Welcome to The Governance Institute’s E-Briefings!

This newsletter is designed to inform you about new research and expert opinions in the area of hospital and health system governance, as well as to update you on services and events at The Governance Institute.

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Healthcare Forecast 2017: Top Trends Driving Board Strategic Priorities
By Steven T. Valentine and Guy M. Masters, Premier, Inc.

2017 will be a transition year shaped by changes proposed by President-elect Donald Trump and a Republican Congress. Chief healthcare concerns include legislative proposals to “repeal and replace” the Affordable Care Act (ACA), along with the continued movement to implement alternative payment models (APMs) as called for in the Medicare Access and CHIP Reauthorization Act (MACRA). We will address the potential changes ahead when it comes to shifting health benefits, provider supply, new care models, transparency, and the continued growth of consumerism. 2017 will be a dynamic year as we pivot and move in a new political direction.

1. Inpatient Volume Will Experience a Push-Pull Effect

As the population continues to age and grow, health status indicators decline, and the population with health insurance remains about the same for 2017, volume of both inpatient and outpatient services should continue to grow, but market trends will keep that growth in check. These mediating forces include new care models (e.g., ACOs, bundled payments, chronic disease management, and patient-centered medical homes that can help curb acute care utilization) and use of incentives and technology to improve efficiency (e.g., use of hospitalists, case managers, clinical protocols, and economic incentives to shift care to less expensive settings). Taken together, these forces have been very successful in reducing acute care utilization in several states, such as Maryland, so hospitals and health systems should anticipate that per capita utilization rates will remain flat or decline.

In the boardroom:
• Closely track new federal and state healthcare policies that affect volume, revenues, and payer mix.
• Track inpatient and outpatient shifts in utilization and their effect on revenues.
• Listen to your medical staff members to identify changes that affect physicians.
• Build partnerships with physicians to implement value-based payment arrangements through clinically integrated networks (CINs) and other vehicles.

2. Costs Continue to Rise

Pharmacy costs as a category are expected to increase more than 6 percent in 2017, but could rise as much as 19 percent for certain classes of medications, such as specialty drugs. In total, pharmacy costs will account for more than 12 percent of the overall healthcare spend. Post-acute care and behavioral health costs will outpace inflation as demand continues to increase and providers struggle to keep up with demand.

Labor costs will rise faster than inflation given the baby boomer retirements, shortages of workforce personnel, and union unrest. If inflation begins to creep into the economy (which it already has started...
to do), watch the potential growth of construction and equipment costs as well.

Consumer-driven health plans will cause consumers to fund a greater proportion of their healthcare costs and drive the continued growth of retail health services in areas such as urgent care, diagnostic imaging, etc.

**In the boardroom:**
- Monitor changes in bad debt as potentially more people are unable to pay their deductibles, and if more people move into the ranks of the underinsured.
- Look to pharmacy benefit administrators and services to mitigate the high cost of specialty drugs.
- Watch for the development and growth of restricted formularies for Medicare, Medicaid, and CINs to help mitigate the pharmaceutical cost curve.
- Technology innovations and applications may offer solutions to reduce workforce expenses.
- Monitor efforts to consistently improve work-flow and productivity among staff.
- Proactively address potential construction cost increases by locking in prices and structuring bids to mitigate fluctuations due to inflation.

3. **An Increasing Focus on Consumerism**

Consumers are being asked to foot more of the costs of their health plan premiums and out-of-pocket co-pays. Further, as commercial HMOs experience a decline in membership, PPOs and consumer-driven health plans with higher deductibles will grow. The PPOs will have significant employee participation in the cost of the premium. Employers will provide some relief to employees by offering health savings accounts (HSAs) and contributing approximately $1,200 dollars annually.

Consumers, because they have more money at risk, will be increasingly engaged in their healthcare and become more price sensitive for primary and retail healthcare services. They will use the ever-increasing Internet sites and apps to price shop and check cost, quality, and access to providers. Quality metrics will begin to matter more to the individual. Consumers will become more engaged with their healthcare as they use patient portals to access their personal health record and healthcare system. Providers will need to develop a strong social media strategy and focus on developing “patient stickiness.”

On a final pricing note, some providers were early adopters and are doing a good job of providing price information on their Web sites. Check out Web sites for St. Clair Hospital in Pittsburgh, INTEGRIS Health in Oklahoma, and Geisinger Health System in Danville, Pennsylvania.

**In the boardroom:**
- What is your organization’s transparency and social media philosophy and approach?
- What are you doing regarding benefits for your own employees?
- Have you evaluated the price competitiveness in outpatient services?

4. **Growth in Information Technology**

According to Intel and other technology observers, health information technology will become more user-friendly, accepted, sought after, and accessible, enabling and encouraging consumers and patients to use:

- App-enabled patient portals (73 percent)
- Telehealth (62 percent)
- Text communication (57 percent)
- Remote patient targeting (49 percent)

Of particular note is the explosive growth projected by Intel from approximately 250,000 telemedicine users today to 3,200,000 in 2018—and this growth is happening in spite of telehealth not being reimbursed in most cases. Currently only rural providers get paid for telehealth under Medicare, and it is possible to apply for a waiver under alternative payments. In essence, growth in telehealth is another way to get at growth of value-based care, since the organizations making this investment are likely those that are able to take advantage of the waivers and/or make up the costs they incur through shared savings.

Hospitals, physicians, home care services, and health systems will be investing in telehealth in 2017. This technology will also be critical to the growth and development of the “hospital in the home” model. Healthcare organizations will also continue to implement patient portals to create that “stickiness” we recommend.

Part of the healthcare technology explosion will come from new innovators improving the way we detect and diagnose disease to those changing how we deliver care. Look for more wearable devices, better analytics, and use of big data, 3D printing, and others.

But all that additional electronic data flowing around does create risks. Expect increased expenditures in the cybersecurity area, as healthcare providers have become high-value targets for cyber-attacks.

**In the boardroom:**
- Does your hospital/health system have IT strategies that proactively and effectively address telehealth, cybersecurity issues, and increased patient connectivity and engagement?
- As a board, ensure that there is a specific, effective longer-term IT strategic plan in place.
5. Physician–Hospital Alignment and Collaboration

Many hospitals and health systems have made a substantial investment in the acquisition and employment of physicians, even though many still lose $100,000 to $175,000 a year per physician. Expect a few hospitals and health systems to sell or transfer their employed physicians to another physician organization, and instead pursue contracts, agreements, and partnerships to retain the volume those physicians generate. Most hospitals are continuing to build alignment and partnership vehicles such as CINs, bundled payments, and gain-sharing models. Otherwise, health systems and hospitals will continue to pursue ACOs, co-management agreements, and shared risk pools to foster alignment and collaboration.

Some joint ventures of ambulatory surgery centers may be entering a phase where they are being sold or restructured to allow current investors to get out, new investors to get in, or buy outs of third-party operators from their ownership and/or management agreement. With the election results, we may see a rebirth of physician-owned and joint venture healthcare entities, such as surgical centers.

In the boardroom:
- Monitor your organization’s physician integration, alignment, and partnership strategies—its performance and effectiveness.
- MACRA is a forgone conclusion. If you employ physicians, do an economic impact analysis of the options. If you have a MACRA roadmap, follow it religiously; if you don’t, work with your physicians to develop one immediately.
- Assess your APM-qualifying options to determine whether Merit-Based Incentive Payment System (MIPS) or APM tracks are most advantageous for your physicians.
- Monitor the current (and projected) performance status of your alternative delivery and payment models (e.g., ACO, bundled payment, CIN, others).
- Monitor the performance of the organization’s value-based payment arrangements to ensure the organization is optimizing the results and incentive payments.

6. Continued Consolidation, Alliances, and Affiliations

Healthcare industry consolidation should continue with health plans, super CINs, health systems, hospitals, surgery centers, imaging centers, and physician organizations. We have seen consolidation with urgent care centers and retail health centers as well. All of this action underscores the continued downward pressure on profit margins, and the need for scale and larger populations. Organizations are seeking to eliminate overhead, duplication of services (administrative, clinical, and management), or avoid capital expenditures. We can also see consolidation in the post-acute world.

The drivers that force the sale, merger, or affiliation are many:
- Access to capital is difficult or not feasible
- Greater relevance in the market to drive a larger population to the organization
- Enhance management depth and talent, and specialized expertise (such as medical informatics)
- Gain economies of scale
- Access to IT or existing facility investment
- Access to a population health service organization with alternative payment delivery models

Lastly, health systems may seek to gain greater control of the continuum of care through merger, acquisition, or affiliation with non-acute providers.

In the boardroom:
- Monitor competitors’ performance and activities in this area.
- Monitor your own performance and benchmarks against best practices.
- Assess your organization using the six drivers listed above.

7. The ACA and Payment Sources

It is expected that the ACA will be “politically” repealed and replaced in 2017, yet implementation of the changes or new components of the model could be two to three years out. It is anticipated that Republicans will reduce the regulatory barriers to sell insurance across state lines, encourage growth of Medicare Advantage participants, and encourage increased competition among health plans.

As a result, employer-sponsored health plans will bump premiums up between 7 and 9 percent, while the health plans available on the exchanges appear to have increased premiums around 13 percent (with some going up 25–100 percent). Additionally, some major health plans have announced their intent to get out of the public insurance exchanges (e.g., United Healthcare, Aetna, and more than 35 others). Exchanges could be further destabilized if Congress does an immediate repeal of ACA over a three-year period, with a punt on replace until late. While they know changes are coming, insurers need certainty in order to know what products to offer, at what premium price, etc., so that uncertainty could lead to even more companies walking away from the exchanges.

There will be continued growth in direct-to-employer contracting (Boeing is a recent example). We expect this trend will continue in urban areas, especially where there are health systems that can offer themselves as a preferred delivery choice.
As mentioned earlier, HMO commercial enrollment is in decline, while the PPO high-deductible plans are growing. Medicare will have economic challenges given the growth of Medicare recipients (estimated at 10,000 new beneficiaries per day). Medicaid probably will be unchanged or grow slightly in 2017 if additional states find it palatable to expand Medicaid as a result of potential block grants and additional flexibility measures that are likely with this Congress. We also expect to see growth in Medicare value-based payment models and a Medicaid choice program similar to Medicare Advantage.

The private exchanges that were of keen interest to employers' benefits managers in 2015 and 2016 should see slow growth, but will not be a major change factor in the short term.

Lastly, keep an eye on the site neutral pricing for hospitals. The days of getting paid more for hospital-based outpatient services may be coming to an end.

In the boardroom:
- Track new policies introduced by the Trump administration, but be careful not to be too reactive to the politics and rhetoric.
- Monitor payer mix changes and their impact on financial performance.
- Ensure that there is a strategy for your hospital/health system to listen to health insurance brokers in your market.
- Monitor new niche outpatient players in the market.

8. Provider Shortages Will Accelerate

The baby boomers who put off retirement after the Great Recession are finally running out of gas, and are ready to cut back or retire. With the recent stock market gains, the aging baby boomers have seen their net worth increase, retirement plans bounce back, and now feel more secure about their economic situation. As nurses, allied professionals, and physicians retire, expect to see more IT applications, self-diagnosis, and self-treatment. This includes increased use of telehealth, social media, apps, and patient portals. Use of more support staff to improve productivity of caregivers will rise, but expected productivity gains from the EMR will disappoint.

Expect salaries, benefits, performance bonuses, and sign-on bonuses to increase at a rate above inflation as hospitals seek to expand their reach into the population to gain market share. As the economics improve and salaries and signing bonuses go up, physician turnover will, too.

In the boardroom:
- Monitor staff vacancies, turnover, and project retirements (consider programs to attract and retain mature workforce members).
- Track recruiting efforts and costs to fill vacancies.
- Look for new delivery models and technologies to improve and ensure peak productivity of the existing workforce.

9. Patient Satisfaction

Healthcare organizations will continue to focus on patient satisfaction. The industry still has a long way to go to match other industries regarding communication and contact with its customers. Better and more frequent contact with the patient via social media, emails, patient portals, and follow-up phone calls will all matter more as provider compensation gets increasingly tied to patient satisfaction scores.

As providers compete for more lives (population), patient satisfaction will play a bigger role. The time has come to focus in this area, measure, and then improve.

In the boardroom:
- Monitor patient satisfaction, performance, and benchmarking.
- What are your patient engagement and “stickiness” strategies?
- Do you have a robust social media approach? Is it reviewed frequently to make sure it is effective and up-to-date?

10. Rating Agency Outlook for 2017

The rating agencies have a negative outlook on the non-profit sector. The for-profit operators have seen stock prices decline as analysts expect higher bad debt, fewer Americans having health insurance coverage, and price/revenue pressure due to transparency and low rate increases. Further, they expect continued movement to value-based payment systems. The rating agencies are very interested in hospitals and health systems and their focus on:
- Payer mix
- Movement to population health and alternative payment systems
- Quality and patient satisfaction scores vis-a-vis their competitors
- Bad debt
- Ability to manage expenses
- An aligned physician base

In the boardroom:
- Track financial performance, payer mix, and per-unit costs. What are the trend lines and future forecasts telling you?
- Track and analyze physician economic alignment. Do we have appropriately aligned economic incentives with our physicians? What more can be done in this essential area?
Conclusion

The rating agencies have concerns that we have raised. Hospitals, health systems, and physicians need to watch the Republican administration and its focus on “repeal and replace.” You should also keep an eye on Medicaid changes (potential movement to block grant funding), and the economy (if job growth is robust it may help to offset the expected decline in people with insurance). Technology will play a greater role in our future as we seek to automate and integrate information, diagnosis, and assisted treatment. Amidst the turbulence, the future is as bright as your organization’s ability to proactively anticipate and respond to inevitable change.

The Governance Institute thanks Steven T. Valentine, M.P.A., Vice President of Advisory Consulting Services, and Guy M. Masters, M.P.A., Principal, of Premier, Inc., for contributing this article. They can be reached at (818) 512-0349 or Steve_Valentine@premierinc.com and (818) 416-2166 or Guy_Masters@premierinc.com.

Looking Back While Projecting Forward: Noteworthy 2016 Governance Developments

By Michael W. Peregrine, McDermott Will & Emery LLP

Last year was notable for the number of significant public policy, regulatory, and enforcement developments that impacted the governance of non-profit hospitals and health systems. As boards jump into 2017 and orient themselves to future challenges facing their organization, they may benefit from an awareness of these developments and their continuing significance on this year’s board agenda.

The following 10 developments are not intended as an exclusive summary of key 2016 governance developments, but rather are reflective of those that received the most public attention.

1. A Governance Summer

Over a one-month period, two important commentaries on corporate governance were released by leading business/CEO consortiums. The first release was “The Commonsense Principles of Corporate Governance,” prepared by a diverse collection of leading corporate and financial executives and pension and investment funds. The second release was Business Roundtable’s periodic Principles of Corporate Governance.

Both offer serious recommendations on critical elements of governance that affect sophisticated non-profit corporations. Their release, in close proximity of each other, makes a consequential statement about evolving concepts of governance. These concepts are worthy of consideration by non-profit hospital and health system governing boards.

2. The Strategic Board

During 2016, the National Association of Corporate Directors advocated through its formal programming for boards to assume greater responsibility for positioning themselves to respond to the rapidly evolving legislative and regulatory environment.

This is, essentially, a “continuous improvement” message directed at boards that have historically been too sluggish or passive in response to industry and governmental change. The underlying theme is that boards are more likely to be successful in adapting to significant change if they hold themselves more accountable for their levels of performance and engagement. This is a message that has great relevance for for-profit and non-profit corporations alike.

3. The Strong Hand of State Attorney Generals

State charity officials demonstrated in 2016 the scope of their authority over, and willingness to closely regulate, non-profits and their boards through a series of actions.

These included 1) much more invasive and lengthier state reviews of major corporate transactions such as M&A/change of ownership; 2) a willingness to challenge the governance structures of leading non-profits (e.g., the Hershey Trust settlement); and 3) the ability to team with federal authorities to investigate, and achieve multi-state settlement with, charities and their leadership over alleged legal compliance concerns (e.g., Cancer Fund of America).

The scope of jurisdiction and authority of charity officials should continue to be respected by non-profit boards.
4. Yates and Individual Accountability

The application of Yates Memorandum-based principles of individual accountability were reflected in the latest 2016 Stark law and False Claims Act-based complaints and settlements involving the Department of Justice and the Office of Inspector General and healthcare companies. Several of these late 2016 settlements involved significant financial and other penalties payable by current and former board officers and corporate executives.

These developments represent the beginning of what may become a consistent pattern of complaints and settlements involving senior corporate leaders. They continue to prompt boards to pursue greater compliance efforts, as well as steps to assure anxious corporate gatekeepers of available liability protection.

5. The Board and Strategic Planning

Multiple important regulatory developments in 2016 attracted the involvement of the strategic planning committee and underscored the decreasing “life span” of the organization’s strategic plan (e.g., release by CMS of the final rules under MACRA, the new position of FTC on hospital acquisitions of physician groups, and the two Court of Appeals decisions with respect to FTC challenges of hospital mergers).

This served to underscore the continuing importance of keeping board members aware of developments affecting the strategic plan. It remains the obligation of the board and their strategic planning committee to monitor and adjust to developments that may require the organization to alter or refine the implementation of its strategic plan. Certainly that continues with the obvious degree of uncertainty facing hospitals and health systems in 2017.

6. Refocusing the Compliance Program

The compliance committee was challenged by multiple 2016 developments to increase its engagement with respect to the scope and balance of the compliance program.

These developments included 1) regulatory changes in 2016 that significantly increased penalties for False Claims Act violations; 2) the appointment of a compliance program expert by the Department of Justice, and increasing DOJ guidance on the effectiveness of compliance programs and on elements of “corporate cooperation”; 3) the introduction of criminal antitrust law enforcement activity affecting corporate employees that previously didn’t have significant interaction with the compliance department; and 4) the implications of compliance controversies in other industries.

Particularly noteworthy were the lessons from financial service industry controversies about the risks of conflict between compliance culture messaging, and practical realities to employees of business and compensation incentives and initiatives.

7. The 15th Anniversary of Enron

The 15th anniversary of the Enron bankruptcy (December 2, 2001) provided an excellent opportunity for the general counsel to review with a new generation of corporate officers and directors the problematic board conduct that proved to have seismic and lasting implications for corporate governance.

The self-identified failures of Enron director oversight not only led to what was at the time the largest bankruptcy in U.S. history, but also served as a leading prompt for the enactment of the Sarbanes-Oxley Act, and the corporate responsibility movement that followed. The alleged Enron board conduct included a wide variety of conflict-of-interest, attentiveness, oversight, and decision-making failures that could easily (if unintentionally) be replicated in a modern corporate (e.g., health system) board.

8. New Pressures on Conflicts of Interest

2016 witnessed three particularly important developments impacting the way in which boards, state charity officials, and the media (at least) review conflict-of-interest issues involving non-profit organizations.

The first was the Pennsylvania Attorney General’s seminal settlement with the Hershey Trust, addressing a broad scope of conflict-of-interest and board composition concerns. Another was the August 2016 feature article in The Wall Street Journal on hospital board conflict-of-interest practices and controversies.3 The third development—which continues into 2017—is the extent to which conflicts of interest and the appearance of conflicts-related issues have dominated the political landscape from the presidential campaign through the transition period and likely well into the new administration.

These developments strongly suggest much greater attentiveness of the board committee responsible for conflict-of-interest policy compliance.

9. Constituent Challenges

A series of developments in the non-profit sector suggested an increase in the willingness of constituency groups (e.g., minority board blocs, legacy groups, affiliate boards) to mount challenges to parent company authority. The facts surrounding the current challenge to actions of the Baylor University Board of Regents demonstrate how a well-organized

A constituent group, acting in what it believes to be in the best interests of a non-profit, can organize to bring public pressure on governing board decision making.

According to media reports, the alumni group was frustrated by what it perceived as an insufficient response by university governance to the tragic controversy involving sexual abuse and the football team, and its impact on the reputation of the university.

“Bears for Leadership Reform” is an intriguing example of how powerful constituents of a non-profit corporation (such as a hospital or health system) can use means outside of litigation or political involvement (e.g., heavy social and traditional media use and high profile) to raise questions of governance accountability and transparency, and pressure the board to make related governance changes.

10. The Increasing Prominence of the General Counsel

Board oversight of executive leadership was impacted by the emergence of a new best practice of treating the general counsel as a senior member of the leadership team. A series of 2016 surveys, analyses, and legal industry commentaries combined to promote the increasing prominence of the general counsel (i.e., as a lawyer-statesperson who is an outstanding technical expert, a wise counselor, and an effective leader).

In this expanded role, the general counsel is a core member of top management (comparable to the CFO) who participates in leadership conversations on a broad range of topics that extend beyond traditional legal and risk analysis.

Summary

As healthcare board members prepare to work with management on the challenging 2017 agenda, they may be well supported in this effort by their awareness of the major corporate law and governance issues that emerged in 2016. The healthcare organization’s general counsel is well-suited to assist in briefing the board on the details of these engagements.

The Governance institute thanks Michael W. Peregrine, Esq., Partner, McDermott Will & Emery LLP, for contributing this article. He can be reached at mperegrine@mwe.com.

Making the Journey to Population Health Easier: The Cambridge Health Alliance Story

Held October 29–30, 2016, at the Omni Nashville Hotel, Alignment of Governance and Leadership in Healthcare: Building Momentum for Transformation brought together chief executives, board chairs and directors, and clinical and administrative leaders from healthcare organizations across the country to discuss critical issues related to community benefit and community health. Soma Stout, M.D., M.S., Lead Transformation Advisor and Former Vice President of Patient-Centered Medical Home at Cambridge Health Alliance, and Executive Lead, 100 Million Healthier Lives, for the Institute for Healthcare Improvement, discussed the Cambridge Health Alliance story as summarized below.

Background

Cambridge Health Alliance (CHA) is an integrated delivery system serving 100,000 patients across seven cities. With just under 3,400 employees, the system has 12 community clinics, two hospitals, three EDs, and numerous sites offering specialty care. Half of CHA’s patients speak a language other than English and 70 percent have some form of public health insurance. Approximately 20 years ago, CHA faced a crisis that also became an opportunity. Historically reliant upon the state government for FFS payments, CHA received word from the governor that the state could not afford to pay $40 million it owed the system, and that upcoming payments of approximately $100 million were also at risk. Recognizing the inherent problems with reactive FFS medicine, CHA leaders decided to embrace the Institute for Healthcare Improvement (IHI) Triple Aim—simultaneously improving population health, the patient care experience, and per capita costs. CHA leaders decided to add a fourth aim as well—restoring joy and meaning to the CHA workforce. To make this approach work financially, CHA leaders began aggressively transitioning to risk-sharing and global payment arrangements. Over a five-year period, these payments went from 0 percent to 60 percent of total revenues. Going forward, CHA leaders expect this number to increase, as the Centers for Medicare and Medicaid Services (CMS) has set out the goal of having 80 percent of payments in “alternative” (i.e., value-based) payment models by 2020. Other payers are expected to follow suit.

Beyond their own predicament, CHA leaders also recognized the unsustainability of the existing FFS, episode-based model that dominates the industry. If current trends continue, healthcare costs will likely consume 20 percent of gross domestic product by...
2020. The average family spends 30 percent of its take-home pay on healthcare expenses, and medical costs account for roughly half of all personal bankruptcies, making them the single largest cause of such bankruptcies in the country.

To succeed, CHA leaders knew they had to change the focus of the organization, away from providing acute, episode-based care to improving the health and well-being of the underserved communities that surround CHA facilities.

Root Cause: Inequities That Lead to Increased Risk of Chronic Disease

CHA leaders began dissecting the root causes of excess spending and poor health outcomes. They quickly discovered that to really make a difference, the organization had to begin tackling systemic social inequities that lead to greater risk of chronic disease. For example, the U.S. spends $322 billion today caring for diabetes and pre-diabetes. By 2020, that figure will likely reach $550 billion.

Reducing these costs is not just about coaching and other interventions to get people to change health-related behaviors such as diet and physical activity. Rather, it requires addressing underlying social inequities that lead to greater likelihood of acquiring diabetes and other chronic conditions, and that make it much more difficult to manage them. For example, children exposed to toxic stress in early childhood have up to a 40 times greater risk of chronic disease (including diabetes) by age 50.

As shown in the map in Exhibit 1, health and social inequity are inextricably linked, with rates of childhood obesity within geographic areas closely mirroring levels of economic hardship.

These place-based inequities are not accidental. Rather, the current systems propagate them. Various public and private policies, systems, practices, and procedures produce inequities and poor health outcomes. Underlying these are larger societal issues, including racism, poverty, gender bias, and related stigmas. Without recognizing and addressing these issues, all the individual health coaching in the world will not make much of a difference.

Exhibit 1: Health and Social Inequity Are Interconnected
Transforming the System

CHA embarked on a journey to transform its system, focusing on five key shifts:

- From a healthcare system to a connected health and well-being system that brings together everything needed to affect social, health, and spiritual well-being.
- From working on equity as a way to “do good” to recognizing that everyone is interconnected and hence cannot afford the price of poverty and inequity in terms of both health outcomes and costs.
- From scarcity to abundance, viewing this challenge as an opportunity to transform the system.
- From pathology to vision and the recognition that change is possible.
- From communities of poverty to communities of solution and untapped potential that can be leveraged to produce better outcomes.

CHA followed the IHI model developed as part of the 100 Million Healthier Lives campaign. This model focuses on four levels of change.

- Level 1: The patient’s physical and mental health.
- Level 2: The patient’s social and spiritual well-being.
- Level 3: The community’s social and spiritual well-being.
- Level 4: Communities of solution, where the capacity of the community itself is unlocked to address the problems it faces.

Using this approach, CHA achieved the following:

- Meaningful improvement in patient experience scores.
- Total cost reductions of 10 percent (15 percent compared to others serving Medicaid managed care enrollees), with the savings reinvested to address the social determinants of health.
- Improved quality health outcomes to levels above the 90th percentile nationally.
- Significantly enhanced joy and meaning among its workforce.

Examples of some of the major changes made at CHA include the following:

- **ED redesign:** CHA sees its ED not as a portal for patients to enter the hospital, but as a vehicle for connecting them with a primary care medical home (PCMH). To that end, CHA built effective support systems to make those connections. CHA also eliminated the triage nurse, instead using a friendly “greeter” who asks a few screening and triage questions. This change and others led to dramatically reduced wait times, to the point that 94 percent of ED patients see a doctor within 20 minutes of arrival. Even with increases in ED volume, average wait times have never exceeded three minutes in the last five years.
- **Complex care management:** As illustrated in Exhibit 2 on the following page, CHA focuses on providing care management support for the most complex patients. The goal is to understand what is going on in their lives and address any issues that may be affecting their health, including social determinants of health. Overall, these and other programs have helped to cut ED visits in half and reduce hospitalizations by 40 percent for this population. At the same time, there has been a greater than 100 percent improvement in getting this subset of patients in to see their primary care doctors and a 30 percent reduction in their total costs.
- **Integrated mental health:** Because one in five patients has a mental health issue, CHA briefly screens all patients for mental health issues and refers those who screen positive to an in-house team led by social workers who have support via telemedicine from behavioral/mental health physicians. CHA also has a mental health registry to manage patients proactively, through steps such as the routine screening of patients with diabetes for depression.
- **Team-based care:** Multidisciplinary teams care for patients, with teams including receptionists and medical assistants (MAs) who receive training on how to interact with the patient. Patients often share things with frontline staff and MAs that they may not be comfortable saying to the doctor. The entire team meets each week for 30 minutes to discuss patients, while MAs and doctors have brief five- to 10-minute huddles each day. Teams meet monthly with integrated specialists (e.g., mental health professionals, care coordinators) to review patients on their shared panel.
- **Cross-sector collaboration:** CHA has many cross-sectoral partnerships. For example, it works with school nurses to give them access to the registry of students with asthma so they can identify symptoms early. CHA also works with the public health department to get nurses into the homes of these children to screen for mold and other potential issues. Through these and other efforts, hospitalizations for childhood asthma have fallen by 90 percent. CHA uses a similar approach with diabetes, working with schools to increase consumption of fruits and vegetables and levels of physical activity. CHA also supports collaborative efforts to make it easier for low-income students to get a healthy breakfast in school.
Exhibit 2: The CHA Model

Drivers of Cost
- Acute Illness
- Chronic Disease
- Under-Use of PCP
- Over/Under Use of ED/Inpatient
- Social Disconnection
- Substance Abuse
- Mental Health
- Disabilities
- Poverty

Rising Risk Cohort

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<table>
<thead>
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<th>Percentage</th>
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<td>6-10%</td>
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**CHW**

Complex Care Mgmt Team

CCM Team

PCMH Care Team & Patient Resource Coordinator

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Exhibit 3: The CHA Model – Top 5-10%

Lessons Learned

Key lessons in CHA’s transformation include the following:

- Build patients into the improvement and transformation process, tapping their expertise early. Patients should be more than just advisors, but rather full partners in redesigning direct services, systems, and policies at the institutional and community levels (see Exhibit 3).

Exhibit 3: Patients as Full Partners in Redesigning Care

<table>
<thead>
<tr>
<th></th>
<th>Consultation</th>
<th>Involvement</th>
<th>Partnership</th>
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<tbody>
<tr>
<td>Direct service or observation</td>
<td>Ask what they would want/need in a service</td>
<td>Motivational interviewing integrated; health literacy</td>
<td>Peer to peer (CHW, VHA), collaborative planning</td>
</tr>
<tr>
<td>Community or system design and governance</td>
<td>Journey-mapping, surveys (before, during, after), focus groups</td>
<td>Advisory board, community members on taskforce and work groups</td>
<td>Community champions as part of leadership team</td>
</tr>
<tr>
<td>Policymaking</td>
<td>Community needs assessment, town hall meeting</td>
<td>Community recommendations drive change</td>
<td>Equal representation in decision-making over resources</td>
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- Recognize that every population is different; organizations need to understand—and design programs specifically for—each population.
- Align the financial, clinical, and policy aspects of the transformation.
- Recognize the importance of executing a cultural transformation in what is essentially a human system.
- Eliminate silos in the patient’s health continuum, both within and beyond the delivery system.
- Leverage IT as a critical facilitating factor.
AGLH Initiative

Supported by the Robert Wood Johnson Foundation (RWJF) and co-sponsored by The Governance Institute, Stakeholder Health, and the Public Health Institute, the Alignment of Governance and Leadership in Healthcare (AGLH) conference is part of a larger initiative designed to support non-profit hospitals and health systems in building, managing, and maintaining an effective, tailored population health and community benefit strategy in partnership with local community stakeholders. Along with these conferences, the AGLH initiative also includes conference calls and Webinars where health systems can report on and discuss their current community health activities, including obstacles, challenges, opportunities, and emerging lessons. The next intensive will be February 4–5, 2017, at the Boca Raton Resort & Club in Boca Raton, Florida. For more information on future AGLH programs, go to www.governanceinstitute.com/AGLH.

Upcoming Events

Leadership Conference
Boca Raton Resort & Club
Boca Raton, Florida
February 5–8, 2017

Leadership Conference
Fairmont Scottsdale Princess
Scottsdale, Arizona
April 23–26, 2017

Governance Support Forum
The Westin Copley Place, Boston
Boston, Massachusetts
August 13–15, 2017

More information and registration coming soon.

Click here to view the complete programs and register for these and other conferences.

Upcoming Webinar

Combining Medical Staffs in a Multi-Hospital Setting
February 7, 2017
2:00–3:00 p.m. Eastern Time/11:00 a.m.–12:00 p.m. Pacific Time

Multi-hospital integrated delivery systems (IDS) have been forming and growing at a rapid rate in many regions of the country. Maintaining multiple organized medical staffs within a single integrated health system can be inefficient, expensive, reduce the effectiveness of medical staff initiatives, and increase liability. This Webinar will describe how to determine if one or more medical staffs should be merged within an IDS, how to proceed with a full or partial merger project and achieve board approval, what design options exist when considering more efficient medical staff bureaucracy within an IDS, how to promote physician buy-in for the process and address the concerns of medical staff professionals, and what implementation steps should be undertaken to successfully complete a merger project.

Click here to learn more and to register.
New Publications and Resources

Healthcare Acronyms & Terms for Boards and Medical Leaders, Ninth Edition (January 2017)

Alignment of Governance & Leadership in Healthcare: Building Momentum for Transformation (Conference Proceedings, December 2016)

Maximizing the Effectiveness of the System Board's Quality Committee (System Case Study, December 2016)

Moving from Good to Great Governance: Sarah Bush Lincoln Health System's Successful Implementation of a Governance Restructuring (System Case Study, December 2016)

Governance Notes (Governance Support Newsletter, December 2016)

Improving Community Health (case studies, December 2016)

Improving Community Health: Leading Governance Practices to Catalyze Change (white paper, Fall 2016)

BoardRoom Press, Volume 27, No. 6 (BoardRoom Press, December 2016)

The Role of Palliative Care in Achieving Value Strategies (Webinar, November 2016)

To see more Governance Institute resources and publications, visit our Web site.