BoardRoom Press

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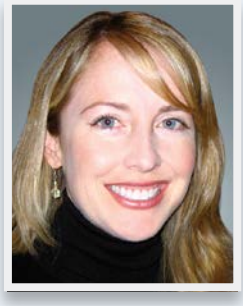

As we continue through the thicket of all things healthcare in 2017, The Governance Institute is focusing on what may change for boards, as well as a continued focus on what should remain the same. The articles in this issue are targeted to some specific challenges that different types of organizations are facing right now: mergers and partnerships that work for academic medical centers, recommendations for creating advisory boards in health systems, the board's responsibility in dealing with late-career physicians, and the concept of "rational thinking" in the boardroom.

The special section aims to uncover some reasons why acute-care organizations have struggled to show results with population health and creating care models to overcome these barriers and accelerate results.

The constant thread is that healthcare is local and unique organizations have unique challenges, but the core job of the board remains the same, with a few exceptions. We hope these articles tackle some specific issues our members are facing. At the end of the day, boards that continue to devote the time to deep and thoughtful engagement, and generative discussions around their unique challenges, will be able to make informed decisions and steer their organizations in the desired direction.

Kathryn C. Peisert, *Managing Editor*

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Academic Medical Centers Active in M&A: Five Critical Success Factors

BY CHRISTOPHER T. COLLINS, ECG MANAGEMENT CONSULTANTS, AND EB LEMASTER, PONDER & CO.

AMCs have become increasingly active in pursuing new partnerships and consolidation strategies. While major teaching hospitals account for less than 7 percent of non-federal hospitals in the United States, AMCs have been involved in 20 percent or more of the announced change-of-control hospital transactions over the past three years—nearly three times the level in 2009.[1] The percentage involving AMCs climbs even higher if a wider range of structures is considered, such as clinical affiliations, collaborations, practice acquisitions, and clinically integrated networks. However, the paths taken by AMCs vary widely, such as:

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- **New affiliations with major capital and structural commitments**: Includes new physician structures and 20-plus-year contractual mission support payments whereby AMCs have joined or aligned with regional health systems, such as the Banner Health–University of Arizona merger and the ProMedica–University of Toledo College of Medicine affiliation.
- **Statewide or regional collaborations**: Includes approaches without capital infusions or changes in ownership that provide important services and support, such as the Vanderbilt Health Affiliated Network and the BJC Collaborative.
- **Mergers and partnerships with community hospitals**: Such as Michigan Medicine–Metro Health and the University of Kansas Health System–Hays Medical Center.
- **Unwind and reemerge as an integrated academic health system**: Micro trend of AMCs exiting affiliations/alliances with national health systems to reclaim their major teaching hospital, and chart a new course. Examples include the University of Louisville's plans to end its operating agreement with KentuckyOne Health, as well as the University Hospitals Authority and Trust's (University of Oklahoma) plans to end its 18-year operating and affiliation agreement with HCA.

Regardless of the path or approach taken, we offer five critical success factors below for AMCs to consider pre- and/or post-transaction as they develop new organizational and financial structures.

1. Leaner, Competency-Based Boards

Academic health systems and affiliated faculty group practices have historically embraced representative boards, which also tend to be larger than non-academic healthcare organizations (e.g., a faculty practice board with 25-plus members, including all department chairs). AMCs would be well served to get outside the political comfort of representative boards and adopt best practices from successful companies whose boards aim to establish an appropriate mix of perspectives and competencies while focusing on the best interest of the single entity. Further, the board should elevate itself to strategically and financially guide the organization—not manage its operations. With respect to size, 15 or fewer voting board members is a good starting point.

2. Integration between the Teaching Hospital and Physicians

Most consumers do not understand and/or frankly care about how hospitals and physicians are reimbursed differently by payers. They demand easier access to highly coordinated, specialized care at a lower cost regardless of whether the costs are incurred by the hospital or physicians. That said, corporate structure notwithstanding, AMCs should aim to at least achieve financial integration between the teaching hospital and affiliated physician organizations to achieve benefits such as joint-payer contracting and shared-cost management of the non-physician expense structure (e.g., billing and collections, non-physician personnel, facilities). Studies have shown that the degree of functional integration between the teaching hospital and faculty practice can have a direct impact on the performance of the academic health system.[2] One highly effective vehicle for achieving financial integration is to pool all clinical revenue at the system level and, in turn, distribute funding to the hospitals and physician organizations/departments through a performance-based methodology that rewards productivity, access, quality and safety, and cost-efficiency.

3. Single Integrated Hybrid Physician Organization

Certainly the profile and orientation of a full-time clinical faculty physician can be very different from that of a non-academic health system-employed physician. However, the health system (which may include a major adult teaching hospital and several community hospitals) should expect and want physicians and staff to deliver consistently high-quality, patient-centered care regardless of

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Key Board Takeaways

Major transactions involving AMCs are at all-time highs and they run the gamut from light affiliations to full mergers. Boards should be aware that:

- Resulting organizational structures from these transactions are becoming more diverse.
- Regardless of organizational structure, there are a set of critical success factors required for academic health systems to thrive in the market.
- Ultimately, an AMC must balance its three-part mission while driving clinical margin to fund its future.

1 The percentage reflects total non-federal primary teaching hospitals (336) over the total number of non-federal U.S. hospitals (4,862), excluding non-federal psychiatric and long-term care hospitals (sources: American Hospital Association and Association of American Medical Colleges).

2 Christopher Collins et al., *Are Integrated Academic Health Systems Better?*, ECG Management Consultants, November 2015.

"Rational Thinking" and Community Healthcare Governance: A Core Competency of a Board

BY DANIEL K. ZISMER, PH.D., AND KEVIN J. EGAN, J.D., CASTLING PARTNERS

It is commonplace that members new to a not-for-profit community healthcare board will ask a fundamental question: "What is my job?" With the first formal board orientation session of new members, they have typically learned:

1. They are a member of a governing board that oversees a substantial community asset. They are entrusted with the responsibility and accountability for the execution of the mission of that organization as well as the responsible and effective management of the affairs of the organization, and the organization's obligation to deliver high-quality, safe services to patients cared for by the organization.
2. Directors, individually and collectively, owe the organization the duty of care in the execution of their work, fidelity to the mission of the organization, and loyalty to the organization as it behaves in complex markets and environments.

Following that first board orientation session, the new member's question may shift to: "How do I do my job?" This question moves the reader to the core issue of this article: the need for a governing board of a community hospital or health system to "think rationally" and act accordingly on behalf of the organization they serve.

Rational Thinking: Define and Implement

First, let's begin with what rational thinking is *not*. We will then move to a definition of what it is and then on to a practical display of "the how," illustrating how a board member executes this responsibility. Rational thinking (or rationality) is not merely the application of personal belief systems based upon one's history, judgements shaped by personal experience and bias, or a "bringing to the table" of the successes and failures of a career path. Rational thinking for a community hospital or health system board is rather an ongoing process of structured and disciplined decision making based upon a systematic approach of analysis and selection of actions among choices to best benefit the organization, given a complex set of changing dynamics, environmental conditions, and obligations as directors. It could be argued that rational thinking is at the core of a director's duty of care as they discharge the actions of the board. It has been correctly noted that the goal of board decision making is not to be "right every time," but instead to be "less wrong over time."

Case Example

Community Hospital has become Community Health System (CHS), having moved aggressively to employ physicians, establish branded satellite clinics, merge in two smaller community hospitals, and partner with a large orthopedic group to create a center for joint replacement. This growth was expensive and net-operating margins declined to 1.25 percent over the last two accounting periods. Free cash flow productivity has underperformed for the current fiscal year.

The current three-year capital plan calls for an investment of $175 million to fund routine and strategic capital investment opportunities. A conservative, third-party estimate of the system's capital capacity is $95 million; a 45.7 percent reduction in the suggested total potential spend, providing the board elects to invest the maximum of this estimate. Senior leadership believes the estimate is low and the team has confidence that the strategic investment portion of the plan will rebuild balance sheet capacity. The board is faced with the decision to take a risk that the senior team feels is reasonable, or adopt a position based upon a conservative estimate of capital investment capacity.

The choice is not black and white. If the response to the senior team is "no," it may send an unintended message ("the board lacks confidence in the senior team"). If a commitment is made above the $95 million suggested limit, the board may be viewed as reckless, even if its "bet" pays off. The CHS board is thus faced with a classic test of rational thinking.

Key Board Takeaways

Healthcare boards need to be able to think rationally to make smart decisions and successfully fulfill their fiduciary duties to the organization. A few things for boards to consider:

- A board's duty of care is central to the responsibilities of a fiduciary.
- Acceptance of a duty of care demands illustrations of how that duty is exercised in decision making by a board.
- Rational decision making, by definition, is a group process that can be learned.
- The processes of rational decision making necessarily involve senior leadership in furtherance of a productive relationship between the board and management.

The Approach: Create a Framework for Dialogue and Decision Making

This framework begins with the reminder that the board carries the duty of care as it exercises its decision-making authority; a principal duty of the fiduciary in this setting is to make decisions prudently in a reasonable manner. Management is hired by a board with an expectation that management brings their full powers of experience, business acumen, skills, and imagination to their responsibilities as senior managers.

In our case example, the "pull and tug" is the putative dispute between a $175 million expenditure and a smaller $95 million capital expenditure. The management team feels confident in its ability to deliver. The board has in its possession a report from a qualified, independent expert stating that the $95 million spend is "prudent"; by some, such a report might be the proverbial "smoking gun." Neither of the available decisions is, on its face, right or wrong. The question for the board is which is less wrong in the event that either, if selected, fails. Here, the board carries the higher responsibility and accountability.

So what is the rational decision? In theory there are several. One choice that clearly qualifies is the approval of the $95 million capital spend. After deliberation, management is directed to provide its best plan to allocate the total over "replacement capital" (investments required to ensure

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The Population Health Secret

BY BRIAN J. SILVERSTEIN, M.D., AND RICK WEIL, PH.D., HC WISDOM

Population health is alive and well and working in small scale all around the country. You can experience the difference in these models where there is benefit to both patient and provider. However, most acute care health systems are having the opposite experience with population health: significant investments followed by limited results. The current wave of support towards population health creates a crushing pressure. Why is it so challenging to get results from something that we have proof of concept for? What is the secret that makes population health work?

The secret is in understanding the operational details of population health. Most organizations are framing the issue as a system strategy and applying traditional operational expertise and best practices to implement the strategy into daily operations. However, this deployment strategy does not work with population health for several reasons including:

- Acute care needs for any given patient are largely unrelated to payment status or any other external factor.
- Population health is largely a clinic strategy.
- Payment for population health is dramatically different than payment for other healthcare services.
- Population health requires operational tools that are not contained in traditional healthcare delivery.
- The present day financial opportunity with population health may be limited and using existing deployment models have negative ROI.

In addition to exploring why traditional deployment strategies are not producing the expected results, this special section will highlight models that do work and explore some of the operational details that result in success including:

- Clinics designed to manage proactive care
- Smart patient segmentation
- Staffing strategies for results
- Systems and processes that support the care model
- Little to no change to acute care services

After there is a clear understanding of the smart strategies and operational keys to success for population health there is a local market factor to calibrate rate and depth of adoptions. It is well known that healthcare is local and part of the secret related to population health is doing the things that are smart based upon your market. There are a number of local market factors to consider including:

- Total cost of care
- Price of services
- Insurance status
- Employer interest
- Market maturity

This special section aims to uncover the secret to population health success. Your understanding of the secret is what will lead to your market success.

Why Population Health Does Not Work

At The Governance Institute's January and February 2017 Leadership Conferences, we surveyed a large group of healthcare executives and board members about their readiness and proficiency for emerging population health models. They told us that while they are pretty certain that population health will work in their market, presently it is not working all that well. Further, they do not believe they are well prepared for it; 57 percent said they are somewhat prepared while 23 percent said they are not prepared at all (see **Exhibit 1**). Most interesting is that they do not believe they have a thorough understanding of just what population health is (see **Exhibit 2**).

Many health systems today are "all in" when it comes to population health.

Key Board Takeaways

Many healthcare organizations are finding population health management to be a challenging endeavor, but one worth pursuing since there can be significant benefits to both the patient and provider. Some proven secrets to success include considerations around the following ideas:

- Population health is largely a clinic strategy; this is the epicenter of population health and where the real opportunities to deliver care differently exist.
- Payment for population health is dramatically different than payment for other healthcare services.
- Operating a value-based clinic includes smart patient segmentation, adjusting the staffing model, setting different success metrics, and new workflow tools.
- Little to no change needs to occur to acute care services.
- It is very important to have a clear picture of your market and identify the right strategies for your organization.

Exhibit 1: How Prepared Is Your Organization to Operate a Population Health Model?

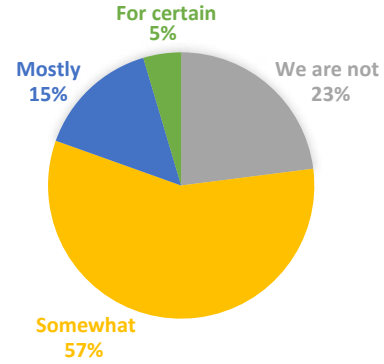
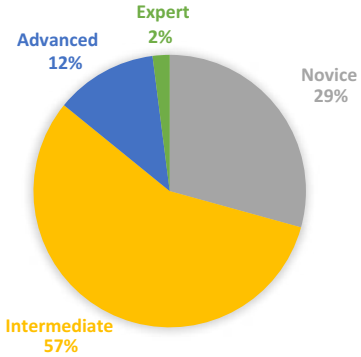


Exhibit 2: How Well Do You Understand Population Health Management?



However, we are commonly not seeing results from their strategies. This introduces the question of whether they are bad strategies or they are poorly executed. Or perhaps both? We would suggest that the secret to understanding the results is to review the expected goals of a population health strategy and how it is being framed.

Population health is largely a clinic strategy. While we would like to change a whole system to be focused on the needs of a group of patients and create strategies to optimize care delivery for the group, the epicenter of this interface is where the patient interacts with the system, outside of the hospital.

Acute care needs for any given patient are largely unrelated to payment status or any other external factor. Health systems grew out of an acute care mindset even as the majority of their revenue and an even larger portion of their profit come from services other than inpatient care. In the acute care setting, when a patient presents with a heart attack, or a congestive heart failure patient presents with shortness of breath, the stabilization and management of the acute issues are of paramount importance to get the patient out of the hospital. These goals are largely the same irrespective of insurance status.

However, if we are managing the same patient in the clinic setting, except that they do not have any acute symptoms, the management of the patient could be dramatically different based upon their insurance. For example, the key interventions for this patient type are behavior modification to impact diet and medication compliance. In a fee-for-service model, the incentive is for delivering more acute care and there are not systems and processes in place to prevent the breakdowns that result in admissions. The range of interventions in the clinic setting is larger and more expansive. This is the epicenter of population health and where the real opportunities to deliver care differently exist. To make the shift from just treating the acute problem to identification of risk and implementing strategies to improve outcomes requires a different staffing and operating model.

In a capitated environment, the clinic focus shifts from managing the problems to identifying potential problems and implementing interventions to avoid the breakdowns. This requires a completely different operational setup than the fee-for-service environment.

Population health requires operational tools that are not contained in traditional healthcare delivery. The core of population health is mass customization of segmentation and interventions to help better manage outcomes for patients with disease and, to a lesser extent, reduce risk from future diseases. To bring this strategy to life requires data and analytical capabilities that are typically not a core competent of most health systems. As health systems have recognized this need, there has been increased attention to this area. However, most of the source data comes from historical claims, which is not a good predictor for the future on an individual basis. In addition to more sophisticated segmentation and interventions, workflow tools are necessary to implement new processes, along with dashboards to monitor progress.

Payment for population health is dramatically different than payment for other healthcare services. We live in a world where payment is on a per unit of delivery basis. The core revenue cycle function is smartly designed around what we are doing for patients and the resultant documentation that is required to receive payment. Population health changes this foundational model to payment based upon how many people are under care management. The revenue model completely changes and, along with it, the systems required to be successful have a different focus and orientation.

When you examine the present day financial opportunity with population health and then look at the investment required, the opportunity may be limited using existing deployment models. It is going to require a more nuanced approach to find the path forward.

What It Takes to Get Population Health to Work

While it is interesting to understand why many of the current strategies for population health don't work, it can be more relevant to look at organizations that have had success with population management and understand key strategies and operations that have resulted in improved clinical and financial outcomes. As we explore these models it has become clear that deploying population health across an entire system without the contracts and financial models is a challenging situation.

It is very challenging to deliver different types of care to patients in a clinic setting. The most notable difference is going to be the processes to manage patients before they have an acute crisis. Many physician offices today don't have capacity even to see patients on the same day when they have an issue. In a capitated environment, the clinic focus shifts from managing the problems to identifying potential problems and implementing interventions to avoid the breakdowns. This requires a completely different operational setup than the fee-for-service environment. If in the clinic, a segment of the patients is fee-for-service and another segment is value-based, it is operationally difficult, if not impossible, to deliver both models of care.

The beginning point for a clinic to operate in a value-based environment is smart patient segmentation. Segmentation is a process for dividing all people into sub-groups based on some type of shared

characteristics. In healthcare most segmentation is done based upon historical healthcare utilization. (See **Exhibit 3** for an example of healthcare consumer segments.) A key competency in population health is identification of segments where you can deploy interventions to improve health and reduce costs. It is interesting to note that when these concepts are applied to the whole U.S. population over 50 percent of the people are healthy and account for less than 7 percent of the total spend. There are other groups where spending is highly concentrated. In some cases, it is easier to identify which people need what services. However, in many cases, changes in health are more challenging to predict and past healthcare utilization is not always a marker for future needs.

Staffing a value-based clinic can be done in several ways. One option is to use a traditional staffing model and reduce the panel size to allow increased access and time to focus on proactive outreach. An alternative approach is to enhance the care team with other professionals including care coordinators, care navigators, a nutritionist, a pharmacist, and community health workers, and then expand the panel size. In this alternative model the role of the physician migrates from primarily focused on direct patient care to overseeing and managing a team that is taking care of patients.

Current operations are typically focused on volume of patient visits, relative value units, and the resultant revenue from these activities. Value-based clinics require a completely different set of success metrics as well as tools to achieve these goals. For example, a value-based clinic is by far more concerned with the total cost of care of the patients that are either enrolled or attributed to the clinic rather than the revenue from the visits due to those patients.

Since the fundamental care model is different, the staff will need tools to operationalize the segmentation and reach out to the right patients with the right proactive care options. This requires workflow tools to support outreach to the right patients at the right time. These tools need to feed into dashboards to monitor the right metrics.

It is worth noting that all of these changes occur in the clinic setting while at the same time there needs to be little to no change to acute care services.

What You Should Do in Your Market

We all know healthcare is local and as such is it very important to have a clear picture of your current market and identify the right strategies for your organization. This requires a calibration exercise to compare and contrast how your market is similar or different than other markets.

There is no one single secret to identifying the right strategy for your marketplace. Even if you do have the optimal strategy your results are by far more likely going to be dependent upon operations rather than the strategy in and of itself. That being said there are several metrics that you can look at to help understand where your market is and what population health opportunities exist.

The first metric we would recommend looking at is total cost of care by population. This number should be an all-in number that accurately represents the total financial cost of a given patient for their healthcare in any given time period. This analysis should be performed for each payer type individually and compared to a national, regional, and local normative value. For example, you will want to look at the total cost of care for Medicare, Medicaid, and various commercial insurance products. It is possible and even likely that in some payer categories your total cost of care will be higher than normal values and in others it will be lower. This will be informative and help identify opportunities for population health.

Exhibit 3: Healthcare Consumer Segments Example

Effective patient segmentation and interventions

Segment	Population	Cost/Person/Year	Total Cost/Year
Healthy	160 million	$800	$130 billion
Maternal and infant health	10 million (4 million mothers and babies, 2 million fertility)	$12,000 per delivery, $2,000 per infant, $1,000 per fertility problem	$60 billion
Acutely ill but mostly curable	12 million	$25,000	$300 billion
Chronic with adequate function	110 million	$7,000	$800 billion
Stable with significant disability (often not elderly)	7 million	$40,000	$290 billion
Short period of decline near death (mostly cancer)	1 million	$45,000	$50 billion
Intermittent exacerbations and sudden death (mostly heart and lung failure)	2 million	$45,000	$100 billion
Long dwindling course (mostly frailty and Dementia)	6 million	$45,000	$270 billion
Totals	300 million	$6,600	$2.0 trillion

Source: J. Lynn et al., "Using Population Segmentation to Provide Better Healthcare for All: The 'Bridges to Health' Model," *The Milbank Quarterly*, June 2007.

In addition to the total cost of care, it is going to be relevant to look at your pricing compared to competitors. This analysis has traditionally been done by looking at a charge master. The charge master rarely reflects the actual payments received for services. We recommend looking at an average collection for each service by payer category. That collection number should include any patient co-pay or deductible. This can then be compared to normative values to determine whether you have a pricing advantage or disadvantage.

It is worth noting that the actual cost of the service is not as important as the total cost in treating the problem. There is a more sophisticated analysis called episode analysis that looks at the cost to treat a given complaint. With episode analysis there are standards that define the beginning of the episode, what is included and excluded from the episode, and the end of the episode. This can help truly reflect when a provider is more efficient in delivering care. For example, if your provider orders a relatively expensive test more frequently, this may be viewed negatively on a pure utilization report. However, an episode analysis may demonstrate the provider is more efficient overall when the other services required to treat a given problem are considered.

Another marker of market readiness is employer interest. In most marketplaces there is an employer coalition on health. These groups will meet on a regular basis and review what benefit changes they're making and how they expect that's going to impact your healthcare costs. Some employers are very aggressive and willing to take chances on benefits in order to save money. However, other employers are more conservative and more likely to not want to make a change until the results are known or proven. Based upon your local employers that will be a key indicator for market readiness.

As healthcare costs have increased, many employers have shifted some of the burden of that cost to employees. As employees are exposed to more of the initial cost of healthcare it will have an impact on their utilization and choices. Thus, as your market moves into products that expose the patient to the true cost of healthcare, patients will make different choices and your health system should be prepared to anticipate and assist patients in this new paradigm.

While there is no one metric that identifies market maturity, we have articulated a number of factors to consider to present a clear picture of where your market is today as well as where it is likely to move to in the future.

As your market moves into products that expose the patient to the true cost of healthcare, patients will make different choices and your health system should be prepared to anticipate and assist patients in this new paradigm.

Conclusions

Population health presents a difficult conundrum for provider organizations in determining short- and long-term strategy, as there will be a period of time in which providers will be dealing with both fee-for-service contracts and value-based payment models. It is yet to be determined how long this transition will take, but providers can consider proactive options now to interact with payers and create payment strategies that will succeed.

Healthcare is still very much a local business and it will be critical to understand local market dynamics in order to select strategies that will bring success. Different strategies will be relevant depending upon the provider organization's aspirations and roadmap.

A key factor that most organizations will need to consider is the depth in which the organization can operationalize population health. It is increasingly clear that a broad-based approach is not viable for most organizations and has resulted in some believing that population health is a failed strategy.

Yet when you understand how population health really only applies in the clinic setting and the acute care operations are unchanged it unlocks a new perspective. So it seems there is indeed a bridge from volume to value that likely requires two different organizations to implement both models successfully. Companies that are successful at population health management don't look like the traditional hospital system. Hospital systems can certainly take advantage of this trend by creating a separate organization that manages the value-based population contracts, while simultaneously preparing for the cost and volume changes to the current business. Population health management has the potential to drive traditional volumes down; however, the opportunity to operate at a lower cost structure can convert the value delivery to incremental volume. Healthcare boards and senior leaders have a long list of questions to ask themselves to help determine viable strategies. Below is a list to begin the discussion.

Key Questions for Board Members

1. What are our current financial and clinical results for our inpatient business, outpatient business, and physician enterprise?
   - » How do these results compare to local and national benchmarks?
   - » What is our competition in each area and how are we differentiated?
2. What is the current supply and demand for essential healthcare services in our market and how is this going to change over time?
   - » In a market where there is a shortage of hospital beds, it will be difficult for any outside organization to play a significant population health management role.
   - » Primary care physicians are the foundation to a program.
   - » Select specialists based on effectiveness.
3. What current competencies do we have for population health management?
   - » Data infrastructure
   - » Management talent with experience in population health management
   - » Patient-centric care management systems
   - » Business processes that have proven results of increased quality and reduced costs
4. What percent of our revenue comes from performance-based contracts?
   - » How are we doing this calculation? Is it based upon the amount at risk vs. the total contract?
   - » What are we doing to manage this business?
   - » What about the impact of MACRA?
5. Who in our market is best positioned to be the population health manager?

The Governance Institute thanks Brian J. Silverstein, M.D., Managing Partner, HC Wisdom, and Governance Institute Advisor, and Rick Weil, Ph.D., Partner, HC Wisdom, for contributing this article. *They can be reached at briansilverstein@hcwisdom.com.*

Effectively Using Advisory Boards in Today's Health Systems

BY NICK A. FABRIZIO, PH.D., FACMPE, FACHE, MGMA HEALTHCARE CONSULTING GROUP

Successfully navigating through today's healthcare waters is extremely difficult. Given the current challenges facing health systems, including physician compensation, recruitment and retention, governmental mandates and shifting priorities, pay-for-performance, penalties for quality or data reporting outliers, and a host of other initiatives, they need to have a much more diverse group of leaders and stakeholders involved in organizational success.

Key Board Takeaways

Advisory boards complement the system board and play an important role in enhancing governance for the entire organization. When forming advisory boards:

- Define the roles, responsibilities, and objectives of the advisory board.
- Ensure the right members are on the advisory board and there is clear criteria for success.
- Celebrate the advisory board's accomplishments and make sure they are known throughout the organization.

The overall role of governance becomes critical in guiding healthcare organizations during rapid change. An advisory board can be a tremendous complement to the effectiveness of the system board as it works to carry out a complex, major role (developing a cancer center) or specific initiative (building a new medical office building).

Different than corporate boards, advisory boards have no fiduciary responsibility and their advice is non-binding. The advisory board does not have formal authority to govern the organization, meaning that they cannot issue directives, which must be followed. Instead, the advisory board serves to make recommendations and provide information to the system board.

However, advisory boards play an important role, which can be called little "g" governance. Effective uses of these boards include providing alternative viewpoints, expanding current strategies or playing devil's advocate, and maintaining strong ties to the organization's community. Membership varies but in general, advisory boards provide the opportunity to involve physicians in organizational success. They also help identify and groom physicians for future leadership and governance roles including on the health system's board.

Forming Advisory Boards

A recent issue that health systems are facing is the creation of multiple subsidiary boards, usually the result of mergers and acquisitions. These subsidiary boards often have some degree of fiduciary duties and responsibilities within their scope of authority. The use of subsidiary fiduciary boards often creates role confusion between the main health system board and the local subsidiary. This uncertainty is extended to the members of these subsidiary boards as well. Many healthcare centers are transitioning these local subsidiary boards into advisory boards with detailed bylaws, duties and responsibilities, membership, and reporting relationships. These advisory boards can then establish local committees based on their unique needs and communicate with the system board so information is relayed in a clearly delineated fashion.

Health systems should concentrate on the following when forming advisory boards.

Determine the need for advisory boards: What are some of the key issues that the organization is struggling with today? Some hospitals and health systems are struggling with physician–hospital integration, compensation, recruitment, retention, and medical staff development and planning. Creating an advisory board can be helpful for addressing these challenges. Several health systems are exploring having a "physician–hospital integration advisory board."

Define the objectives, duties, and responsibilities of the advisory board: First determine the goals and objectives of the advisory board. Once you determine the primary role, develop a board charter with duties and responsibilities clearly delineating what the advisory board is designed to do, who it reports to, membership including terms of office, frequency of meeting times, and how this group connects to other committees, senior leadership, and the organization in general.

Select the right people: When this board is created, it's important to select the right people to serve—both in quality and quantity. Keep the size of this group to no more than 13 people. Too many people are cumbersome and can negatively impact responsive decision making and too few people may limit a diversity of opinion. Depending on the purpose of the advisory board, the health system should look to include physicians, non-physician providers, nurses, and operational administrators to allow for diversity in both opinion and job role. Involving community members can also be beneficial to help ensure that the community's needs are being met by the health system.

Establish criteria for success: The advisory board needs a chair that has the time and support to keep the group well organized. Establish meetings in advance at a time and place that is convenient for the group. The chair must be result-oriented and facilitate the meeting so all group members are heard and encouraged to participate. Meeting minutes need to be kept and distributed to members in advance of the meeting and agendas should include action items that are consistent with the advisory board's charter. The chair must also develop a good working relationship with the health system CEO so that the work of the advisory board is appreciated, valued, and consistent with the intended purpose.

Consider compensating the advisory board: Depending on whom you are asking to serve on this group and what position

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"Rational Thinking"...

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ongoing support of existing programs and mission work) and apply any remainder to management's best recommendation for the advancement of the organization's strategy. The board agrees to revisit the capital investment strategy quarterly as the plan's performance plays out. With this decision, management's recommendations have not been rejected out of hand, the board has properly considered the advice of outside experts, and there is mutual agreement to revisit the alternative option as the plan moves forward.

Can Boards Learn to Think Rationally?

Rational thinking is an acquired skill; it can be taught to individuals and whole boards. It can be baked into an orientation process and it can be a topic of ongoing board development. Related efforts and processes should be a part of the regular agenda of all boards. Additionally, a recorded board mandate for such training will be viewed favorably by outside regulators. Evidence of a process in-action is required, however, effort matters here. Findings by courts involving a board's exercise of its duty of care demonstrate that, in the absence of a "bright line test," a community board's outward demonstration of a reasonable and rational approach to decision making, in service to the entrusted organization, carries significant weight.

Board chairs, in collaboration with CEOs, are advised to create an ongoing approach to board education in this regard. The learning of rational thinking skills lends well to case study examinations, facilitated workshops, and examinations of the outcomes of past decisions.

The Governance Institute thanks Daniel K. Zismer, Ph.D., Co-Founder and Managing Director, Castling Partners, Professor Emeritus, School of Public Health, University of Minnesota, and Kevin J. Egan, J.D., Co-Founder and Managing Director, Castling Partners, for contributing this article. They can be reached at daniel.zismer@castlingpartners.com and kevin.egan@castlingpartners.com.

Effectively Using Advisory Boards...

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they hold, it's important to consider compensating certain members. This is designed for and speaks directly to physicians who are serving on this advisory board. Many health systems have a productivity-based plan for compensating their employed/contracted physicians. Therefore, asking physicians to serve on any committee without providing some form of compensation can seem unfair. While providing some form of compensation is reasonable, it may not be reasonable to compensate physicians based on a clinical dollar equivalent for their specialty or dollar per wRVUs per hour spent in meetings. You must determine what level of compensation makes sense. Many organizations prefer to compensate their physicians a flat rate for each meeting they attend.

Keep in mind that members of this advisory board will benefit in a variety of ways. Being involved with this group will expose them to ideas, initiatives, and market intelligence that they would have otherwise never been exposed to. It will also allow them to develop their individual skills, which will help them to be a better future system board member.

Remove ineffective members: You must have a mechanism to remove members who are not a good fit or are not contributing or attending meetings. Unlike the system board, advisory board members can be replaced without the majority of legal issues. Be clear to communicate expectations during the establishment of the advisory board and in the recruitment of new members. The chair should discuss the frequency and duration of meetings and time commitments required, as well as other work that might be necessary for successful participation.

Get broader input: Since many of these board members are on the front lines and highly respected, they often have their pulse on the organization. They should in turn find ways to engage the medical and operational staff in identifying key organizational issues and future areas of focus. This engagement is crucial to the health system CEO in order to have increased participation, commitment, support, and feedback to and from stakeholders.

Celebrate the advisory board's success: Make sure you have an organizational process to report the initiatives that the advisory board is working on and has accomplished. Have a systematic and formal process to communicate the work of this group to the system board and organization in general. Also, think about ways to disseminate information to the executive staff, through department meetings and electronic communication.

Forward Thinking

The advisory board can create an environment where these experts can discuss opportunities, challenges, and next steps. Leverage the advisory board members with vetting potential short- and long-term organizational objectives. Health system CEOs and their boards can use the advisory board to capture market intelligence and "work-up" various options to many business strategies and initiatives.

The effective use of an advisory board is critical for success in today's healthcare environment where cost, quality, outcomes, access, and customer service is demanded by the communities we serve as well as the numerous stakeholders involved in the care we provide.

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Academic Medical Centers...

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site of service. That said, academic health systems that maintain multiple physician organizational structures—including different governance, corporate, leadership, and financial structures—within the same system just to satisfy historical cultural differences (or avoid political resistance) will fall behind in the market. In a clinical capacity, all employed physicians within a system should aim to achieve maximum integration to the benefit of their single health system and the communities they serve. Further, the physicians should be treated equally with respect to clinical time and compensation based on performance and productivity.

4. No (Health System) Margin, No Mission (Support)

With the exception of a select few AMCs, external funding to support medical education and research has declined or remained flat on a per-faculty basis over the past five to seven years. This increases the dependency on clinical margin to supply the needed investments for growth and development in medical education and research. The health system's margin is ultimately the source of the investment as the physician enterprise margin continues to decline due to shrinking professional fee reimbursement. With universities and medical schools wanting and needing more discretionary funding from the health system, AMCs should embrace more performance-based and formulaic approaches to "mission support" payments. For example, a meaningful variable payment to the university could be tiered and based on the overall financial standing of the health system. This positions the payment as an investment in the academic enterprise while aligning the financial interests of the parties (regardless of corporate structure).

5. Shared Accountability with Strong Physician Leadership

In a market that is demanding more price transparency, greater cost efficiency, and higher scores for quality and safety, an AMC will not thrive without the legitimate engagement of chairs and physician leaders. Historically, many large teaching hospitals have relied on an administrator-led structure with physician "input." High-performing and highly ranked AMCs and large non-academic health systems have long embraced a physician-led philosophy commonly with a dyad structure that teams physician leaders with administrative executives at every level in the health system. Ideally, the chair of the academic department (or division chief or designated center director) in the medical school concurrently serves as an empowered chief of service in the primary teaching hospital with shared accountability for operations spanning inpatient and outpatient services.

The organizational, cultural, operational, and financial challenges that present themselves during major transactions involving an AMC are fundamentally different and more complex than those between multiple non-academic parties. Further, AMCs have historically had a mixed reputation for their ability to be nimble and responsive to the fast-moving healthcare market. As the clinical enterprise of an AMC embarks on a new partnership or major restructuring, it presents a ripe opportunity to rethink and reset the governance, leadership, and financial structures. Building a more contemporary structure and streamlining the manner in which decisions are made and resources are allocated will help enhance the market position of the health system, improve its margin, and more effectively sustain the three-part mission of the AMC.

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Board Responsibility...

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(e.g., use of an amplified stethoscope), decrease or limitation in scope of practice, and ongoing education with respect to electronic health records documentation. Some healthcare organizations encourage retention of older physicians by adjusting on-call requirements, waiving medical staff dues, or assisting with scribes. Any of these accommodations can be controversial, so boards must discuss them carefully with medical staff leaders before any are adopted and implemented.

The flip side to the retention of older practitioners is the recruitment of new, younger practitioners. While many hospitals and health systems have greatly increased their efforts at recruitment and retention in recent years, many have not. Board members should insist on being kept informed about medical staff and management efforts to strengthen the onboarding of new doctors and to create a professional community appealing to millennials. The Henry Ford Health System has been a pioneer in such efforts through the adoption of numerous recruitment and engagement strategies for Generation Y. For example, Gen-ERG-Y is a team created by the HFHS Diversity Council for employees born after 1980. Its charge is to leverage multi-generational differences and commonalities to attract and retain talent. Gen-ERG-Y holds meetings, workshops, and events that focus on effective communication among the generations, collaborative work styles, career life cycle, and more.

The board can't simply assume that problems posed by an aging workforce will automatically be addressed by the medical staff and management. Boards should hear regularly from leaders about how they are planning for and responding to the impact of the demographic changes described in this article. Boards must also guard against the possibility that in the face of growing physician shortages, the hospital's standards for competency will be lowered to keep staffing adequate. There are many considerations surrounding physician generational challenges, but with proper board attention our hospitals, professional workforce, and our communities can age safely and well.

The Governance Institute thanks Todd Sagin, M.D., J.D., President and National Medical Director of Sagin Healthcare Consulting and Governance Institute Advisor, for contributing this article. *He can be reached at tsagin@saginhealthcare.com.*

Board Responsibility in the Face of a Coming Tsunami of "Late Career" Physicians

BY TODD SAGIN, M.D., J.D., SAGIN HEALTHCARE CONSULTING

The aging of the general population is certainly not news to anyone who works in healthcare. Indeed, as the health needs of baby boomers become ubiquitous, our hospitals and health systems will find a constant drumbeat for their services.

Key Board Takeaways

The board has two main responsibilities related to the coming tsunami of aging practitioners:

1. To make sure that all "late career" clinicians to which the board grants privileges are competent and not impaired by the health concerns that become more prevalent with age.
2. To adequately undertake "manpower" planning in the face of the daunting demographics. This means ensuring there are plans for medical staff development and working closely with physician leaders on issues of recruitment and retention.

But the trend that brings patients to hospitals' doors may also usher out large numbers of healthcare providers who reach retirement age. Board members will need to pay increasing attention in the years ahead to staffing needs in the face of growing shortages of physicians and nurses. The American Medical Association has estimated that in 2020 nearly 20 percent of active physicians will be over the age of 65; nearly 40 percent will be older than 55. As the economy continues to climb out of the depths of the 2007–2008 recession many physicians will find their retirement portfolios recovering. Add to that an endemic physician "emotional burnout" rate of nearly 50 percent of practicing doctors, hospitals and health systems are likely to see physician retirements in droves over the next decade. Replacements won't be easy to come by either. The graduate medical education pipeline is simply not adequate to replace the aging population of doctors and it is expected there will be a national shortage of at least 100,000 doctors in just a few short years.

Shortages are just one facet of the challenge posed by an aging physician population. Aging affects the physical and mental capabilities of all humans and physicians are not exempt. This is an important reality when significant numbers of physicians are still practicing into their 70s, 80s, and even 90s. While hospitals may be well served by such physicians, there is growing evidence that the ability of doctors to perform competently wanes with age. Some countries have mandatory retirement ages for surgeons and require competency testing of older physicians as they hit certain age benchmarks. While this is true for some professions in the United States (e.g., commercial pilots and FBI agents) it is not the case for physicians. In addition, there is a preponderance of evidence that suggests that physicians have a limited ability to accurately self-assess their abilities. Studies show the worst accuracy in self-assessment among doctors is found in those who are least skilled and most confident of their abilities. Surprisingly, one-third of physicians *do not even have a primary care physician.*

Ensuring Physicians Are Fit to Continue Practicing

The board has two important responsibilities created by the tsunami of aging practitioners. The first is to make sure that all "late career" clinicians to which the board grants privileges are competent and not impaired by the health concerns that become more prevalent with age. Most boards wait until competency problems manifest themselves in an older doctor before they become alerted that a problem exists. Such discovery may come too late to prevent harm to a patient. To avoid this scenario, many medical staffs and hospital boards are deliberating the implementation of an aging policy to which doctors over a specified age (most typically 70) would be subject.[1] Such policies frequently require some type of "fitness for work" physical exam and cognitive screening, which takes place annually or at the time of medical staff reappointment. Other institutions require routine proctoring or focused professional practice evaluation (FPPE) on a periodic basis once a physician reaches a specified age. Where such examinations or competency monitoring suggest a possible problem, there are several formal programs situated around the country that perform intensive assessments of older practitioners (e.g., the LifeGuard program in Pennsylvania, PACE program in Southern California, and CPEP program in Colorado and North Carolina).

Boards that push for the adoption of an aging policy sometimes find significant pushback from the older population of practitioners on the medical staff. It is natural for older doctors to feel their careers and professional identity threatened by such policies. However, assessment of older practitioners has benefits that go beyond protecting patients. Early identification of health or other issues affecting competency may enhance a practitioner's ability to practice longer. Such assessments can also provide a renewed sense of confidence for the practitioner and his/her colleagues. Issues may be identified that are easily remedied or a physician may be provided with information to evaluate options, including recognition of other professional opportunities. In my experience, many older physicians and their colleagues are relieved to know that age-related disabilities will not be overlooked or ignored.

Planning for Aging Physicians

A second board responsibility is to adequately undertake "manpower" planning in the face of the daunting demographics. Unfortunately, many boards put little effort into medical staff development plans and do not work closely with physician leaders on issues of recruitment and retention. Where recruitment of new practitioners is difficult, some hospitals and health systems will be well served by considering practice accommodations for late career practitioners. Many physicians are willing to practice well past the traditional retirement benchmark of 65, especially if the hospital can provide appropriate assistance. Examples of accommodations to consider include decreasing hours and/or caseloads, allocation of more time with patients through schedule adjustments, accommodations based on physical findings

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1 For a sample medical staff aging policy, email Dr. Sagin at tsagin@saginhealthcare.com.