benefit from sharing insights with other healthcare leaders. The organization (and often, the board) also profits from the external knowledge the CEO gains from these activities.

Key Board Takeaways

- Certain non-economic elements, all of which are within the control of the board, are as important as the financial package to achieve long-term CEO retention.
- Boards that practice strategic governance reduce the risk of CEO turnover.
- A strong board culture is very attractive to CEOs.
- Sound governance practices are foundational to an effective CEO retention strategy.
- When boards and CEOs work together as partners, all parties benefit.

Final Thoughts

As a point of clarification, "rubber stamp" boards or boards that always agree with the CEO are not contributors to CEO retention. Instead, CEOs thrive in a respectful atmosphere in which directors pose challenging questions to one another and to the CEO—and the CEO does the same. In the ideal boardroom, directors and the CEO are continuously learning from one another and are working in partnership to advance the organization's mission. Finally, the risk of CEO turnover can be mitigated when the board considers both economic and non-economic factors that contribute to retention.

The Governance Institute thanks Kimberly A. Russel, FACHE, Chief Executive Officer of Russel Advisors and Governance Institute Advisor, for contributing this article. She can be reached at russelmha@yahoo.com.

1 American College of Healthcare Executives, "Hospital CEO Turnover Rate Remains Steady" (press release), May 23, 2022.
2 Kimberly Russel, Marian Jennings, and Andrew Chastain, "Retaining Executive Leadership for Healthcare's Next Generation" (Webinar), The Governance Institute, November 4, 2021.