



SAMPLE TEMPLATE FOR A BOARD STRATEGIC PLANNING DISCUSSION
Governance Implications of Changing from Hospital to Care System Governance

Introduction

The American Hospital Association's report, *Hospitals and Care System of the Future*, describes the transformation of health care delivery from first curve to second curve, driven by a shift from volume-driven to value-driven payment systems.

While there is no single "end state" model that suitable for all organizations or communities, the report offers a compelling vision of "care systems" that are accountable, integrated and coordinated around patient and community needs."

Hospitals and care systems will not be the same. Compared with a typical hospital today, a care system is likely to span the continuum of care (acute inpatient, outpatient, home, school/workplace, rehabilitation, sub-acute facilities), focus on promoting wellness as well as treating illness, be accountable for costs as well as quality, and have physicians deeply involved in leadership, to name a few distinctions.

Consequently, governance of care systems also will differ from hospital governance or even current governance in many hospital-based health systems.

The survey tool and discussion stimulator on the next page extracts several hypotheses about governance of the future from the *Hospitals and Care Systems of the Future* report.

Questions after are designed to stimulate board discussion about future governance.



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Hypothesis 1: Structuring Governance to Optimize Health System Performance

As health care delivery systems become more integrated to optimize efficiency, governing boards will not only oversee the performance of individual units, but also evaluate whether operating units are aligned to optimize system-wide performance.

Health system parent boards will reassess the authority and roles of their subsidiary governance structures for hospitals, medical practices, and local care systems. Some systems will eliminate subsidiary entity governance entirely, while others will retain supplementary boards in advisory roles. A third segment will develop “shared governance” structures in which additional boards have certain delegated responsibilities.

Boards also will need the ability to make decisions quickly—in the words of one CEO, “to execute with speed, through streamlined governance and management.” Systems that are slowed by multiple levels of governance with ambiguous responsibilities and a lack of alignment between system wide and subsidiary goals will engage in careful governance assessment and redesign processes. Such changes cannot be management-driven because they will alter board authority and trigger concerns of reducing local autonomy. Thus, governance redesign efforts are a culture change that will require trustees’ full engagement and support.

Discussion Questions:

- Do you agree with this hypothesis for our organization? Why or why not?
- Are the authority and roles of our corporate governance, subsidiary governance, and management ideally designed and aligned to support our evolution to a “care system”?
- Have we defined our desired “future state” for the structure of our organization’s governance?
- What enhancements should we consider in our governance structure short-term or long-term?

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Hypothesis 2: Rethinking System Performance Metrics

Boards characterize each organization's definition of success when they approve the assessment measures of organizational performance (*e.g.*, dashboards, scorecards, executive evaluation criteria). Management priorities are directly impacted by the board's decisions concerning incentive and bonus programs.

The majority of current hospital and health system dashboards reflect first-curve, volume-driven financial incentives. For example, boards typically review measures of profitability, quality, patient experience, and employee engagement for individual operating divisions or individual units such as hospitals, medical practices, and nursing homes.

In the future, as payers move toward value-based reimbursements, organizational metrics must evolve. Boards will add second-curve metrics of financial and quality measures for clinical service lines and patient populations to first-curve dashboards. For example, rather than seeking to raise revenue by increasing the volume of services provided, boards will examine whether the average costs per case and the annual per-capita spending for patient populations are being controlled. Boards will examine patients' quality of life after frequently performed procedures such as joint replacements and cardiac bypass surgery. The choice of metrics is powerful; what the board measures, the organization does.

Discussion Questions:

- Do you agree with this hypothesis for our organization? Why or why not?
- What the metrics we should use to assess achievement of our vision?
- What are the milestones we should achieve along the way?



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Hypothesis 3: Recruiting Trustees Based on Their Skill Sets to Match Specific Facility Needs

Boards have typically selected members based on generalized judgments of who would make a good trustee, utilizing relatively informal approaches. Many boards have not identified the specific skill areas or personal traits that they seek in prospective trustees, nor do they maintain an ongoing list of potential members for a vacancy occurrence. Many boards say they want greater diversity of ethnicity, gender, and race to reflect the community, but they have no specific plan to make those changes. Today's demands for excellence in governance render these informal approaches outdated and inadequate.

In the future, board succession planning will be ongoing, based on explicit needs-based criteria, and include a plan to increase diversity. In addition to traditional needs for trustees with backgrounds in finance, investment, audit, human resources, and health care, the transformation from hospitals to care systems suggests a need for such competencies as population and public health; insurance risk management; information technology; quality assurance; mergers and acquisitions; strategic alliances and collaboration; and change management in complex organizations. Community-connected trustees will remain important, but there will be increased recruitment of outside directors who bring specific expertise and an independent perspective.

Discussion Questions:

- Do you agree with this hypothesis for our organization? Why or why not?
- Do we have an explicit, competency- or attribute-based board succession planning process today?
- Will we need different competencies or attributes on the board as we evolve toward our vision?



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Hypothesis 4: Engaging Physician Participation in Major Decisions and Initiatives

It will remain important to have physicians on the governing board for most hospitals and health systems, but the selection criteria for ideal physician members will change as hospitals align and integrate with the medical staff as full economic partners.

Over time, physicians who are closely aligned with the hospital economically and clinically will be selected for leadership positions on the board and on the medical staff. Boards must encourage physicians to redesign medical staff structures to reflect the future of financially aligned, integrated, and accountable patient-care teams.

Discussion Questions:

- Do you agree with this hypothesis for our organization? Why or why not?
- How are physicians selected to be on the board today? Are there specific criteria and an objective nomination process to elect the physicians most qualified to serve on the board?
- In addition to the board, how are physicians engaged in leadership and decision making in the organization today?
- In the future, how should physicians be involved in governance and other forms of organizational leadership and decision making??