Governance & Leadership in a Multifaceted Physician Enterprise

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Discussion Points

1. Context
2. Culture
3. Clinical Integration
4. Governance
CONTEXT
Surviving The Ordeal

127 HOURS

BASED ON THE LIFE STORY OF ARON RALSTON
The Traditional View

- “The only good bed is a full bed”
- Getting physicians to take call was no problem
- The medical staff lounge was a place for professional and social interaction
- Physicians owned and ran their practices, administrators ran their hospitals
- Board service was a form of honorary community recognition
- The most important role of hospital staff was to meet the needs of high volume physicians
Conventional Wisdom – Circa 1977

“The physician is traditionally described as a guest in the hospital and its primary customer. Except when a physician chooses to run a hospital for profit, he has no personal responsibility to see that the hospital is available to provide care for his patients. The physician uses the hospital as his workshop....

“Whenever a physician admits a patient to the hospital, he is free to order whatever tests or treatments he deems necessary. Thus he basically determines the amount of services used and consequent costs of individual patients’ care....Physicians have every reason to want the best possible institutional setting in which to practice medicine, especially when it is provided at no personal cost to them.”

Today’s Environment

• More and more mergers of hospitals and health systems

• Many failures or dissolutions due to culture clashes

• Proportion of employed physicians continues to rise

• Many organizations struggling to “integrate” physicians into their enterprise
Today’s Environment

• Governance STRUCTURE is important…
  – For profit or not-for-profit?
  – Scope of authority?
  – Relationship to parent?

• But governance PROCESS often makes the difference between success and failure
Virtual IDN

HOSPITAL SYSTEM

Virtual IDN

- Public & Private Agencies
- Independent Hospitals

Virtual MSG

- Independent Physicians

Post Acute

Ambulatory

Employed Physicians*

KEY: ------ Control  ---- Contract

* Note: All references to physicians include appropriate utilization of mid-level practitioners.
CULTURE
Culture From The Top

- The “secret sauce” is the culture and values of our company.
- Many Companies are reducing hours [to avoid healthcare expenses]. That is a short term solution and, ultimately, is not going to add value to the enterprise, the company and ... customers.
### How Long

<table>
<thead>
<tr>
<th>Question</th>
<th>Timeframe</th>
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<tbody>
<tr>
<td>Do hospital buildings remain in use?</td>
<td>38 years</td>
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<tr>
<td>To train a physician?</td>
<td>$\approx$ 10 years</td>
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<tr>
<td>To change physician culture?</td>
<td>10 years</td>
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<tr>
<td>To make IT interoperable?</td>
<td>Forever</td>
</tr>
<tr>
<td>To change management / board culture?</td>
<td>Why would we do that?</td>
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Some Questions to Consider

• Does your organization have a coherent culture that supports your strategic objectives?

• Are your physicians (employed and voluntary) engaged with the organization and actively working to support your strategy?

• Do you provide regular feedback to employees and physicians on individual and organizational performance around quality, safety, patient satisfaction, and efficiency measures?

• Are your compensation programs aligned with your performance measures?
The Bottom Line

• Healthcare today DEMANDS measurable performance
• Performance REQUIRES alignment, engagement and integration of the work force—and a CULTURE committed to performance
• The work force INCLUDES physicians, other clinicians, management, support staff, volunteers, and board members
**Alignment**

Improved communication, trust-building, involvement in decision-making, joint ventures

**Engagement**

Pronounced enthusiasm characterized by belonging, pride and loyalty which foster a mutually committed relationship between physicians and organizations resulting in the enduring pursuit of organizational goals and career enrichment

**Integration**

Not just structural, but operational synchronization of services to provide optimal, efficient, effective patient-centered care
The Role of Culture

• Culture is a driver of alignment and engagement

• Blending diverse cultures is a major challenge to governance and management

• Mergers and acquisitions—of other hospitals or of physician practices—can be a major source for culture clashes
The Role of Measurement

“If you can’t measure it, you can’t manage it”

• Performance? Absolutely! Quality, safety, patient satisfaction, efficiency

• Culture? You bet! An array of organizational characteristics that drive engagement

• Engagement? Yes! Enthusiasm, pride and dedication to the organization among multiple subsets of the workforce, including physicians
A Cautionary Example

Physician discontentment and cultural differences appear to have ended the six-month merger talks between Henry Ford Health System and Beaumont Health System.

MODERN HEALTHCARE
MAY 21, 2013
The Concept

SPECTRUM OF INTEGRATION ACROSS AMERICA’S HEALTHCARE DELIVERY SYSTEM

“Typical” Community Hospital

Single MDs
Small Groups
Single Hospitals

Less Integrated or Organized Systems

Independent Physicians
IPAs
Single Specialty Groups
Hospital Chains

Hospital Staffs;
Some Academic / Faculty Practices

More Integrated or Organized Systems

Multispecialty Groups +/- Hospital Affiliations
Marshfield Clinic
Harvard Vanguard
Vanderbilt U

Integrated Delivery Systems;
Henry Ford
Mayo
Geisinger
Ochsner

CAPPs

Fully Integrated Systems
Kaiser
Group Health
Co-op
VA

www.amga-capp.org/deliverysystem.html
It’s HARD Work!

• Much more than an org chart
• PCP / specialist coordination
• Coordination across ambulatory, hospital, home care, LTC settings
• Seamless integration of clinical information
• Patient engagement and self-care
• Social services, as well as medical
• And more!
Criteria for Group* Membership

1. Provides high quality patient care as defined by best practices (evidence based)

2. Meets/exceeds patient expectations

3. Operates in a financially responsible manner

4. Respects clinical autonomy but adheres to best practices

5. “Captures” appropriate referrals within the network

6. Leverages information technology

* Multi-Specialty Group
Work Smarter
GOVERNANCE FRAMEWORK
# A Responsibility Framework

## Board Fiduciary Responsibilities

<table>
<thead>
<tr>
<th>Core Content Areas</th>
<th>Activities</th>
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<tbody>
<tr>
<td></td>
<td>Policy</td>
</tr>
<tr>
<td></td>
<td>Delegation &amp; Oversight</td>
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<tr>
<td></td>
<td>Decision-Making</td>
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<table>
<thead>
<tr>
<th>Board performance</th>
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<tr>
<td>Management performance (including compensation)</td>
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<tr>
<td>Quality</td>
</tr>
<tr>
<td>Finance</td>
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<tr>
<td>Strategy</td>
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<tr>
<td>Community Benefit</td>
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Board Structure Guidelines

1. Right size
2. Right people
3. Annual calendar
4. Meeting frequency & duration
5. Committee structure
6. Meeting agendas
7. Board portal
Board Process Guidelines

1. Conduct an annual board self-assessment
2. Conduct individual member evaluations
3. Establish and review annual board goals
4. Create written board policies and procedures
5. Focus on effective meetings
6. Implement board leadership development / succession
The board scorecard (governance) is different than the management (operations) scorecard and focused on:

• Operations Outcomes
  - Quality
  - Satisfaction
  - Finance
  - IT
  - Growth
  - People
• Strategy
• Board Performance
Some Governance Best Practices

- Written job description for board members
- Selection for skill set—-not popularity
- Diversity
- Formal on-boarding / orientation process
- Board development / education
- Regular evaluation of individual and aggregate performance
A Harsh Dose of Reality

• Depending on system structure, clarity on roles and responsibilities of component boards can be difficult to achieve

• Balance is essential between
  – Centralization of control, processes, culture, etc.
  – Maintenance of local autonomy and ability to respond to local conditions
Admonition

1. Common Sense
2. Fortitude
3. Discipline
UnityPoint Clinic
January 1, 2012

IOWA HEALTH
PHYSICIANS AND CLINICS

ST. LUKE'S
IOWA HEALTH SYSTEM
Physicians and Clinics

TRINITY
IOWA HEALTH SYSTEM
Physicians and Clinics

IOWA HEALTH
PHYSICIANS AND CLINICS
Methodist • Lutheran • Blank

ALLEN HOSPITAL
IOWA HEALTH SYSTEM
The Health System
- 9 Regions Across IA, IL, WI
- 17 Owned Hospitals
- 15 Community Network Hospitals
- Provider-Owned Insurance Company
- Independent & Employed Providers
- $3.7B Annual Revenues
Governance—Two Perspectives

Health System
Multi-State Health System
501(c)(3) Nonprofit
Traditionally, Hospital-Led

The Clinic
Subsidiary of Health System
501 (c)(3) Nonprofit
Physician-Led
>1,200 Providers & 280 Sites
Health System Structure
Prior to 2012

- A Regional Senior Affiliate is defined as a distinct region with one or more hospitals
- Physicians are employed by Senior Affiliates
Board of Directors
Prior to 2012

• Representational board
• Independent physicians may be appointed to the board
• Bylaws prohibit employees from serving as board members, including employed physicians
Health System Structure
After January 1, 2012

- Clinic on par with Regional Senior Affiliates
- Physicians are employed by the Clinic
Fee for Service with Performance Incentives

Shared Savings (ACO)

Partial Capitation

Full Capitation
Clinic Governance Structure

- **Board of Directors**
  - Maximum 15 members
    - 8 Community Members
    - 6 Practicing Providers
    - 1 Regional Sr. Affiliate CEO

- **Physician Governing Council (PGC)**
  - Maximum 17 members
    - UPC CEO (physician)
    - 16 Practicing Providers
    - ≈ Up to 5 at-large
    - ≈ At least one AP
    - No less than 25% primary care
    - No less than 25% specialists

- **Regional Provider Councils (RPC)**
  - Maximum 13 members
    - Regional VP/Medical Director
    - Regional Sr. Affiliate CEO
    - 11 Practicing Providers
    - ≈ Two at-large
    - ≈ At least one AP
Role of Physician Governance Council

- Make recommendations to the Board of Directors with a primary focus on strategy & policy
- Provide oversight of organizational performance
- Support and advise management
- Makes decisions as authorized by the Board
- Reviews but does not vote on compensation

*The PGC does not engage in management functions*
Top Four Lessons Learned

1. Governance is not intuitive
2. Physicians are people too
3. Representational governance presents challenges
4. Best to Engage Both Independent and Employed Physicians at System Level
Governance is Not Intuitive

Governance

Professional Autonomy

Management
Physicians are People Too

- Self-actualisation
- Esteem
- Social
- Safety (Autonomy)
- Physiological (Compensation)
Representational Governance Presents Challenges

Diversity...Expertise... Focus...Fit
Best to Engage Both Independent and Employed Physicians at System Level

• All physicians are conflicted
• Clinical integration is the goal
• 2014 Bylaws Amendment

Section 5. Employees. Except as to any physician employee appointed as a director ... no employee of the Corporation or of any entities controlled by the Corporation shall serve as a director or a non-voting director of the Corporation.
A Journey of Multiple Destinations
WRAP UP
Surviving The Ordeal

Between a Rock and a Hard Place

Aron Ralston
Bill Jessee joined INTEGRATED Healthcare Strategies in October, 2011, after serving for more than 12 years as President and Chief Executive Officer of the Medical Group Management Association (MGMA). He also holds an academic appointment as Clinical Professor of Health Systems, Policy and Management at the University of Colorado School of Public Health.

Dr. Jessee is one of the nation’s leading experts on physician services management and hospital-physician integration. In particular, he is skilled in the development and implementation of strategies for creating aligned economic interests among physicians, hospitals and payers. He is also widely recognized as an expert on health policy issues, and the role of governance in quality improvement and patient safety.

Before joining MGMA, Dr. Jessee was Vice-President for Quality and Managed Care Standards at the American Medical Association. His experience also includes service as CEO of a regional integrated delivery system in Louisville, Kentucky; as a Vice President of the Joint Commission on Accreditation of Healthcare Organizations; and as corporate Vice President for Quality Management at Humana Inc. From 1980 -1986, Dr. Jessee was a full time academician as Associate Professor of Health Policy and Administration at the University of North Carolina, School of Public Health, Chapel Hill.
Dr. Kaplan currently serves as President/CEO of UnityPoint Clinic and UnityPoint at Home. UnityPoint Clinic is a physician-led, multi-specialty medical group comprised of 1,200 providers serving patients across Iowa, Illinois and Wisconsin.

UnityPoint at Home is a multi-regional home health organization with a full portfolio of services including home care, infusion pharmacy, medical equipment, palliative care and hospice with $100M annual operating revenues.

Dr. Kaplan additionally serves as Senior Vice President/Chief Clinical Officer for UnityPoint Health, which realizes $3.8 billion in annual net operating revenues and is comprised of 17 hospitals and operates an ACO with 325,000 patients covered under shared savings contracts. Dr. Kaplan is responsible for system-wide physician alignment and clinical transformation. Dr. Kaplan has served in his current role since June 2009.

Prior to joining UnityPoint Health, Dr. Kaplan worked at Edward Health Services Corporation in Naperville, Ill., where he served as Vice President, Chief Medical Officer & Operations.

Dr. Kaplan is residency trained and board certified in Emergency Medicine. He earned his Master of Medical Management from Carnegie Mellon University in 2000. He graduated from Rush Medical College in 1985. Dr. Kaplan is a Fellow of the American College of Physician Executives and of the American College of Healthcare Executives. He is a Past President of the Board of Directors for the American College of Physician Executives. Dr. Kaplan has been twice named to Becker’s top 100 list of physician leaders of hospitals and health systems.
BIBLIOGRAPHY
Governance Culture and Performance Improvement

It starts at the top and spreads throughout the organization.

Healthcare is awash with admonitions for provider organizations to prepare for the transition from volume to value. This uncertainty will succeed only if it is based on a culture of performance improvement, where quality, not cost, is the driver. Most board members already understand this and encourage their management and physician leaders to drive the change. But the process of instilling the ultimate quality culture is a marathon, not a sprint, and must be persistently driven by board leadership.

In a September 2013 USA Today article, Starbucks CEO Howard Schultz said, “The secret sauce [to success] is the culture and values of our company. Many companies today are reducing hours of full-time people.” To avoid healthcare expenses... “That is a short-term solution and, ultimately, is not going to add value to the enterprise, the company and customers.”

Despite the volumes written by organizational development experts, culture is hard to define. However, there are a number of cultural indicators at the governance level.

The Board-CEO Relationship
Culture starts at the top, beginning with the board and CEO. Consider Berkshire Hathaway Chairman and CEO Warren Buffett and his son Howard. In a 60 Minutes interview that aired December 2011, the famous businessman said despite his son, a farmer, lacking his father’s investment background, he, nonetheless, will take the reins as chairman of Berkshire Hathaway upon his father’s retirement to be what the news segment called the “guardian of the culture.”

It’s imperative the CEO and board chairman work diligently to fill positions with members who understand the organization’s values and can help create the desired culture.

Board Characteristics
With the right people in place, an effective board will display these team characteristics, according to The Wisdom of Teams: Creating the High-Performance Organization (Harper Business, 2005):

- Participative leadership: a leader style that involves and engages team members.
- Effective decision making: a blend of rational and intuitive methods, depending on the nature of the task.
- Open and clear communication: effective communication methods and channels.
- Valued diversity: different viewpoints solicited, leading to better decision making and solutions.
- Mutual trust: trusting in other team members and trusting in the team as an entity.
- Clear goals: measurable criteria to build commitment and engagement.

Right sizing
There is no discernible evidence that small boards (10 or fewer members) are more or less effective than large ones (20 or more). In The Governance Institute’s 2013 biennial survey, system boards had an average of 17 members, subsidiary boards had 15; independent hospital boards had 15; and public hospital boards had eight members. These statistics have changed very little since 2009. Still, we concur with the thinking of many boards already reducing in size, or planning to during the next three to five years, to improve communication and increase time for policy setting, education and strategy discussions.

Some argue, however, small boards won’t have enough people to get the work done, will lack diversity or won’t be able to provide appropriate oversight. Conversely, we have seen no evidence that larger boards tend to be more diverse in terms of gender, race, ethnicity, age or socioeconomic status. During the last few years, we have informally polled a few thousand board members from all types of organizations across the country, and most agree with the hypothesis that eight to 10 members are sufficient to conduct the board’s work, and the appointment of subcommittees should be eliminated for the purpose of recognizing that the board has one job description, and job sharing is difficult to begin with, potentially more so if someone else is selecting your colleagues. For officers, members sometimes come with priorities that may not be aligned with the fiduciary duties of the board.
In this regard, it is imperative that boards value the clinical input of physicians and nurses on the board (especially now, considering the dramatic changes taking place in the way care is delivered); however, there are several other ways to include the proper clinical input at the governance level without tying them to representation of the medical/clinical staff.

With few exceptions, we believe ex officio positions should be eliminated for the purpose of recognizing that the board has one job description, and job sharing is difficult to begin with, potentially more so if someone else is selecting your colleagues.

Other Tactics to Support Performance Improvement

Beyond richtigising, there are a number of other techniques boards can employ to develop and support a culture of performance improvement, which are described below.

Chair succession. Many boards could do a better job of identifying committee and board chairs in advance. This is a process that should begin with the selection of new board members by simply asking, “Do we see our future leadership in this group?”

Board scorecards. Boards need their own scorecards, separate from scorecards for management and committees. There should be a drop-off of information from operations to the committee to the board. A periodic board finance scorecard, for example, might have 30 indicators—half from the income statement and half from the balance sheet. This keeps the board focused at the right interim level and saves precious time. An important conversation for the CEO to have with the board is to ask how the information presented to the board should be different from the reports used by management.

Nonboard members. Use of nonboard members on committees is a great way to supplement board expertise, spread the work and assess potential board members. These committee members must be subjected to the same code of conduct regarding confidentiality and conflicts as board members.

Consent agenda. The vast majority of boards now use a consent agenda, but many do not use it to its full potential. Reviewed in advance, items come off the consent agenda only when requested before the meeting. The logic is simple: The chair is expected to run an effective, timely meeting, and this requires knowing how to structure the agenda.

Self-assessment. In order to improve their own performance, boards must have a standard against which to measure themselves. High-performing boards will take advantage of the opportunity to make improvements by using these tools on a periodic basis.

Individual assessment. This is a simple, straightforward process in which all board members should participate. For boards with term limits, each individual should be assessed before reappointment.

Fewer meetings. Any board that is appropriately focused on its fiduciary duties, strategy, policy setting, delegation and oversight doesn’t need to meet every month. There are many examples of high-performing systems and independent boards that meet only four to six times a year.

Web portal. Most boards now use a Web portal to review board information, and many organizations supply members with tablet computers to gain access. They report great satisfaction due to improved communication, availability of information and, of course, environmental sustainability.

A high-performance culture of continuous improvement starts with the board itself and spreads throughout the organization. As healthcare moves from volume to value, boards must adopt best practices in governance to provide the leadership needed to create a culture of positive change.

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