



The Board's Role in Holding C-suite & Physician Leaders Accountable for Transformative Change



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Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association and the Center for Healthcare Governance.

Your Speakers



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Your Speakers



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Session Learning Objectives

- Highlight 4 areas of focus boards should hold hospital leaders accountable to in order to thrive in the transformed healthcare environment
- Articulate best practice examples with regard to areas of focus
- Provide strategies and tools boards can leverage to instill accountability
- Facilitate knowledge sharing amongst the participants

Agenda

- Set the context of the “New World”
- Share 4 areas of focus to drive healthcare transformation
- Provide an overview, accountability strategies, and best practice example for each area of focus
- Q&A

Shift to the “New World”

PERFORMANCE

First Curve

Fee-for-Service
Quality Not Rewarded
Pay for Volume
Fragmented Care
Acute Hospital Focus
Stand Alone Providers Thrive

Straddle



Second Curve

Value Payment
Continuity of Care Required
Systems of Care
Providers at Risk for Payment
IT Centric
Physician Alignment

Revenue Drops
Minimal Reward for Quality
Volume Decreases

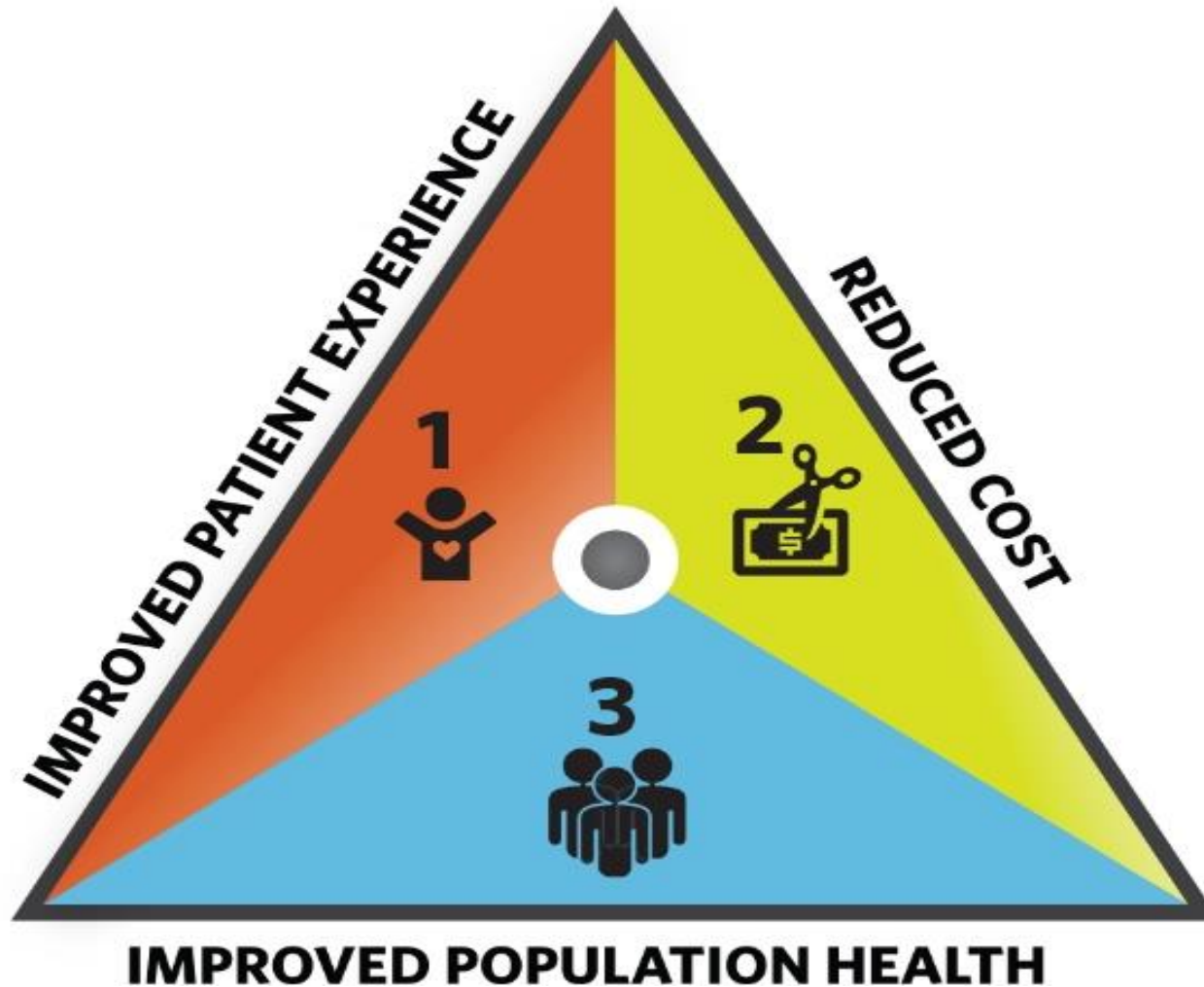
No Decisive Payment Change
Pay for Volume Continues

High Cost IT Infrastructure
Physicians in Disarray

TIME

Triple Aim

Three Dimensions of Value



The Role of the Board

- Get and stay educated (e.g., terms and trends)
- Engage physicians and other clinicians in joint education, discussions, and planning
- Add clinicians to boards and committees (appropriately)
- Develop a baseline assessment of your organization's clinical integration capabilities and current physician alignment
- Convene strategic planning retreats to determine vision for the future (e.g., ACO, medical home) and set measurable indicators of success
- Monitor progress toward the clinical integration strategies and goals
- Hold management and physicians accountable for achieving the desired level of clinical integration and physician alignment

Accountability Leads to Lasting Partnerships

- Drive more collaboration
- Make better decisions
- Work through inevitable conflict effectively
- Create real alignment to put patients first

4 Areas of Focus Required to Drive Healthcare Transformation

- Talent Management
- Clinical Integration
- Value-Driven Care
- Patient Experience

1: Talent Management

Talent Management is Necessary to Be Positioned for Success

- Healthcare leaders must meet growing demands and complexity related to the shift to a value-based system
- The healthcare industry has been faced with the crisis of high turnover and talent shortages
- Increased importance of attracting, preparing and retaining talented clinical and non-clinical leaders to:
 - Manage the challenging healthcare climate
 - Meet the ambitious expectations of health reform
 - Reduce costs
 - Ensure quality of care



Common Evidence of Problems in Talent Management

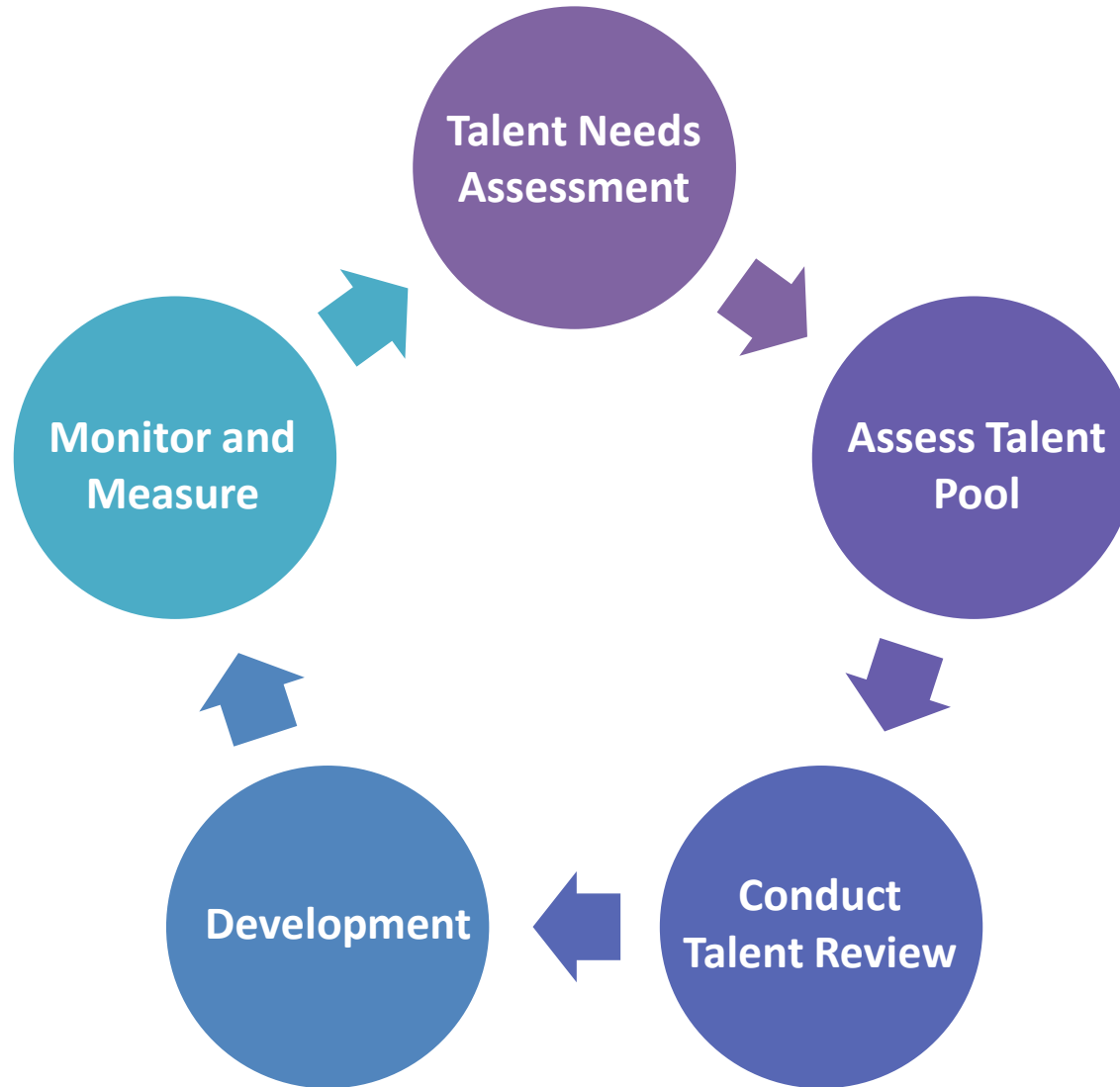
- Lack of bench strength is concerning Board/Execs
- Politics & popularity vs. qualifications
- Key roles unfilled for long periods
- Unsuccessful replacements
- Emergency/Key Roles filled from outside
- High turnover among HIPOs

Best Practice Talent Management

Boards at top-performing companies understand issues related to executive talent (e.g. CEO succession) and non-executive talent (e.g. employee engagement)

1. Include issues that impact critical talent segments such as:
 - Engagement capital
 - Employee value proposition
 - Workforce planning
2. Increase executive accountability for talent outcomes by developing robust talent measures with clear links to business value
3. Strengthen CEO succession strategies by actively broadening rising leaders' experience profiles

Talent Management Model



Adapted from:

- Church & Silzer (2013)
- *CEO insights* (2004, April)

How it Works?

- Develop future-focused competency model
- Create success profiles
 - Identify essential skills and experiences needed to meet the demands of the role
 - Define leadership expectations
 - Identify behavioral and cultural competencies
- Assess talent utilizing:
 - Interviews
 - Psychometric assessments
 - 360 Feedback
- Monitor performance against metrics for success
- Continuously improve

Best Practice Example: Newton Medical Center

Situation

- Reduced reimbursement and transition to value based care necessitated a re-organization at Newton Medical Center (NMC), a general medical and surgical hospital in Newton, NJ.
- Board held C-suite responsible for executive staff reductions without an interruption in quality or cost.
- Creation of newly combined role, CNO/COO to report directly to the CEO.

Solution

- Board collaborated with CEO to design a success profile approach borrowed from corporate best practice.
- Design of a success profile for new position to identify, assess, and select candidates for the role.
- Board member on selection committee for new executive.

Results

- Accelerated on-boarding of new executive.
- Better integration into C-Suite and NMC.
- Board alignment to succession planning.
- Performance measures of success in top 10% for new role.

Questions to Consider

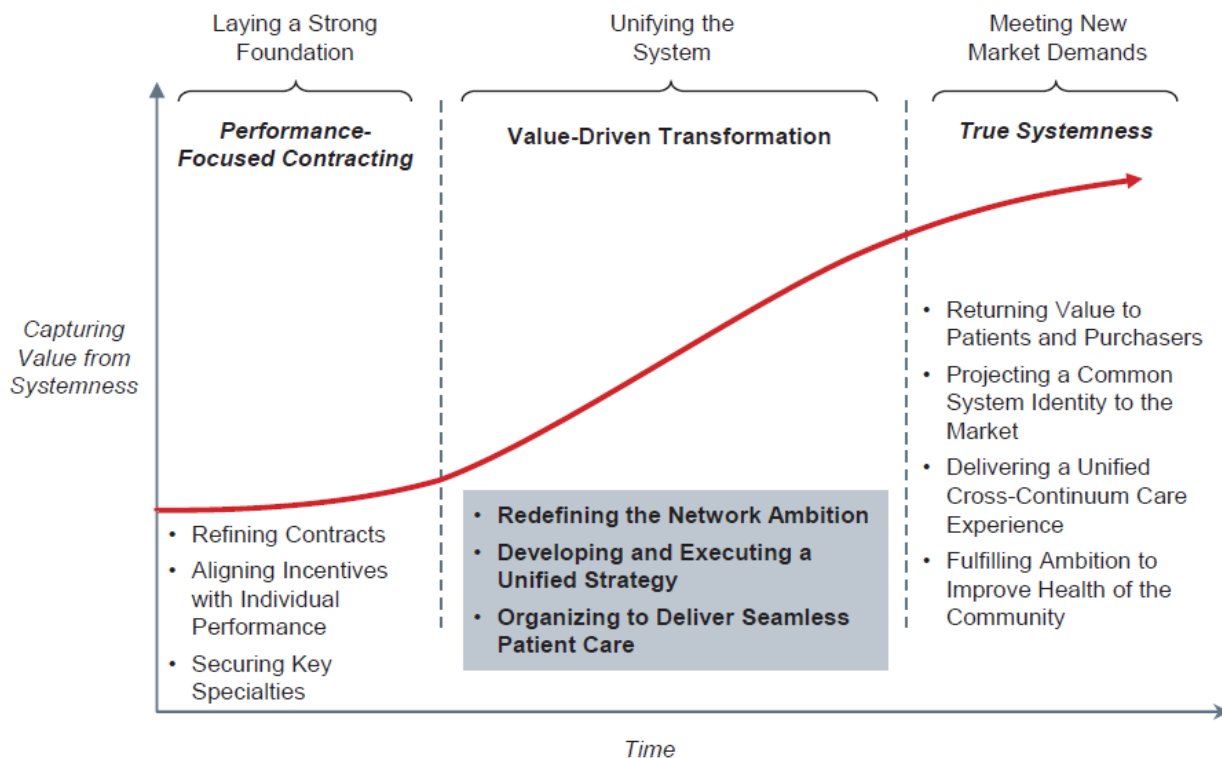
1. Do you have a formal succession plan in place for all of your C-suite leaders?
2. Have you clearly articulated what new skills and competencies your organization will need to thrive in a transformed clinical delivery system?
3. Have you considered strategic partnerships with other organizations and consultants to supplement your in-house talent?
4. Is your culture transparent enough to support holding each other accountable?
5. Does your culture encourage cognitive conflict or do you shy away from disagreements?

2: Clinical Integration

Physician Integration is Required to Meet Market Demands

New Compact Must Be Built on Strong Contractual, Operational Foundation

Evolution of Hospital-Physician Partnerships



Source: The Advisory Board, "From Contract to Compact Moving Physician Partnerships Beyond Financial Alignment to Create a Culture of Clinical Success," 2012.

Clinically Integrated Organizations vs. Others

| | Geisinger Health System | Intermountain Healthcare | Average Health System |
|---|---|--|---|
| 1 Physician Alignment & Leadership | Physician leaders Physician involvement on board and committees | Integrated clinical and financial management systems | Administration leads; not physicians Physician involvement in governance limited |
| 2 Care Management Programs | Initiatives and guidelines across the continuum (e.g., PCMH, navigators) | Care management medical home model | Disparate care management, minimal coordination |
| 3 Data and Information Sharing | Wide electronic medical record use | Advanced EHR: reminders, care pathways, and predictive modeling | Hospital EMR, imaging and lab systems, physician practice management, and limited EMR |
| 4 Quality Monitoring Program | Financial incentives for hospital and physician quality reporting | Physician financial incentives | Hospital reporting, limited physician reporting, no financial incentives |
| 5 Payment Arrangements | Innovative payment models with integrated provider health plan (e.g., bundling, etc.) | Innovative payment models with integrated provider health plan (Select Health) | Standard FFS and some pay-for-performance; little bundling |

Key Ingredients of Clinical Integration

Physician Alignment & Leadership

Care Management Programs

Data and Information Sharing

Quality Monitoring Program

Payment Arrangements

Active Physician Involvement & Leadership is Key to Success

- Trusting relationships, built through doing real work together
- Active, committed physician participation in all plans and processes (e.g., vision and goal creation; clinical protocol development; quality and cost improvement processes)
- Rigorous credentialing and monitoring of participating physicians to ensure high quality
- Physicians leading all efforts (e.g., dyad management), supported by robust physician leadership development “institute”
- Physician involvement in management and governance at all levels of the organization

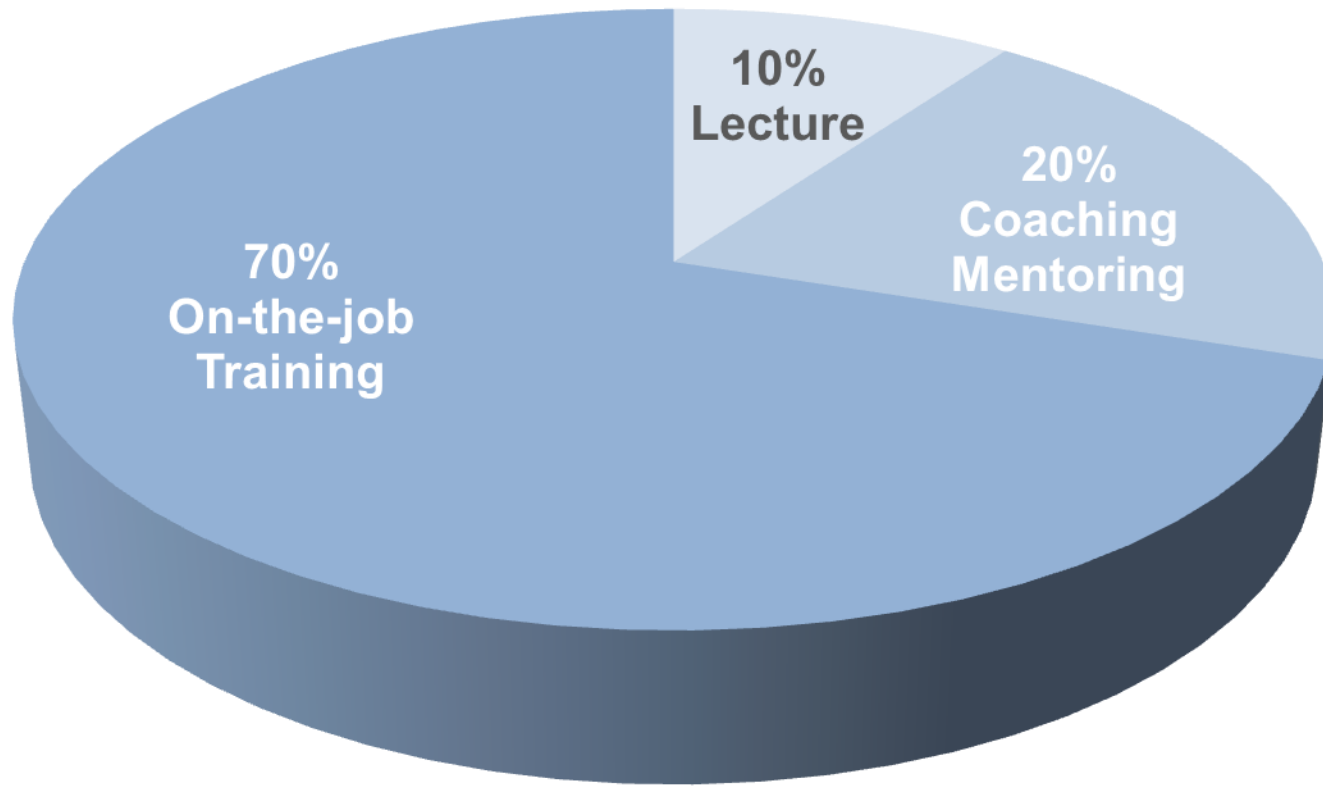
Best Practice – Competency Model

PHYSICIAN LEADERSHIP SUCCESS MODEL



Best Practice: Physician Leadership Development

Physician leaders will benefit most from learning that occurs on the job and with interaction from peers, coaches and mentors.



Best Practice Example: Palomar Health

Situation

- 3 Hospital System in San Diego, California
- Need to develop physician leaders as partners in meeting system, operational and clinical performance goals
- Determined to create clinical (physician and nurse) leader partnerships
- Lack of formal physician leadership (CMO) on senior management executive team
- Lagging performance on HCAHPS scores

Solution

- 1:1 assessment and coaching, including emotional intelligence (EI) development
- Learning modules and application sessions
- Partnership Activation projects

Results

- Improved Press Ganey scores (physician, nurse, and overall ratings)
- Increase in HCAHPS scores on the question “My physician listens carefully to me”
- Participants gained valuable learning competencies including:
 - Knowing their role as a physician leader
 - Having a clear purpose for their partnership relationship(s)
 - Driving patient satisfaction and physician engagement

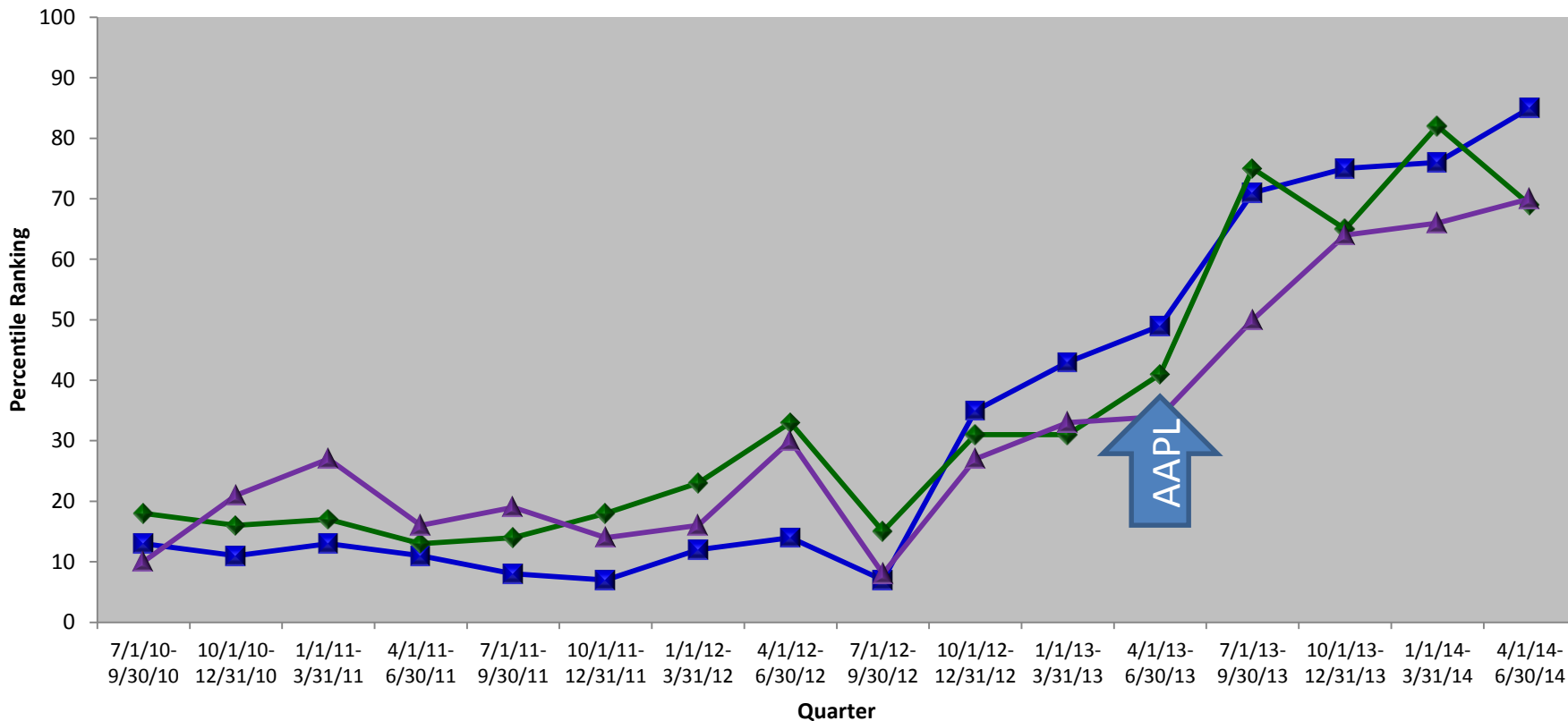
Results



Palomar Health - OVERALL PATIENT SATISFACTION PERCENTILE RANKINGS Press Ganey Overall System, Nursing, and Physician National Rankings



***Official Quarterly Results**



■ Overall System Percentile Ranking
▲ Overall Physician Percentile Ranking

◆ Overall Nursing Percentile Ranking

Questions to Consider

1. Is your organization taking responsibility for the quality of the care delivered across the continuum of care in your community?
2. Do all of the doctors who practice in your system understand the strategic goals of the organization?
3. Do physicians feel as though they are heard and have a say in the direction of your organization?
4. Have you developed leadership training programs for your physicians, nurses, allied health, and other staff?
5. Have you made your organization attractive to payers and employers in your community who are trying to control costs?

3: Value-Based Care

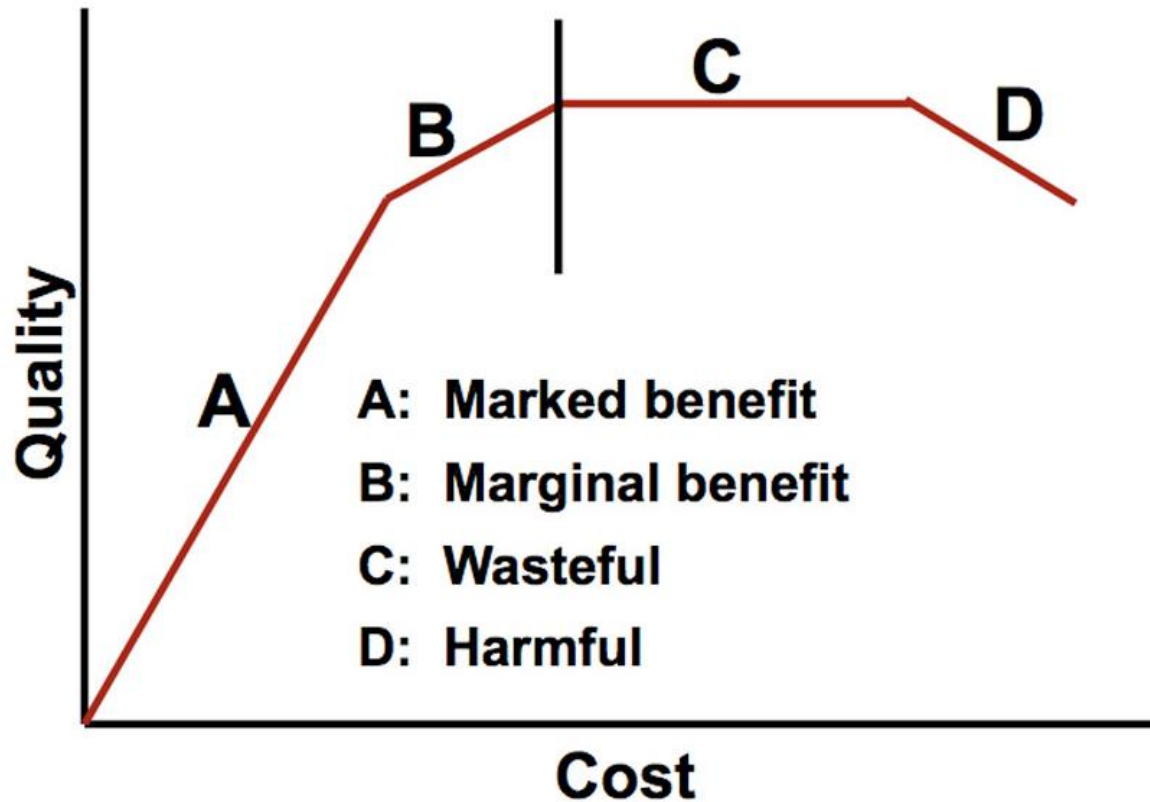
Value-Based Care

- Programs that link hospital and physician financial reimbursement to performance on quality and cost
- 3 main types of payment models are being introduced by CMS and private payers
 - P4P
 - Shared savings
 - Bundled payments

Need to Drive Leadership to Be Successful in New Payment Models

- Impact of moving away from volume-based, fee-for-service payment to new payment models
 - Determine new economic model that creates the profit necessary to sustain the business
 - Assume more risk
- Declining reimbursement and rising costs - more concern re: bottom line
 - Need to provide better care for less money
- Increasing data transparency

The Cost-Quality Curve



- A:** Marked benefit
- B:** Marginal benefit
- C:** Wasteful
- D:** Harmful

Goal: Move curve to the left

Rand Study Identified Features Associated with Successful Value-Based Purchasing Implementation

- Sizeable incentives
- Measure alignment
- Provider engagement
- Performance targets
- Data and other quality improvement support

Culture that Supports Value-Based Care

- Organizational nimbleness
- Willingness to change
- Willingness to honestly identify problems
- Ability to correct defects
- Promote innovation

Best Practice Example: Blue Cross Blue Shield of MA Alternative Quality Contract

Situation

- State wanted to try innovative ways to pay hospitals and physicians and support the Triple Aim
- Distrust between providers and payers
- Lack of engagement of physicians
- Skepticism about new payment models

Solution

- Alternative Quality Contract with global budgets and long-term contracts
- Regular information updates on spending and quality

Results

- Improved health outcomes 12 points above national average
- Documented savings
 - 2009 - 2.4%
 - 2010 - 3.1%
 - 2011 - 8.4%
 - 2012 - 10%

Bottom Line

“There must be total ownership of the medical staff for the reputation of the enterprise and the quality, safety, service, and profitability of its services.”

*Paul Convery, MD, MM
Former System CMO
Baylor Health System, Dallas, Texas*

Questions to Consider

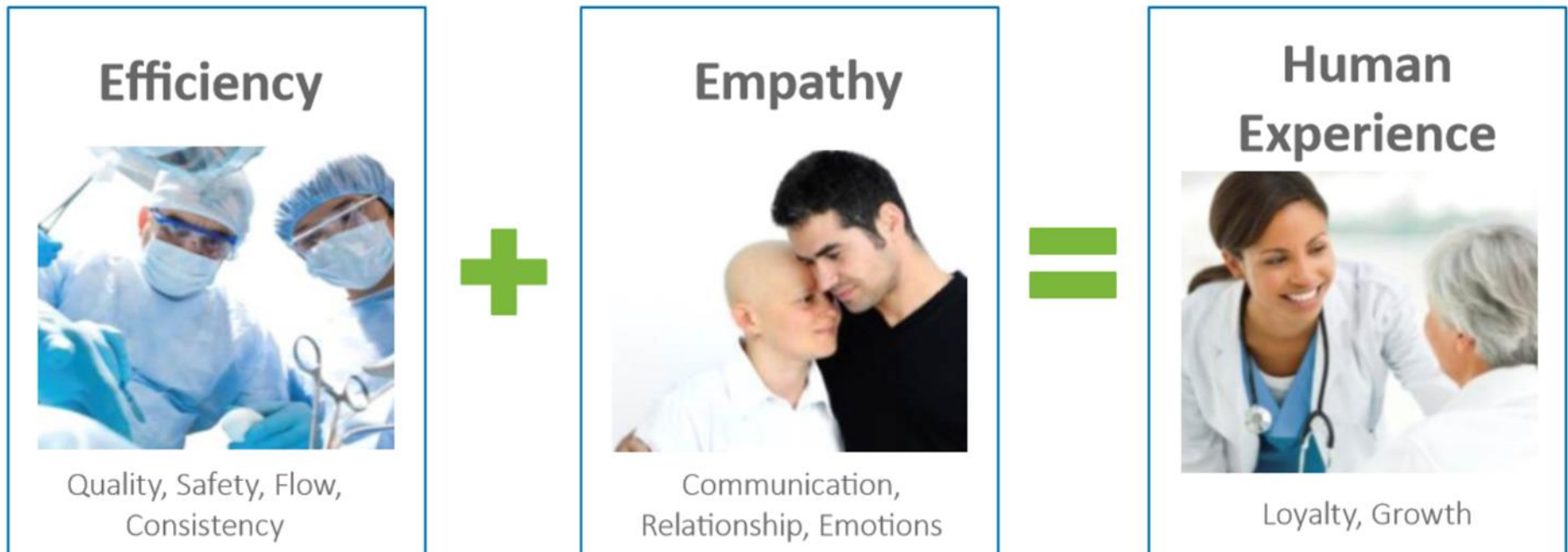
1. Does your organization know how to assume more financial and clinical risks when negotiating with payers?
2. Does everyone in your organization understand how fast your local market is going from fee-for-service to value based payments?
3. Have you assessed the probability of narrow networks being introduced into your market? Will your organization be included?
4. Does your organization have a well thought out data analytics strategy so you can produce actionable correlations to support the Triple Aim?
5. Have you implemented compensation models where your employees are at risk for quality and cost targets?

4. Patient Experience

Patient Experience

The sum of all interactions shaped by an organization's culture that influence patient perceptions across the continuum of care.

- The Beryl Institute



Best Practice Example

Situation

- Cleveland Clinic
- Excellent clinical quality, poor patient experience
- Lack of care coordination
- Rounding was inconsistent
- Insufficient communication between caregivers and patients

Solution

- Make patient satisfaction a strategic priority
- Develop care model that involves collaboration and interdisciplinary teams
- Create of new role: Chief Experience Officer (CXO) and Office of Patient Experience
 - Responsibilities: conducting and analyzing patient surveys, addressing patients' complaints, training employees, and working with units to identify and fix problems

Results

- Survey of 4,600 hospitals showed patient satisfaction among top 8%
- Clinic's percentile rankings amongst hospitals surveyed for the proportion of patients who gave the highest score rose for the following dimensions from 2008 to 2012 :
 - Overall satisfaction: 55th to 92nd
 - Nurses' communication: 16th to 72nd
 - Doctors' communication: 14th to 63rd
 - Staff responsiveness: 4th to 40th
 - Discharge information: 33rd to 97th
- Successfully established Chief Experience Officer and Office of Patient Experience

Chief Experience Officer

- Oversees a team of direct reports dedicated to understanding and solving gaps in the human experience of care
- Builds cultural awareness and engagement among physicians and staff
 - Focus on communication skills
 - Create systems of accountability
 - Work with physicians to deliver on experience expectations
- **Role/Responsibilities**
 - Experience Strategy, Improvement, and Innovation
 - Complaints/Compliments
 - Experience Analysis (i.e. patient surveys)
 - Friends & Family
 - Quality/Performance Improvement

Questions to Consider

1. Do your physicians score well on patient satisfaction surveys?
2. Is it easy to access care at your facility?
3. Are patients involved in your board, in your quality improvement efforts, and in your fundraising?
4. Are millennials impressed by your social media and digital efforts?

Summary

Determinants of Board Effectiveness in Holding the C-Suite Accountable

1. Knowledge: the combined knowledge/experience of board members must match the strategic demands of the company
2. Information: the quality and quantity of data a board receives on its business issues
3. Power: ability to make decisions and hold CEO accountable for his/her performance
4. Motivation: incentives to motivate directors' performance
5. Time: allocate time to focus on key issues and make effective decisions

Do You Have the Right People on Your Board to Drive these Competencies?



Questions?