AHA Trustee Services

Advent of "Care Systems" Means Governance Must Also Transform

by Barry S. Bader

Society and industries are always evolving; revolutionary change occurs sporadically when powerful forces align to disrupt the old order.

The health care delivery system today is in the midst of an historic transformation to redesign how care is delivered. The quite immodest aim is to take 20 to 30 percent of costs out of the system while maintaining or improving clinical outcomes and patients' health. A central driver is a shift from volume- and cost-based payment systems, with prices that are opaque to consumers, to value-driven payments and greater transparency of both prices and quality results.

Community-based hospitals are preparing for payment reforms by re-organizing into larger, integrated delivery systems that are economically aligned with physicians and can accept accountability for their costs and quality.

The hospital's future is as a "care system" composed of hospitals, physicians and other providers that are:

- patient-centered,
- financially aligned and operationally integrated along the care continuum,
- managed with discipline for high performance,
- accountable and rewarded for "value" and penalized for waste and error,
- co-led by clinicians and executives,
- organized to achieve economies and synergies of size and scale, and
- transparent in reporting their results.

Large systems with subsidiary operating units in various states and regions will move from being loose-knit confederations to more tightly integrated organizations with centralized core functions and support services and a common set of clinical standards and practices system-wide.

Are Boards Changing Too?

Governing boards have provided the leadership to initiate major organizational changes, but boards have not necessarily changed themselves. Many retain structures and practices rooted in a fading era when the delivery system was community-based and acute care-centric, most physicians were in private practices, and most hospitals were freestanding, not part of systems.

Although today's boards govern integrated care systems, many retain a sort of "organizational DNA" in their cultures, passed down from their local, community hospital ancestry. Some of these traits were assets in the past but could well be liabilities in the future. For example:

- **Local focus.** Most trustees come locally from the community's "elite" establishment and have business and financial backgrounds. By contrast, care systems will serve a broader area and will need higher levels of competence and additional subject area knowledge and skills in health care quality, population and community health, enterprise risk management, and executive leadership in complex, transforming industries. Boards also need trustees who bring an independent perspective, and thus may need to look outside their communities for particular competencies and an independent perspective.
- **Volunteer ethic.** Hospital boards have tended to have a "volunteer ethic," typified by gratitude for trustees' service but a reluctance to ask for too much in the way of participation. The deference to volunteers has led many community hospitals to maintain large boards to make up for so-so meeting attendance, and many took a permissive attitude toward conflicts of interest involving trustees doing business with the hospital. Boards sometimes let philanthropic generosity or family ties outweigh disruptive behavior, such as meddling in

operations. Board leadership was a by-product of seniority, rather than which trustee had the "right stuff" to serve as the chairperson.

- **Overvaluing autonomy.** Populated by community leaders, it's not surprising that many local boards, including subsidiary hospital boards in multi-unit systems, so cherish local autonomy that they resist system-wide improvements to centralize services and standardize functions to improve efficiency and achieve a single standard of high quality. They also may not objectively evaluate strategic alliance and merger opportunities.
- **Outdated measures.** Hospital boards have judged hospital and executive performance using metrics that are rooted in an acute care, volume-driven past, and may not be as relevant under value-based payment schemes.
- **Non-aligned physicians.** Many hospitals have benefitted from the service of physician board members. Boards still need medical competence, but it's hard to find physicians on the medical staff who also have the independence required. In the past, medical staff officers served as *ex-officio* board members, and some medical staffs actually elected physician trustees to represent them. Now, more and more members of the medical staff are employed or contracted by the hospital, while others are hospital competitors. Both have inherent conflicts of interest. Thus, traditional methods of choosing physician trustees and engaging physicians in leadership are becoming problematic.

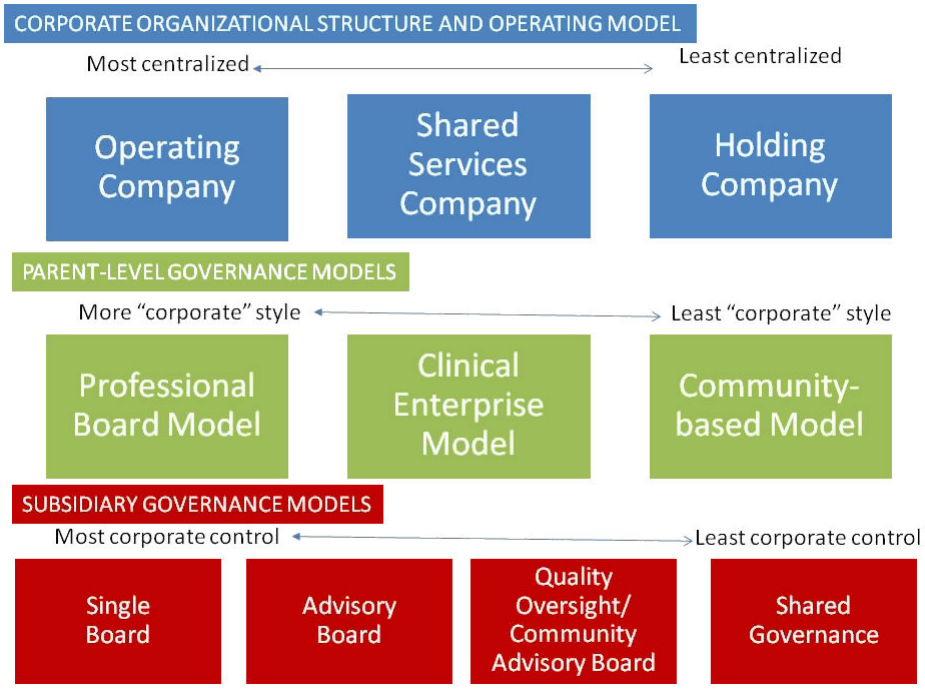

Figure 1. Three Emerging Care System Governance Models

Re-envisioning Governance

Integrated and accountable care systems should recognize the strands of hospital DNA in their cultures and be willing to consider new approaches. Boards need to revisit and rethink their governance roles, structures, and practices to ensure they are positioned to provide the leadership and oversight needed by integrated, accountable care systems.

There is no single governance model that's likely to suit all care system boards, because care systems themselves will differ in their size, service area, scope of services, and core culture. As hospitals transform into care systems, their hospital-based governance models will need to evolve to reflect the differing essential characteristics of their new organizations. The latest industry-wide survey of health care leaders, *FUTURESCAN 2013* published by the Society for Healthcare Strategy and Market Development of the American Hospital Association and the American College of Healthcare Executives, confirms that leaders see governance evolving in the future. Systems are gravitating toward one of three governance models or are "cross-pollinating" key attributes from each into a unique hybrid model.

Professional Governance Model

This model is emerging among health systems that see themselves as a "health company" that, although not-for-profit in motive, embodies the culture of a high-performing, customer-focused corporate enterprise. They aspire to be the Apple Computer or Southwest Airlines for health care delivery.

As a result, governance at the parent level will be viewed as a professional commitment, with higher performance standards than for the typical volunteer board. The board chair or CEO will not be reticent to remove a director who isn't participating and contributing up to expectations.

Directors will be chosen based on the rigorous application of competency criteria, without regard to living in the communities the system serves. The professional board's deliberations will be engaged, high level and strategic, and it will display the sort of no-nonsense, rigorous oversight of performance and risk exhibited by the best corporate boards.

The professional board will be lean in size, committee structure and meeting frequency, although board meetings may last a day or more. Directors may well be compensated, in recognition of the high performance expectations to which they'll be held. The entire board

will be comprised of independent directors with no conflicts of interest (except for the CEO and possibly CMO). The organization will engage medical staff members as clinical leaders but generally not as voting board members.

The system board will have formal and final authority over all subsidiaries, and local boards will generally be advisory bodies or may be eliminated altogether. In the FutureScan survey, 50 percent of respondents indicated it was very or somewhat likely to display elements of the professional governance model by 2018.

Clinical Enterprise Governance Model

This model is often found among multi-specialty medical groups that own hospitals and other facilities and see their distinguishing feature as being a "physician-driven, professionally managed, and patient-centered" delivery system.

The model often features dual boards: a corporate parent or foundation board that, like the professional board, has predominantly independent members chosen for subject matter competencies. The CEO, CMO, and possibly several other executives serve as "inside directors." The parent board has unquestioned ultimate authority, focuses on high-level strategic and financial decisions, and bears public accountability for the independent oversight of financial stewardship and audit, executive and physician compensation, corporate compliance, and clinical quality and credentialing.

An empowered, active "clinical enterprise" board of senior executives and senior physician and nursing leaders is accountable to the parent board and directs the clinical operations of the organization. In the FutureScan survey, 40 percent of respondents indicated it was very or somewhat likely to display elements of the clinical enterprise governance model by 2018.

Enhanced Community-Based Governance Model

This model has the strongest traditions and likely will remain the most common model for care systems that see their

defining characteristic as their close connection to their community. Enhanced community boards, however, will govern not just hospitals but care systems or parts of care systems organized to function under payment reforms. Therefore, they will borrow some elements from the professional and clinical enterprise governance models.

Like professional boards, trustees will be chosen with deliberate use of competency-based criteria and an objective succession planning process, but most trustees will continue to live in the communities the system serves and not be compensated. A few trustees may be recruited from outside the service area to bring a particular, needed expertise or independence, and these positions could be compensated.

As in clinical enterprise governance, the enhanced community board will integrate aligned physicians into the board and other organizational leadership roles. They will choose physician leaders based on objective criteria, not to represent the medical staff.

The board also will adopt recognized best practices to make board recruitment more objective, meetings more strategic, and oversight more rigorous. As in the other models, it will place a high priority on strategic thinking and quality oversight, but reflecting its community orientation, it will also emphasize strategic relationships with parent system boards and community partners, demonstrating community benefit, reducing health disparities, and supporting philanthropy. In the FutureScan survey, 66 percent of respondents indicated they were very or somewhat likely to display elements of the enhanced community hospital governance model by 2018.

Rethinking the Engagement of Physicians

In order to be accountable for their quality and costs under new payment systems, hospitals and physicians can't continue working side by side like craftsmen of different guilds. They must function as an integrated team around the needs of patients and patient populations. Consequently, hospitals and physicians as well other providers

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are becoming clinical and economic partners, with financial incentives for each to provide "value" to payers and patients through efficient and effective, evidence-based care. Many medical staff members now are and will be employed by the health system or have exclusive contract arrangements with the health system.

As a result, care system boards whose "hospital DNA" includes a commitment to physician participation on the board, face new challenges in engaging physicians in governance. Employed and other economically aligned physicians are not considered "independent" and, although they share the hospital's goals, they have an inherent conflict of interest. Conversely, private practitioners on the medical staff may or may not be strongly aligned with the care system; in fact, their primary allegiance could be to a hospital competitor or a competing medical group or outpatient facility.

Thus engaging physicians as trustees has become more problematic. (For further discussion, see these past issues of *Great Boards*, *"Q&A: Physicians on Hospital Boards: Prepare to Challenge Traditional Wisdom,"* Fall 2012, and *"Physicians on Hospital Boards: Time for New Approaches,"* February 2011). The Clinical Enterprise Governance Model addresses this quandary directly by engaging physicians on an influential subsidiary board.

Under both the Professional and Enhanced Community models, care system leaders should work with aligned physicians to develop a shared vision of integration, to choose physician trustees based on competencies, and to find new "sweet spots" for physician leadership and engagement in decisions. These may include board quality committees, medical group boards, co-managed clinical service lines, boards of clinically integrated physician hospital organizations, joint ventures, and hospital quality improvement councils. Physician leaders on these bodies may need a dose of "Governance 101" and "Management 101" orientation and continuing education to help them succeed in their new roles.

More Questions than Answers

By re-examining their model of hospital governance for an era of accountable, integrated care systems, boards will ensure they are prepared for changes to come. The inquiry process will allow trustees to ask themselves such questions as:

- What will be the distinguishing characteristics of our organization in the future that should be reflected in our governance model?
- What are the subject matter competencies and other attributes we will need on our board in the future? Can we find the competencies and independence we need locally, or should we consider recruiting more broadly?
- What measures should the board use to assess care system (as opposed to just hospital) performance and to hold executives accountable?
- How will we engage physicians and other clinicians in care system leadership and decision making that reflects their new roles and responsibilities?
- What board committees will be needed to oversee an accountable care system? How will these differ from today's hospital-centric committees?
- How will we find time on already busy agendas for strategic thinking and continuous learning?
- Do we continue to need subsidiary boards for our hospitals, regions, or other facilities? If so, what should be their role, structure and make-up?

Cheerleaders or Change Agents?

Governance Practices in an Era of Health Care Transformation, the recent Blue Ribbon Panel Report from the Center for Healthcare Governance, encouraged all health care boards to reflect on their own challenges and practices and to begin transforming their governance today to meaningfully shape a value-driven care system that makes a difference for stakeholders.

Boards have been clearly at the forefront of the revolutionary organizational changes occurring in health care delivery. The question facing boards is whether they will be sideline cheerleaders in the change process or be models of the change they desire? Will they opt to stay in the comfort zone of traditional norms of choosing trustees and conducting board work, or are they willing to change as much as they are asking their organizations to transform?

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