Trends and Effective Governance in a Time of Challenge and Change

Jamie Orlikoff
President
Orlikoff & Associates, Inc.
773-268-8009
j.orlikoff@att.net
Healthcare: Facing the Perfect Storm?
Consistent Themes Nationally, Regionally, and Locally

- Rising Costs
- Declining Revenues
- Limited Access to Capital
- Shifting Demographics
- Increasing Demand for Quality / Cost Performance
- New Payor Strategies / Payment Reform
Facing the Perfect Storm?
With a BIG Wild Card!!

RISING COSTS

DECLINING REVENUES

SHIFTING DEMOGRAPHICS

NEW PAYOR STRATEGIES / PAYMENT REFORM

LIMITED ACCESS TO CAPITAL

INCREASING DEMAND FOR QUALITY / COST PERFORMANCE

TRUMP ADMINISTRATION?!!
The Changing Environment

Transitioning to Care Models of the Future: Volume to Value

**Curve 1: Fee-For-Service**
- All about volume
- Reinforces work in silos
- Little incentive for real integration

**Curve 2: Value-Based-Payment**
- Shared savings program
- Bundled/global payments
- Value-based reimbursement
- Rewards integration, quality, outcomes and efficiency

Current Position

Natural Trajectory
Population Health Sweeping the Country?

% Hospitals Reporting *Any* Capitated Revenue

Source: American Hospital Association Annual Survey (2016)
The Leadership Challenge

VALUE

VOLUME

VALUE
How to Bridge the Gap?
Four Key Interrelated Themes

- Total Cost of Care - Affordability
- Consumer Engagement
- Physician Alignment and Performance
- Governance and Leadership
Well Known U.S. Healthcare Crisis

- In 2010 we spent $2.6 trillion on health care, or $8,402 per person.
- The share of economic activity (GDP) devoted to health care has increased from 7.2% in 1970 to 17.9% in 2009 and 2010.
- Health care costs per capita have grown an average 2.4% faster than the GDP since 1970.
- Half of health care spending is used to treat just 5% of the population.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011.
9.1. Health expenditure per capita, 2013 (or nearest year)

Note: Expenditure excludes investments, unless otherwise stated.
1. Includes investments.
2. Data refers to 2012.

Benefit for the Cost?

Recent News: More of the Same

• US Health Spending Grew 5.8% in 2015

According to CMS, and reached $3.2 trillion. On a per person basis, spending on health care increased 5.0%, reaching $9,990. The share of gross domestic product devoted to health care spending was 17.8 percent in 2015, up from 17.4 percent in 2014.
Recent News: More of the Same

• US life expectancy DECLINED in 2015!!!

In 2015, rates for 8 of the 10 leading causes of death rose. An American born in 2015 is expected to live 78 years and 9½ months, on average, according to the Centers for Disease Control and Prevention. An American born in 2014 could expect to live about a month longer, and even an American born in 2012 would have been expected to live slightly longer. In 1950, life expectancy was just over 68 years.

The United States ranks below dozens of other high-income countries in life expectancy, according to the World Bank. It is highest in Japan, at nearly 84 years.

Associated Press December 8, 2016
Health Spending Largest Item in the FY 2017 Federal Budget

Federal Budget Authority for - FY 2017

- Health Care 28%
- Pensions 25%
- Defense 20%
- Education 3%
- Welfare 9%
- Protection 1%
- Transportation 3%
- General Government 1%
- Other Spending 3%
- Interest 7%
Price changes (1996-2016)
Selected Consumer Goods and Services

- Textbooks
- College Tuition
- Health Care
- Childcare
- Food and Beverage
- Housing
- New Cars
- Household Furnishings
- Clothing
- Cellphone Service
- Software Toys
- TVs

Overall inflation (+55%)

Source: BLS

Mark Perry/American Enterprise Institute

Carpe Diem

The Washington Post
Winboklog August 17, 2016
Why Change?

If food prices had risen at medical inflation rates since the 1930s

*Source: American Institute for Preventive Medicine*

<table>
<thead>
<tr>
<th>Item</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 dozen eggs</td>
<td>$85.08</td>
</tr>
<tr>
<td>1 pound apples</td>
<td>$12.97</td>
</tr>
<tr>
<td>1 pound sugar</td>
<td>$14.53</td>
</tr>
<tr>
<td>1 roll toilet paper</td>
<td>$25.67</td>
</tr>
<tr>
<td>1 dozen oranges</td>
<td>$114.47</td>
</tr>
<tr>
<td>1 pound butter</td>
<td>$108.29</td>
</tr>
<tr>
<td>1 pound bananas</td>
<td>$17.02</td>
</tr>
<tr>
<td>1 pound bacon</td>
<td>$129.94</td>
</tr>
<tr>
<td>1 pound beef shoulder</td>
<td>$46.22</td>
</tr>
<tr>
<td>1 pound coffee</td>
<td>$68.08</td>
</tr>
<tr>
<td><strong>10 Item Total</strong></td>
<td><strong>$622.27</strong></td>
</tr>
</tbody>
</table>
Two-thirds of people in human history who have reached the age of 65 are alive right now!

Dr. Robyn I. Stone, LeadingAge
U.S. Population growth mostly driven by the elderly:

- 65+ cohort will grow 28% in the next decade
  - 10,000 baby-boomers turn 65 every day (that’s one every 7 seconds)
  - This will continue for the next 18 years

- 65+ cohort will be 15% of total U.S. population by 2016
- Much higher ED use compared to other age cohorts
- 25% of Medicare beneficiaries have five or more chronic conditions, see an average of 13 physicians and fill 50 prescriptions per year.
Is This the Metaphor for Our Future?
What Will Happen to Healthcare Under Trump Administration??
Future of Medicare??

Medicare Vouchers? Transfer of Risk from Feds to Medicare Beneficiaries. Even CURRENT Medicare requires significant out-of-pocket cost.

“A 65-year-old couple retiring in 2016 will need an estimated $260,000 to cover health care costs in retirement, according to Fidelity's Retiree Health Care Cost Estimate. This is a six percent increase over last year's estimate of $245,000 and the highest estimate since calculations began in 2002.” - Fidelity

Health Care Costs for Couples in Retirement Rise to an Estimated $260,000, Fidelity Analysis Shows
Long-Term Care Insurance Could Add an Additional $130,000
Future of Medicaid??

Currently, the federal government pays an agreed-upon percentage of each state's Medicaid costs, no matter how much they rise in any given year.

Republicans have argued that states have little incentive to keep expenses under control, because no state pays more than half the total cost. Both House Speaker Paul Ryan and Trump's pick for secretary of health and human services, Georgia Rep. Tom Price, want to switch to block grants.
Future of Medicaid??

Medicaid Block Grants? Transfer of Risk From Feds to States.

“If this isn’t done right, if the money doesn’t match what needs to be done, this is potentially the greatest intergovernmental transfer of financial risk in the Country’s history.” Matt Salo, Executive Director, National Association of Medicaid Directors.

Disruptive Leadership Questions:

And Hospitals and Systems...?
Annual Percent Change in Hospital Prices

## Inpatient Demand Side

<table>
<thead>
<tr>
<th></th>
<th>1980</th>
<th>2013</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>36.1 M</td>
<td>33.6 M</td>
<td>(7%)</td>
</tr>
<tr>
<td>Admissions per 1000 of Population</td>
<td>159.1</td>
<td>106.6</td>
<td>(33%)</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>7.6</td>
<td>5.4</td>
<td>(29%)</td>
</tr>
<tr>
<td>Average Daily Census</td>
<td>747 k</td>
<td>500 k</td>
<td>(33%)</td>
</tr>
</tbody>
</table>

## Inpatient Supply Side

<table>
<thead>
<tr>
<th></th>
<th>1980</th>
<th>2013</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Staffed Beds</td>
<td>988 k</td>
<td>796 k</td>
<td>(19%)</td>
</tr>
<tr>
<td>Staffed Beds per 1000</td>
<td>4.3</td>
<td>2.5</td>
<td>(42%)</td>
</tr>
<tr>
<td>Number of Community Hospitals</td>
<td>5,830</td>
<td>4,974</td>
<td>(15%)</td>
</tr>
</tbody>
</table>

The Law of Supply and Demand?

AHA Guide and AHA Hospital Statistics
Top Line Weakness
2008-2017

Unit Revenue Growth
Admissions

Source: JP Morgan, Altarum
Size, Scale, Reputation, Market Dominance Offers No Protection From The Trend

- Providence Health- $511 million decline (-$250 million net op loss)
- Dignity Health- $487 million decline (-$63 million net op loss)
- Catholic Health Initiatives - $525 million decline (-$460 million net op loss)
- Trinity Health- $411 million decline ($46 million net)
- SSM (St. Louis)- $220 million decline ($10 million net)
- MD Anderson Cancer Center (-$266 million loss in FY16)
- Partners (Boston)- $214 million decline (-$108 million loss)
- Cleveland Clinic- $341 million decline ($139 million net)

Jeff Goldsmith, June 30 2017
And This is Happening At the TOP of An the Economic Cycle!

Jeff Goldsmith, June 30 2017
The Quality of Governance that was Sufficient to Get your Organization where it is Today will be Insufficient to Get It Where It Needs to be Tomorrow
Worrisome Winds Blowing for Governance

- A healthcare market where the pace of change continually accelerates as its complexity grows.
- As the size, scale, and scope of healthcare systems grows, so does the complexity of effective system governance.
Worrisome Winds Blowing for Governance

• Accountability continues to grow for hospital and system boards.

• These changes and challenges inexorably present increasing demands on system boards and their members.
Dilemma for Nonprofit Hospitals

Some administrators' and board members' business ties can pose conflicts at facilities

BY ANDREA FULLER
AND MELANIE EVANS

Nonprofit hospitals have extensive business ties that can pose conflicts of interests for their administrators and board members, a Wall Street Journal analysis of newly released Internal Revenue Service data shows.

While having relationships with companies doing business with a nonprofit hospital isn't necessarily improper—as long as the deals are disclosed and at market rate—administrators and board members sometimes may be forced to choose between what's best for the hospital and what's best for their private interests.

"Just because something is legal doesn't mean that it's appropriate," said James Orlikoff, a Chicago-based hospital governance consultant. "You run the real risk of violating the public trust."

Hospitals rank among the largest nonprofits in the country. Because they often are big employers and have complex business arrangements, they face these dilemmas far more often than businesses that are not nonprofits, the IRS says.

For the fiscal year ending in 2014, the Wall Street Journal found that nonprofits had transactions totaling nearly $300 billion. That is up from $268 billion in 2013, according to the IRS.

The newspaper's analysis focused on nonprofits that filed Form 990 with the IRS, a tax-exempt organization's annual disclosure of its finances and activities. The IRS requires nonprofits with more than $1 million in gross income to file the form.

For the fiscal year ending in 2014, the Wall Street Journal found that nonprofits had transactions totaling nearly $300 billion. That is up from $268 billion in 2013, according to the IRS.

The newspaper's analysis focused on nonprofits that filed Form 990 with the IRS, a tax-exempt organization's annual disclosure of its finances and activities. The IRS requires nonprofits with more than $1 million in gross income to file the form.

Nonprofits can have transactions with people who are related to them, but must disclose those transactions. The Wall Street Journal analyzed those relationships and identified more than 100,000 unique nonprofits that had transactions with related parties.

In many cases, the nonprofits were able to negotiate with insiders to keep the transactions below the threshold that would trigger disclosure. The Wall Street Journal found that nonprofits had $29 billion in transactions with insiders who worked for the nonprofit, $13 billion with insiders who owned more than 10% of the nonprofit's stock, and $5 billion with insiders who were members of the nonprofit's board.

Nonprofits are not required to disclose those transactions in their 990 forms, but they are required to disclose any transactions with insiders who have more than a 10% stake in the nonprofit. The Wall Street Journal found that nonprofits had $5 billion in transactions with insiders who owned more than 10% of the nonprofit's stock, but it did not find any nonprofits that had transactions with insiders who owned more than 10% of the nonprofit's stock.

The Wall Street Journal found that nonprofits had $29 billion in transactions with insiders who worked for the nonprofit, $13 billion with insiders who owned more than 10% of the nonprofit's stock, and $5 billion with insiders who were members of the nonprofit's board.

In many cases, the nonprofits were able to negotiate with insiders to keep the transactions below the threshold that would trigger disclosure. The Wall Street Journal analyzed those relationships and identified more than 100,000 unique nonprofits that had transactions with related parties.

By CARRIGAN

Missouri bankruptcy approved Peabody Energy's $200 million pledge to environmental damage in three states, owing a hearing on cline, Judge Barry Parker signed off on the deal, as well as up to $12 in bonuses meant to incent top executives trying to reorganize the company's operations.

Louis-based Peabody Energy's Peabody Energy and Wyoming—environmental obligations are held of secured lenders who hold creditors' interests.

The company has mines in the U.S., where coal is concentrated in the Illinois basin in the East, and the Illinois basin in the West.

The Wall Street Journal said "eJet met the criteria for the open-bidding process," he said. "Nathan Dean didn't respond to interview requests."

Dignity Health solicited competitive bids for the marketing job, and said eLead's bids were "fair and reasonable" and "market competitive." Dignity declined to say if eLead was the lowest bidder.

Unlike government entities that solicit contracts, nonprofits aren't required to disclose their bidders.

Dignity's board reviewed eLead's bids and performance, said Peter Hanelt, who chairs the committee tasked with the reviews. "The conflict is not inherently wrong," Mr. Hanelt said. "You simply want to disclose it and vet it and make sure it's fair."

Hospitals in small towns may face a particular dilemma when it comes to managing conflicts, said Michael Peregrine, a Chicago-based lawyer and governance consultant. They may think that because "governance gurus are telling us we've got to get the best and brightest people," their only choice is to turn to the local business leaders known by the hospitals.

Rob Montagnese, chief executive of the Licking Memorial Health Systems in Newark, Ohio, said his hospital banned business contracts with board members who have financial stakes in the hospital. "We don't want to have people who are interested in the financial success of the hospital," Mr. Montagnese said. "We want people who are interested in the health of the community."
“In 2014, 46% of more than 2,300 nonprofit hospitals had at least one trustee or officer with business ties to the hospital—either directly or through a relative. That is compared with 7% of all nonprofits in the Journal’s analysis of tax-return data compiled by the IRS. At more than 270 nonprofit hospitals, the arrangements topped $1 million each. Many of the largest transactions involve hospitals and medical companies that have common board members. But in other instances, hospitals have multimillion-dollar contracts with companies owned by trustees in areas such as advertising and construction.”
“Hospitals frequently conduct business with their board members and officers—far more often than other nonprofits.”

Wall Street Journal August 22, 2016
Cybersecurity/ERM: A Time to Worry. 3 Levels of Risk:

1. Data Breach and Theft.
2. Ransom Attack.
3. Terror Attack using “Internet of Things.” Or, targeted murder or assassination.
How to Stop Hospitals From Killing Us

BY MARTY MAKARY

When there is a plane crash in the U.S., even a minor one, it makes headlines. There is a thorough federal investigation, and the tragedy often yields important lessons for the aviation industry. Pilots and airlines thus learn how to do their jobs more safely.

The world of American medicine is far deadlier: Medical mistakes kill enough people each week to fill four jumbo jets. But these mistakes go largely unnoticed by the world at large, and the medical community rarely learns from them. The same preventable mistakes are made over and over again, and patients are left in the dark about which hospitals have significantly better (or worse) safety records than their peers.

As doctors, we swear to do no harm. But on the job we soon absorb another unspoken rule: to overlook the mistakes of our colleagues. The problem is vast. U.S. surgeons operate on the wrong body part as often as 40 times a week. Roughly a quarter of all hospitalized patients will be harmed by a medical error of some kind. If medical errors were a disease, they would be the sixth leading cause of death in America—just behind accidents and ahead of Alzheimer's. The human toll aside, medical errors cost the U.S. health-care system tens of billions a year. Some 20% to 30% of all medications, tests and procedures are unnecessary, according to research done by medical specialists, surveying their own fields. What other industry misses the mark this often?

It does not have to be this way. A new generation of doctors and patients is trying to achieve greater transparency in the health-care system, and new technology makes it more achievable than ever before.

25% Hospitalized patients who are harmed by medical errors

Medical errors kill enough people to fill four jumbo jets a week.

creased from its packaging. I walked the halls marveling at the portraits of doctors past and present. On rounds that day, members of my resident team repeatedly referred to one well-known surgeon as "Dr. Hodad." I hadn't heard of a surgeon by that name. Finally, I inquired. "Hodad," it turned out, was a nickname. A fellow student whispered: "It stands for Hands of Death and Destruction."

Stunned, I soon saw just how scary the works of his hands were. His operating skills were hasty and slipshod, and his patients frequently suffered complications. This was a man who simply should not have been allowed to touch patients. But his bedside manner was impeccable (in fact, I try to emulate it to this day). He was charming. Celebrities requested him for operations. His patients worshiped him. When faced with excessive surgery time and extended hospitalizations, they just chalked up their misfortunes to fate.

Dr. Hodad's popularity wasn't a aberration. As I rotated through other hospitals during my training, I learned that many hospitals have a "Dr. Hodad" somewhere on staff (sometimes more than one). In a business where reputation is everything, doctors who call out other doctors can be targeted. I've seen whistleblowing doctors suddenly assigned to more emergency calls, given fewer resources or simply badmouthed and discredited in retaliation. For me, I knew the ramifications if I sounded the alarm over Dr. Hodad. I'd be called into the hospital chairman's office, a dastardly scenario if I ever wanted a job. So, as a rookie, I kept my mouth shut. Like other trainees, I just told myself that my 120-hour weeks were about surviving to become a surgeon one day, not about fixing medicine's culture.

Hospitals as a whole also tend to escape accountability, with excessive complication rates even at institutions that the public trusts as top-notch. Very few hospitals publish statistics on their performance, so how do patients pick one? As an informal exercise throughout my career, I've asked patients how they decided to come to the hospital where I was working (Georgetown, Johns Hopkins, the Mayo Clinic, Boston Children's) and how they prioritized their care. In the middle of the spectrum, the most common answer was "My insurance." My patients didn't care about their health. They just wanted to make sure their health insurance picked up the bill. One patient said, "I don't want the best. I just want to get through this alive."

To make matters worse, the so-called "100% quality assurance" system of medical errors is a farce. Medical malpractice lawsuits are underfunded and often produce poor results. Million-dollar settlements are rare, and doctors can simply afford to absorb them.

A recent study by the Institute of Medicine showed that the number of deaths attributable to medical errors is 98,000 per year. This is almost twice the number of deaths from breast cancer. If medical errors were as deadly as breast cancer, would we be singing them the national anthem today?
Number of Days a Year Board Currently Spends on Issues

Figures do not sum to total because of rounding

Source: April 2013 McKinsey Global Survey of 772 directors on board practices
The Two Most Common Board Member Complaints I am Hearing:

1. We do not spend enough time as a Board in Strategic or Generative Discussions.

2. Governance is taking more and more of my time. I am a Volunteer and this is too much.
Just like the Population, Board Members are Getting Older...But FASTER!
Figure 2.7 – Board Age

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2011</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;= 50</td>
<td>29%</td>
<td>24%</td>
<td>21%</td>
</tr>
<tr>
<td>51-70</td>
<td>62%</td>
<td>67%</td>
<td>68%</td>
</tr>
<tr>
<td>&gt;= 71</td>
<td>9%</td>
<td>9%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>Freestanding Hospital Board</td>
<td>Hospital Subsidiary Board</td>
<td>System Headquarters Board</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------------------</td>
<td>---------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>90%</td>
<td>86%</td>
<td>86%</td>
</tr>
<tr>
<td>African American</td>
<td>4%</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>American Indian</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>72%</td>
<td>69%</td>
<td>76%</td>
</tr>
<tr>
<td>Female</td>
<td>28%</td>
<td>31%</td>
<td>24%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;=50</td>
<td>17%</td>
<td>19%</td>
<td>12%</td>
</tr>
<tr>
<td>51-70</td>
<td>63%</td>
<td>70%</td>
<td>81%</td>
</tr>
<tr>
<td>&gt;=71</td>
<td>20%</td>
<td>11%</td>
<td>7%</td>
</tr>
<tr>
<td><strong>Clinical Background</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>17%</td>
<td>22%</td>
<td>26%</td>
</tr>
<tr>
<td>Nurse</td>
<td>4%</td>
<td>6%</td>
<td>4%</td>
</tr>
<tr>
<td>Other Clinician (e.g., pharmacist, therapist)</td>
<td>5%</td>
<td>3%</td>
<td>2%</td>
</tr>
</tbody>
</table>
Some Interesting Highlights from the Survey

• Board Members are Getting Older.

• Nearly 40% of Boards DID NOT use competencies in the selection process for new board members OR new Board Chairs.

• 80% of Boards reported that NO Board member has been replaced or not been re-nominated because of failure to demonstrate necessary competencies

• Just over 50% of Boards did a self assessment in 2014; and hardly ANY did performance evaluation of individual trustees or of Board Chairs.

• Most boards did not use assessment results in determining if a board member should be reappointed

American Hospital Association’s Center for Healthcare Governance. 2014 National Health Care Governance Survey
Some Interesting Highlights from the Survey

- 88% of Boards Do Not Compensate their Members (same as in 2011).
- Only 52% of Boards use Electronic Board Portals for Governance Information and Agenda Materials.

American Hospital Association’s Center for Healthcare Governance. 2014 National Health Care Governance Survey
But, I Am An Older Board Member and I am HIP!

Old People
It's funny when they think they are 'hip'..
Generational Differences in Governance

• Hard to recruit and retain Millennials to boards. Different commitment to volunteerism?

• Different approaches to group process, strategic planning, decision making, use of technology.
KEY GOVERNANCE PRINCIPLES For ALL BOARDS:

1. Competency-Based Board Composition.
   Expertise vs. Literacy

2. Board Member Performance Evaluation.

3. Outside Members!

4. A Clear Leadership Focus. The purpose of Governance is to LEAD, NOT TO REPRESENT Constituencies and Stakeholders.

5. Diversity on the Board – Includes Age Diversity!!
KEY GOVERNANCE PRINCIPLES for SYSTEM BOARDS:

1. **Minimalism.** Fewer governance entities are better to help maximize governance efficiency, and reduce decision-making cycle time.

2. **Consistency.** Governance structures are consistent throughout the system. Further, leadership models and structures (governance, management, clinical) are consistent throughout the system.
KEY GOVERNANCE PRINCIPLES for SYSTEM BOARDS:

3. **Authority.** System governance operates on the principle of *centralize authority and decentralize decision-making*. This is clarified and operationalized through the development and use of an authority matrix.

4. **Leadership.** The purpose of governance is to lead the system, not to represent the interests of constituencies, stakeholders, regions, or pieces of the system. Therefore, governance composition models are competency-based, and not representationally based.
KEY PRINCIPLES for SYSTEM BOARDS:

5. Intentionality. Whatever model of governance structure and function is chosen, it is based on conscious choices and explicit principles, and not on history or happenstance.

6. Balance the power structure. No individual, committee, or group of individuals is allowed to hold too many powers of the system board.
A core principle of effective governance is that the authority of the board derives from the group as a whole. If a single committee or individual is vested with too many powers of the system board, effective governance is usually severely compromised. Power Functions of the Board are explicitly identified; Key Power Functions are assigned to the Full Board; and the remaining ones are distributed among various Board Committees.
Balance the power structure: “Power Functions” of a System Board

• CEO hire and fire authority

• Setting CEO performance objectives, evaluating CEO performance, and establishing CEO compensation;

• Governance including board composition; board evaluation; individual board member performance evaluation pursuant to term renewal; conflict-of-interest and director independence monitoring; corporate bylaws revisions and approval; board job descriptions and governance policies and procedures; and, oversight of subsidiary boards

• Audit oversight and approval; compliance
Balance the power structure: “Power Functions” of a System Board

- Quality and safety
- Financial oversight, including monitoring of debt covenants and stock purchases/divestments
- Strategic planning and monitoring
- Integration and oversight of different businesses including strategic allocation of resources, adjusting capacity, and consolidating services to optimize the system as a whole
- Enterprise Risk Management
- Others?
Decision-making authority that should be held and exercised solely by the system board as a whole:

- System CEO hiring and firing (clearly sends the message that the board as a whole is the boss of the CEO; not the board chair, executive or compensation committee).
- Appointing, re-appointing, and removing board members and officers including the board chair
- Corporate Bylaws revisions and approvals
- Mission revisions and approvals, mission loyalty (duty of obedience to charitable purpose if a non-profit health system)
- Strategic plan approval
- Sale of assets, merger or affiliation, consolidation of system components
- Others?
Balance the power structure: Committees

The board strives to assure that the composition of its committees is largely distinct; that is, that the same board members do not serve on multiple “power” committees.
EFFECTIVE BOARD MEETINGS

1. Consent Agenda
2. Agenda Clearly Tied to Strategy, Board Goals and Objectives
3. CEO Report – Verbal Report MUST NOT duplicate written report in agenda materials!!
4. Decision Sequencing (CEO, Committees, MS)
5. Who is in the Room? When?
6. Deep Dive Discussion
7. Post Board Meeting Evaluation
A Leadership Law

There Can Be No Leadership Success without Leadership Succession.
BOARDS AS TEAMS

“Real teams don’t emerge unless individuals on them take risks involving conflict, trust, interdependence & hard work.”

Katzenbach & Smith
GREAT TEAMS HAVE GOOD FIGHTS!

• The complete absence of conflict in a board or committee (team) is *not* harmony, it’s more likely apathy.

• Great teams have these characteristics:
  • they focus on the facts or the tasks
  • they generate and truly consider alternatives
  • they create common goals
  • they use humor
  • they balance the power structure
  • they seek consensus with qualification
Support of Decisions, Strategy, CEO

PRODUCTIVE DISAGREEMENT

Critical Questioning, Challenge, Loyal Dissent
“GENTLEMEN, I TAKE IT THAT WE ARE IN COMPLETE AGREEMENT ON THE DECISION HERE. THEN, I PROPOSE THAT WE POSTPONE FURTHER DISCUSSION TO GIVE OURSELVES TIME TO DEVELOP DISAGREEMENT AND PERHAPS GAIN SOME UNDERSTANDING OF WHAT THE DECISION IS ALL ABOUT”

Alfred Sloan: GM Chairman and CEO from 1923-1956

Quoted in New Yorker, March 8, 2004 p. 30
“To make more effective decisions, develop disagreement rather than consensus. Disagreement provides alternatives and makes you think more deeply about the issue.

In fact, if you don’t have disagreement, you are not ready to make a decision”

Peter Drucker
Well, Great. But…

That All Takes Lots of TIME!!!
Emerging Challenges to Effective System Governance

• Can society expect individuals who are working in professions and running businesses to devote – on a voluntary basis! - excessive amounts of their time to governing health systems?
Emerging Challenges to Effective System Governance

- Many board members are becoming concerned that the complexity, regulation, quality and safety challenges of governing a health system expose them to inordinate and growing amounts of liability and reputational risk.
Emerging Challenges to Effective System Governance

The pool of qualified, potential system board members may significantly diminish in the near future.
The only individuals who can afford the time to serve as volunteer members of healthcare system boards are either retired, or independently wealthy, or who have the luxury of working for generous employers or owning businesses that essentially run themselves; or, who are individuals who are employed by the healthcare system itself.
Emerging Challenges to Effective System Governance

- Can the deeply imbedded tradition of the volunteer board member of the not-for-profit health system, which grew directly from the long-standing model of voluntary governance of the local not-for-profit hospital survive??
Emerging Challenges to Effective System Governance

• Is not the solution to simply compensate system board members? And, do so at a level commensurate with that of their for-profit corporate cousins?
Emerging Challenges to Effective System Governance

As challenging as effective governance of healthcare systems is now, it is only likely to become more so. Thus, to be a truly effective board of a 21st Century system requires an impatience with and unwillingness to be bound by the inefficiencies of the governance models and mentalities of the past.
The Quality of Governance that was Sufficient to Get your Organization where it is Today will be Insufficient to Get It Where It Needs to be Tomorrow.
Wither the Soul of Healthcare Governance?