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Health CareRx

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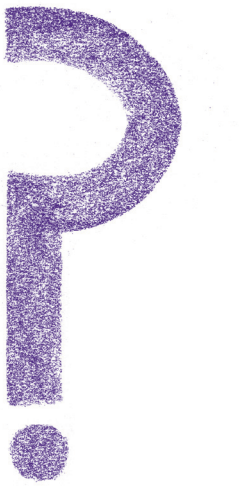
Governance in a dynamic health care environment: A Q&A with Anne McGeorge and Dr. Lawrence Prybil

Health care as a business is changing dramatically. Between health care reform, shrinking reimbursements, accountable care, electronic health records, new technologies, growing scrutiny from regulators and other transformative aspects of health care, hospitals and health care systems are under more pressure than ever to adapt for the future. Effective governance is more important than ever, but what are the best governance features at leading health care systems?

Governance in USA's Largest Nonprofit Health Systems examines the systems' governance structures, practices, and culture in relation to contemporary benchmarks of good governance. The findings, which will be released in spring 2012, are based on 71 on-site interviews with CEOs and senior board leaders in 14 of the country's 15 largest nonprofit health care organizations.

We recently sat down with Dr. Lawrence Prybil, principal investigator of *Governance in USA's Largest Nonprofit Health Systems* and an earlier study, *Governance in High-Performing Community Health Systems*; and Anne McGeorge, national managing partner of Grant Thornton LLP's Health Care practice, to learn more about the current state of governance practices at some of the leading health systems in the United States.



What are the key factors that drive performance in health care systems?

Prybil: There are several factors that have emerged across the country. From the perspective of boards of large systems, there is clear recognition that, because the environment is increasingly difficult and the challenges are becoming greater, establishing and maintaining a strong, values-based leadership team is absolutely imperative. This has always been vital, but it is more critical than ever in today's environment. Boards realize now that management and clinical leadership together are the driveshaft of maintaining and strengthening performance.

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McGeorge: We see executive and clinical leadership working as a team like never before. A strong bond between the CEO and clinical leadership is essential — especially now as integrated delivery networks are emerging as the model for the provision of high quality, cost-efficient patient care. If there aren't synergies between the management team and clinical leadership, the board ends up having to take action.

How is the role of physicians changing?

McGeorge: We have learned from talking to physicians, especially physicians new to the profession, that most don't want to be in a stand-alone private practice. They see integration as their future. This is a distinct shift from what we witnessed 10 to 15 years ago. Now, it seems like there is a much more positive attitude about teaming with hospitals.

There also are more administrative leadership opportunities for physicians within health care systems than in the past. A growing number of physicians are rising to executive ranks within hospitals. For example, many health systems have physician CEOs. Also, we see more physician organizations where physicians have their own board and make their own decisions as a physician organization, but are still affiliated with the hospital organization. This has worked well as it gives the physicians independence, while still maintaining their alignment with the health system's mission and strategy.

As hospitals pursue growing integration and coordination with physicians, what are the biggest challenges they face?

Prybil: Regardless of the exact organizational model for integration and coordination, what is paramount is that the organization establishes common metrics, shared information systems, and a clear organizational vision and direction. There must be one vision of how to get from here to there, and transparent financial and information systems that allow everyone to be looking at the same scoreboard and measures. Without these, how will the organization know if its performance is proving to be successful?

McGeorge: A shared vision and consolidation of systems and metrics are definitely the goals, but these can be a challenge for large health systems with many disparate systems. Trying to consolidate and streamline processes and information systems is a huge undertaking. For example, I was with a client yesterday, whose organization has 120 different financial systems alone. As they evaluate how to streamline their technology solutions, they are trying to create a common dashboard that will bring together all of their data into consistent metrics for decision-making. The challenge is streamlining information systems in a cost-efficient manner.

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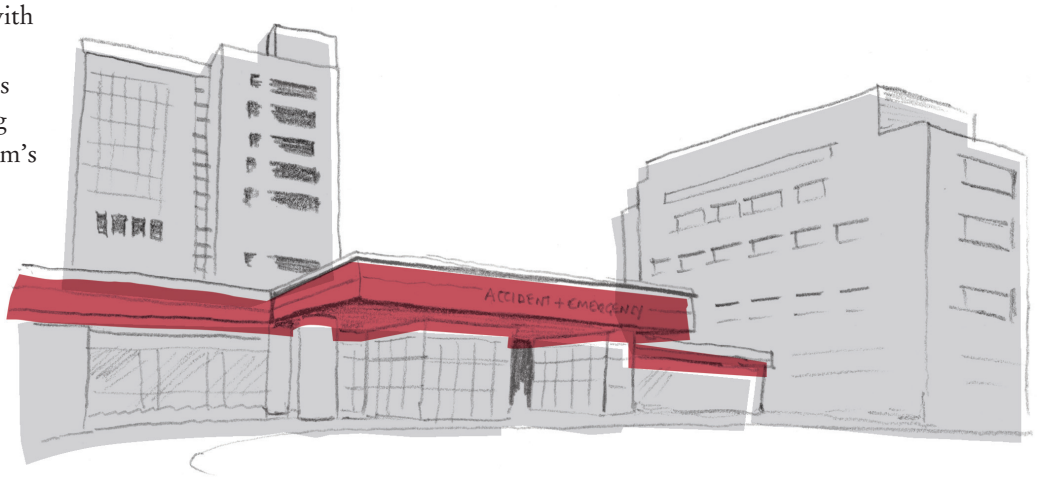
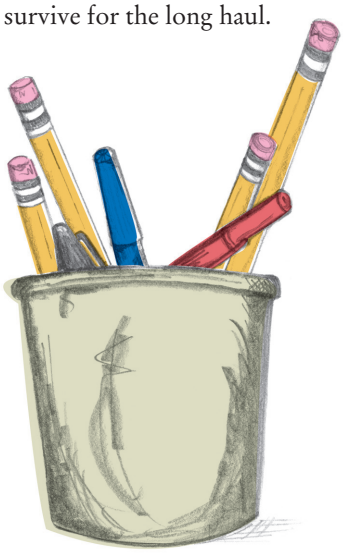


One of your preliminary study findings is that boards are spending more time on strategy than in the past. How are boards becoming more strategic in their thinking?

Prybil: One of the striking findings from our current study of governance in these large health systems, *Governance in USA's Largest Nonprofit Health Systems*, is the growth in attention and focus at the board level on strategy and strategic thinking. The boards of all these large systems recognize that they need to refocus how they spend their time, which is their most precious asset. Boards are making deliberate efforts to carve out more time for strategy and strategic thinking, and decrease the percentage of time they allocate to shorter-term, operational issues. Among these health systems, nearly 30 percent of board meeting time currently is being devoted to strategy and strategic thinking.

Boards recognize that the world and the health care environment have changed dramatically, and that their systems too must change. We cannot just focus on providing acute inpatient care to those that come to our doorsteps. Instead, we need to be asking questions about how to accommodate the needs of a changing population and new financial realities. We need to be able to live within Medicare rates. If we believe this is the likely scenario, how can we change from what we've been to what we need to be? Moreover, how can we do this while still preserving our system's values and soul in the process?

McGeorge: The health care delivery model is gradually changing from a fee-for-service model to a model of preventative wellness and payments for quality outcomes, more like an HMO or capitated environment. Ultimately, systems need to evolve. This doesn't happen overnight. These are entirely new challenges – ones that many boards didn't have 10 to15 years ago. If they don't do something to change, hospitals will not survive for the long haul.



What kinds of training do boards need as they sharpen their focus on strategy?

McGeorge: We think that boards need some training in how to think strategically. Some organizations — and we applaud them — are holding strategy retreats, where they have outside speakers and strategy consultants who help them challenge the status quo. Another area that can be helpful for boards is training on how to identify big-picture, enterprise wide risks that will affect the organization, such as competitors coming into marketplace, not integrating physicians quickly enough, not reacting to changes quickly enough, etc.

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How do high-performing boards differ from ordinary boards?

In addition to sponsoring *Governance in USA's Largest Nonprofit Health Systems*, which will be released in spring 2012, Grant Thornton also sponsored a 2009 study authored by Dr. Prybil, *Governance in High-Performing Community Health Systems: A report of trustee and CEO Views*, focused on the governance practices of leading community health systems. The study concluded that high-performing boards are more likely than other boards to:

- engage in formal assessments of how well they are carrying out their fiduciary duties,
- spell out roles and responsibilities of standing board committees in written board-approved charters,
- have a process that their CEO believes is effective for evaluating board performance,
- regularly engage in formal discussions about their organizations' community benefit responsibilities and programs,
- collaborate regularly with other local organizations in community needs assessment,
- have formal system-level policies and plans with measurable objectives for community benefit programs,
- receive regular reports on their organizations' progress toward established community benefit objectives, and
- engage in active discourse and decision-making processes in which board members are willing to express their views and constructively challenge each other and the management team.

Governance in a changing health care environment: A Q&A with Anne McGeorge and Dr. Lawrence Prybil (continued)

Prybil: Boards and the management and clinical leadership are still grappling with what they should be looking at in terms of quality and safety. There is an explosion of measures and methods in this area. Medicaid just came out with a new study on quality measures. The National Quality Forum and other organizations have released more measures. One of the daunting challenges for boards is to understand: What do we need to look at versus what the quality committee needs to look at versus what local leadership needs look at? What are the right targets to set? If our objective is to reduce hospital-acquired infections, what are the right measures and targets? When you give a board dozens of quality and safety measures to review, their eyes glaze over. There are so many gauges and dials and flashing numbers – but what does the board really need to be looking at? •

Lawrence Prybil, PhD, FACHE

Dr. Lawrence Prybil is professor of health services management and associate dean in the University of Kentucky College of Public Health, and professor emeritus at the University of Iowa College of Public Health. Dr. Prybil is a fellow in the American College of Healthcare Executives and received his master's and doctoral degrees from the University of Iowa College of Medicine. He has served on the governing boards of hospitals, multi-unit health systems, state hospital associations, the American Hospital Association (AHA) and other nonprofit and investor-owned organizations. He currently serves on the National Board of Advisors of the AHA's Center for Healthcare Governance and the board of managers of the Catholic Healthcare Audit Network. He has authored or co-authored over 80 publications. He is recognized for his expertise in organizational governance and leadership, and currently is directing the third in a series of studies regarding governance structures, practices, and cultures in nonprofit hospitals and systems.

Anne McGeorge

Anne McGeorge is the national managing partner of Grant Thornton LLP's Health Care practice, and has represented health care clients for almost 25 years. She has worked extensively with large health systems, academic medical centers, managed care organizations, coalitions and purchasing organizations, health care private equity firms, and physician practices. She has assisted clients in all aspects of financial consulting. McGeorge also focuses on helping clients with establishing community health needs assessments and board governance benchmarking. She has assisted with the publications, *The Tax Economics of Charitable Giving, A Guide to Navigating Intermediate Sanctions, The Essentials of Physician Practice Management,* and *Governance in High-Performing Community Health Systems.* McGeorge was selected as a "Woman Extraordinaire" by *Business Leader* magazine in 2011 and named one of Charlotte's "Most Influential Women" in 2010 by the *Mecklenburg Times*.

About the newsletter

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