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Essential Conversations for Effective Governance

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When Group Norms Override Good Discussion

The boardroom is where a health system's strategic direction is determined, risks are evaluated, and critical decisions are made. Effective decision making and governance practices can be enhanced by recognizing and addressing unproductive group norms. In our practice of advising boards of all sizes across health systems, hospitals, physician organizations, and payers, we have witnessed several common pitfalls that can derail robust, honest board conversation and functioning:

- **CEO townhall:** The CEO and management team dominate the meetings, filling the time with presentations and monologues. As a result, directors become passive recipients of information, with no time or energy left for meaningful, strategic dialogue.
- **Fishbowl effect:** The same few individuals do most of the talking, and the broader board watches from the sidelines.
- **Political sidebars:** Directors are lobbied during private conversations before the meeting, excluding the broader board from critical decision-making discussions. The board meeting becomes a mere formality.
- **Empowered executive committee:** The executive committee makes all the critical decisions and becomes the de facto board. Non-committee members are disengaged, underinformed, and underutilized.
- **Divergent expectations:** Some directors come prepared to dive deep into a particular issue, while others intend to debate high-level options or push for

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immediate action. This misalignment around the expectation to understand versus act can lead to confusion, frustration, confrontation, and/or disengagement. This dynamic often occurs when there is a lack of clarity around the board's role and the altitude at which the board should engage.

By avoiding these common pitfalls, boards can enhance their effectiveness and ensure critical governance issues are thoughtfully addressed. This article examines some of the root causes of these pitfalls and offers solutions for course-correcting them.

What Causes These Pitfalls?

The root causes of unproductive board dynamics and communication patterns are often linked to gaps in leadership competencies, motivation, culture, structure, and/or process.

Issue #1: Leadership (Ineffective Facilitation)

One common problem is when the board and committee chairs fail to *actively* manage conversations. One of their primary roles is to be the air traffic controller who ensures a balance of voices in the boardroom. For instance, they need to invite input from those who have not spoken, even at the risk of "putting them on the spot," or dial back those who speak up too much, even at the risk of offending them. The chair must avoid a circular conversation dominated by a few individuals. Conversely, some chairs dominate boardroom discussions, failing to recognize their role in facilitating balanced dialogue.

Issue #2: Culture (Conflict Avoidance)

Some boards are conflict-avoidant, making it against their culture to challenge peers, the CEO, or the management team during meetings. In other cases, directors are uncomfortable engaging in tough conversations because of the lack of psychological safety. Those who do speak up and are willing to take a contrarian viewpoint or push for generative discourse are seen as disruptors. The norm should be that the boardroom is a safe place for constructive debate, critical review, and lively discussions while demonstrating collegiality and civility.

The root causes of unproductive board dynamics and communication patterns are often linked to gaps in leadership competencies, motivation, culture, structure, and/or process.

Issue #3: Individual (Conflicting Interests)

Due to structural issues, conflicting motives can sometimes overpower the ethical values of even the most disciplined directors. For instance, consider a board of a for-profit physician group comprised entirely of its members, ranging from frontline physicians to department chiefs. The CEO reports to them in the boardroom, but they report to the CEO day-to-day. This dual role creates inherent conflicts of interest and implicit biases,

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whether intentional or not. Thus, the board's challenge lies in effectively balancing these biases with strategic governance policies for checks and balances.

Issue #4: Structure (the Nuts and Bolts)

Some structural issues will derail even the most competent board chair's efforts to run an effective meeting. A common example is ensuring the meeting agenda is focused on the right topics and realistic in its time allotment. However, the concept of flexible meeting times is not often considered. There is an expectation that board meetings must end at a specific time. While this is the goal, some meetings should be extended ahead of time to allow adequate time for learning, discussing, and debating an important strategic issue. Allow the end times to vary as necessary.

The sequencing of agenda items matters, too. A half-finished discussion that ends in a vote is potentially more disruptive than tabling the topic until more time is available or extending the meeting's end time.

Finally, the layout of a boardroom can be instrumental or detrimental to an engaged board. Every board member should be able to make eye contact with everyone around the room. Keep your boardroom's technology current, ensuring it supports the board and does not become an obstacle.

Tough Conversations Require Bold Governance

Solution #1: Aim to Be Bold

In the last two decades, boards have greatly enhanced their oversight by implementing "good governance" practices. It's time to take governance to the next level. The call to action is for bold governance, where directors are not afraid to ask tough questions, are self-aware and able to self-regulate (i.e., knowing when to dial back, speak up, or even resign from the board), and have the personal courage to hold themselves and others accountable for behaviors and words that do not reflect the core values of the organization.

Solution #2: Hold Directors Accountable

A basic level of expectations is that directors study meeting materials, conduct ongoing self-study on healthcare trends and challenges, and ask clarifying questions *before* board meetings. This also means avoiding the temptation to open sidebar conversations during the meeting or speak with a few people in the hallway during break. Instead, share your genuine reactions with the entire board.

By reevaluating the current governance principles, policies, processes, and practices, the board can use this opportunity to create an environment where tough discussions are not only possible but the norm.

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Solution #3: Train the Chair

A chairperson skilled in group facilitation can dramatically elevate the board's performance. They understand their various roles and expertly alternate between them. One minute, they are the air traffic controller; the next, they are a consensus driver.

Solution #4: Update Your Ps

By reevaluating the current governance principles, policies, processes, and practices, the board can use this opportunity to create an environment where tough discussions are not only possible but the norm. Recodifying principles and processes can create new expectations and lead to better decision making, more robust governance, and, ultimately, a more effective organization.

Another critical area is to reevaluate how the board refreshes its composition. There are many ways to refresh the board, but what is right for your organization? An annual election makes sense for some boards, while a maximum of three or four terms works for another. Regardless of the approach, the board needs to be purposeful about it.

Key Board Takeaways: Low-Hanging Fruit Ideas

- **Staggered board packet:** Split up the board pre-reading meeting materials by sending information available in advance and then sending the second set (e.g., financials) as it becomes available. While some board members prefer to receive the information all at once, it is more practical to give them more time to review the materials if it's available sooner.
- **Video presentations:** Use pre-recorded presentations that directors can view before the meeting. This approach is helpful when the directors must hear the entire presentation before asking questions or if there is a significant amount of new information for directors to digest.
- **Adjusted meeting times:** "Train to standard, not to time" is a common phrase in leadership training. If the next board meeting agenda requires more time to discuss important topics, don't be afraid to extend the meeting ahead of time. That said, we must use directors' and managers' time wisely.
- **Consent agenda:** Take advantage of the consent agenda to free up more time for discussion.
- **30-70 rule:** Structure each agenda item so that 30 percent is presentation and 70 percent is discussion time.

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Conclusion

Hospitals and health systems have made tremendous strides in healthcare governance, but there is more work to do. Healthcare boards must move beyond perfunctory board meetings, ineffective leadership, exclusivity via the executive committee, conflict-avoidant norms, and the dominance of a few directors. By being intentional about governance, boards can create a more dynamic, effective decision-making environment that fosters healthy conversations.

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Rapidly Improve Financial Performance—and Create Long-Term Sustainability and Success

By Harrison Burns, Partner in Strategic Transformation, and Hunter Hayes, Partner in Clinical Transformation, *Chartis*

Board members recently heard some good news: many health systems across the country reported improved financial performance in the first quarter of 2024.[1] And while it *is* good news, this financial upswing may be fleeting if leaders don't act quickly.

Numerous health systems continue to face acute and persistent financial challenges. Staff shortages, while not at the crisis level of the pandemic's peak, are still an issue and continue to elevate labor costs. Supply costs remain high due to inflation and supply-demand imbalance. And the continuous growth of the Medicare population produces its own cost and operational challenges.

Health system leaders commonly address these challenges by carrying out extensive cost-cutting and performance improvement initiatives. They often focus on workforce, purchased services, and other major expense categories.

But this approach is no longer sufficient.

Board members should encourage their leadership teams to take this opportunity to step back and think bigger and bolder. Now is the time to consider how to fundamentally redesign the organization for long-term sustainability and competitive advantage. In our experience, focusing on three principles for success can deliver immediate financial stability and long-term sustainability.

Three Imperatives for Transformation Success

Health system leaders should reimagine their care delivery model, portfolio of clinical services, and physician enterprise to thrive in the long-term.[2] And they must do so in a way that harnesses novel solutions and positions them for success amid intensifying market forces.

That may sound like a tall order, but it's achievable when broken down into the following three imperatives.

1. Start with the end in mind. For long-term success, efforts must be rooted in the health system's organizational strategy. Improving near-term financial performance is important. But if doing so doesn't also create strategic differentiation and long-term financial stability, the organization can become entrenched in a never-ending cycle of

1 Alexandra Schumm, "Health System Margins Show Improvement, But Long-Term Financial Sustainability Is Uncertain," Chartis, May 31, 2024.

2 Harrison Burns and Hunter Hays, *Stabilize to Transform: How to Rapidly Improve Financial Performance while Designing the Health System of the Future*, Chartis, May 8, 2024.

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cost-cutting and turnaround efforts. Such efforts at best maintain razor-thin margins and protect dwindling sources of capital.

The first step is to develop a high-level blueprint for the enterprise's future strategic positioning. While traditional strategic planning typically takes several months, leaders should complete this initial planning exercise rapidly, in just four to six weeks.

Some strategic actions boards and senior leaders might consider include:

- Reconfiguring smaller acute care hospitals into freestanding emergency departments, ambulatory surgery centers, or multi-specialty ambulatory centers.
- Consolidating select assets, clinical services, and/or administrative functions (e.g., centralized transfer/referral center).
- Developing virtual consult capabilities in markets with lower population density. Doing so can maintain access while optimizing specialist capacity and limiting travel and call burden.

While these example actions may require a year or more to implement, executives should develop high-level hypotheses within the first few weeks of planning. They can use these hypotheses as an overarching strategic framework to prioritize and "screen" the more immediate financial improvement interventions.

2. Link near-term stabilization actions to long-term strategy. Next, leaders should rigorously analyze, prioritize, and implement a set of immediate financial performance improvement interventions. The selected interventions should materially improve cash flow, enable reinvestment into the longer-term strategy, and deliver value in roughly 60 to 120 days.

Examples of near-term actions include:

- Immediately instituting position control review. Health systems can develop and adhere to data-driven productivity dashboards to inform decision making.
- Consolidating and competitively bidding key purchased services and medical/surgical supply categories. The goals are to standardize operations, streamline contract management, and improve pricing for commodities.
- Adopting AI and technology-enabled solutions to drive efficiencies for repeatable administrative and clinical functions, such as components of revenue cycle and clinical documentation.[3]

Leaders should avoid assigning wholesale expense reduction targets across each department. Instead, they should protect highly strategic programs that can quickly grow and produce a significant return on investment. In turn, they should assign disproportionate expense management targets to other areas that do not carry the same value proposition.

Now is the time to consider how to fundamentally redesign the organization for long-term sustainability and competitive advantage.

3 "AI Roundtable: Streamlining Processes for Better Workforce Productivity and Experience," Chartis, November 3, 2023.

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Key Board Takeaways and Questions to Ask Your Management Teams

1. **Start with the end in mind:**
    - **Define financial goals:** What is the current and forecasted financial performance of the organization? And what is our plan to become financially sustainable for the long-term?
    - **Prioritize clinical offerings:** In which clinical services do we have a competitive advantage? In which services do we not? How should we reconfigure our clinical programs, medical group, and asset mix accordingly?
    - **Think critically about ownership:** Based on these factors, what sites, service lines, and corporate functions should we fully own vs. joint venture or partner on vs. divest?
2. **Link near-term stabilization actions to long-term strategy:**
    - **Take immediate action:** What near-term interventions will most materially improve cash flow and enable (not encumber) the broader repositioning strategies?
    - **Harness data:** Do we have a data-driven process to measure and benchmark productivity by functional area, enabling our leaders to identify the most meaningful near-term improvement opportunities?
    - **Break down access barriers:** Which high-value sites or services have the longest patient wait times or backlog? What budget-neutral initiatives can we carry out to expand capacity in the near-term?
3. **Execute with tenacity and speed:**
    - **Enable execution:** Do we have structure and processes to rapidly execute on the plan—including a steering committee, implementation workgroups, and financial realization tracking tools?
    - **Integrate physician leaders:** Are we appropriately including and leveraging physician leaders in our decision making?
    - **Engage the workforce:** Do we have a comprehensive communication and change management plan in place?

3. Execute with tenacity and speed. Finally, to ensure the transformation doesn't lose momentum or fall apart completely, leaders should identify "quick wins" to achieve immediately while the broader opportunity assessment is still underway. Quick wins should satisfy four criteria:

Enterprise-wide transformation is an ambitious aspiration. It requires asking provocative questions, weighing difficult trade-offs, and making audacious decisions.

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1. They can make a meaningful financial impact.
2. They have low execution risk and resourcing needs.
3. They can create a positive groundswell and momentum for team members.
4. They support the longer-term strategic direction.

Leadership should launch small workgroups to rapidly execute each of the identified "quick wins." Then, they should develop cohesive processes and structures to ensure their success, such as:

- Standing up a centralized project management office to manage the implementation and address risks and interdependencies.
- Building and adhering to data tools and dashboards that enable real-time monitoring of performance KPIs and financial realization.
- Developing and executing a comprehensive change management and communication plan.

A Window of Opportunity

Enterprise-wide transformation is an ambitious aspiration. It requires asking provocative questions, weighing difficult trade-offs, and making audacious decisions. But the rapidly changing healthcare ecosystem and ever-increasing compression of clinical margins requires boards to act now and seize this opportunity.

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Band-Aid Station or Tertiary Center? The Impact of Consolidation on Community Hospital Services

By Jordan Shields, Partner, and Duncan Cannon, Analyst,
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In recent years, we have seen an increase in financially strong hospitals seeking larger partners. This has been driven by a variety of factors, including network pressure from growing managed Medicare and Medicaid plans, a desire for operating stability post-COVID-19 disruptions, narrow-network development in select markets, and others. One of the most common concerns we hear from board members of financially strong community hospitals considering transactions is that they will lose local control over what services to provide for their communities. More often than not, a board member will express concern that their facility will be turned into a low-acuity "Band-Aid station" as the larger system guts services to feed its tertiary hub. On the other end of the acuity spectrum, rural hospitals worry that a system partner will not have the same commitment to obstetrics services, leaving residents to drive miles for deliveries.

To address these concerns around care delivery, we considered client experiences as well as statistical analyses reviewing case mix and service access that Juniper has conducted over the years. This article summarizes those findings and considers why systems can be at an advantage to standalone hospitals at increasing local access to care.

Case Mix Index

Case mix index (CMI) reflects the severity, clinical complexity, and resource needs of all the patients in the hospital and offers a single number to compare facilities. The more challenging the procedure, the higher the CMI. In other words, hospitals with very high CMIs are performing transplants and neurosurgery and hospitals with low CMIs are caring for a disproportionate number of patients with pneumonia. Offering exceptional care for illnesses like pneumonia is core to the missions of most community hospitals and hub facilities are often the most-appropriate sites to seek treatment for complex conditions, but on a continuum, CMI is a good indicator of whether residents will be able to access a full range of care at their local hospital or will need to travel outside their communities.

In 2020, we used multiple linear regression analyses to compare CMI at system hospitals and standalone facilities with similar numbers of ICU beds, payer mix, hospital compare scores, patient days, and average length of stay. That research found that community

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hospitals that are members of systems have higher CMIs than similar independent facilities. While that statistical analysis is more robust than client examples, we have found examples bring the data to life. The table below shows the experience of five Juniper clients that joined larger systems in the mid-2010s. It compares their Medicare CMIs in 2017, shortly after joining their partners and then again five years later once they had integrated into those systems. On average, Medicare CMI went up by over 10 percent after these community hospital organizations joined their larger partners.

Partnership Year	Hospital	Partner	Medicare CMI	
			FY 2017	FY 2022
2014	Port Huron Hospital	McLaren Health Care	1.51	1.69
2015	KishHealth	Northwestern Medicine	1.58	1.70
2015	Aria Health	Jefferson Health	1.66	1.81
2015	Lodi Memorial Hospital	Adventist Health	1.43	1.58
2016	Ingalls Memorial Hospital	UChicago Medicine	1.56	1.77

Access to Obstetrics

As a result of tightening operating margins across the industry, hospitals often face difficult decisions to keep the doors open. One option to reduce losses is to eliminate services with typically low profit margins, like obstetrics. This has created an obstetrics crisis in rural communities with only about 40 percent of rural hospitals offering obstetrics. Closures of obstetrics units in rural facilities can mean mothers driving hours instead of minutes, which contributes to the United States trailing the rest of the industrialized world in infant and maternal mortality.

U.S. Acute Care Hospitals			
	Independent	**In System**	**Total**
Rural Hospitals[1]	791	1,051	1,842
Rural Hospitals[1] w/ Obstetrics	305	476	781
% of Rural Hospitals[1] w/ Obstetrics	**38.6%**	**45.3%**	**42.4%**
Non-Rural Hospitals[2]	419	2,884	3,303
Non-Rural Hospitals[2] w/ Obstetrics	227	1,685	1,912
% of Non-Rural Hospitals[2] w/ Obstetrics	**54.2%**	**58.4%**	**57.9%**

1. Rural acute care hospitals are defined here as critical access hospitals and short-term acute care hospitals with sole community provider status.
2. Non-rural acute care hospitals are defined here as short-term acute care hospitals without sole community provider status.

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This trend is especially prevalent in standalone rural hospitals, which are 17 percent less likely to offer obstetrics services than rural hospitals that belong to systems. While system affiliations alone are not enough to solve the crisis in access to maternal care in rural communities, they offer significant hope. Further, this stark difference in care delivery makes the cost of independence clear.

Why Do Systems Offer Better Access to Care?

This research indicates that systems can be an advantage when it comes to providing access to both complex care, as measured by CMI, and to lower-acuity services, as demonstrated by obstetrics offerings. However, for many standalone hospitals and concerned board members, this remains counterintuitive. We believe that part of the discrepancy in popular sentiment vs. outcomes relates to consolidation in other industries. For example, it is common in health insurance mergers to see payrolls slashed and service lines paired to wring out unit efficiencies and return ever-greater profits to shareholders. Not-for-profit hospital systems do not have shareholders and reinvest their earnings back into their missions. Increasingly, efficient health systems have a narrow set of outlets to redeploy capital. These include investments such as further expansion, facility improvements, spending more on employees (including increased nurse staffing ratios), technology improvements, and, as our research clearly demonstrates, providing increased service access for the communities they serve.

These findings challenge the well-funded narrative currently being promulgated by deep-pocketed, national, for-profit payers. Those organizations have used their scale to squeeze hospital providers, extracting huge profits that are then distributed to shareholders. While payers continue to consolidate, they have been successful in creating a narrative that not-for-profit hospital system growth is a greater threat to healthcare consumers than insurance company shareholder distributions. The top five insurance companies control 50 percent of the U.S. health insurance market, while the top five health systems do not break 15 percent national market share. But market power, as measured by share, is not the issue. It is the fact that insurance companies use that power to underpay health systems and then distribute those savings to their owners. Not-for-profit health systems that are able to nudge this balance back towards equilibrium do not extract profits to enrich shareholders, but instead reinvest those efficiencies back into our healthcare system. As our research shows, health systems are using some of their scale efficiencies to offer better access to care for their communities than standalone facilities.

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Board Discussion Questions

- What is the board's role in making service and access decisions?
- How can our hospital ensure local access to low-acuity services, like obstetrics, as well as complex services?
- What are the clinical implications of maintaining our standalone status?

Conclusion

Like their standalone peers, systems are mission driven and committed to caring for the communities they serve. However, system hospitals are able to realize scale efficiencies that result in more resources to provide that care. Their higher margins aren't the result of providing less care, instead their higher margins allow them to provide more care closer to the communities they serve. A higher CMI observed in system hospitals signals that these hospitals perform higher-acuity, more complex procedures. Not only do system hospitals have higher CMIs, but they have additional capital to reinvest in patient care, greater ability to focus on their community-specific missions, and to reduce outmigration, just to name a few. While there has recently been pushback on system formation from regulatory agencies, this desire to keep hospitals local and subordinate to national payers comes at a significant cost to patient care and access.

TGI thanks Jordan Shields, Partner, and Duncan Cannon, Analyst, Juniper Advisory, for contributing this article. They can be reached at jshields@juniperadvisory.com and dcannon@juniperadvisory.com.

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