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## 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.

### In this issue:

Clinical Integration: What Hospital Board Members Need to Know  
General Industry Influence on Executive Compensation in Not-for-Profit Healthcare  
Board Chairs and CEOs Need to Get Serious About Philanthropy

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## Clinical Integration: What Hospital Board Members Need to Know

By Ellis "Mac" Knight, M.D., M.B.A., Coker Group

**M**ore than a decade ago, disparate groups of providers comprising hospitals and physicians within Advocate Health Care in Chicago came together and successfully convinced the Federal Trade Commission (FTC) and the courts that they could jointly contract as a result of being clinically integrated. Since then, this term is regarded more like a legal concept than a way of organizing healthcare delivery.

Clinical integration (CI) is also often confused with accountable care, and clinically integrated networks (CINs) are sometimes called commercial accountable care organizations or ACOs.

This article, however, will concentrate on the concept of value-based care delivery and how CI is the necessary first step toward the creation of a healthcare system that reliably provides high-quality per unit of cost. This way of looking at CI is becoming more important as providers attempt to re-tool care processes and procedures to operate successfully in a reimbursement environment inexorably moving toward pay-for-value and away from pay-for-volume.

### Defining Value

With the publication of the Institute of Medicine's report on medical errors in U.S. hospitals, healthcare providers across the country dramatically focused their efforts on improving quality and patient safety.<sup>1</sup> The Institute for Healthcare Improvement, led by Don Berwick, introduced many initiatives around quality. Berwick also introduced the concept of the Triple Aim, where quality, population health, and cost control were suggested as the overarching goals around which the U.S. healthcare system should be concerned. Subsequently, in 2006, Michael Porter and Elizabeth Teisberg, published their book,

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<sup>1</sup> Committee on Quality of Health Care in America, Institute of Medicine, *To Err Is Human: Building a Safer Health System*, National Academies Press, 2000.

*Redefining Health Care: Creating Value-Based Competition on Results*, and popularized the notion of value in the healthcare industry being equal to quality divided by cost.

### Value-Based Changes in the Healthcare Economy

Ultimately, Porter and Teisberg envisioned a new marketplace opening up where competition among healthcare providers would center around the delivery of value (quality/cost) as opposed to delivering volume (number of patient visits, procedures, tests, etc.). Although this change in the healthcare economy has not yet occurred entirely, there is no doubt about the movement in that direction. More payers, both governmental and commercial, are coming forth with value-based reimbursement models. The Centers for Medicare and Medicaid Services (CMS), for instance, is committed to having 95 percent of their reimbursements based on value by the end of 2018. Commercial payers are following CMS's lead, and the largest private health plans in the country (Aetna, United, and Blue Cross) all have value-based reimbursement models of various types.

### Organizing Providers Around Value-Based Care Delivery

Changes in the reimbursement system over the last decade, toward a more value-based model, have also driven organizational changes on the provider side. First among these was the ACO, which consists of multi-specialty physician groups and hospitals that come together for the express purpose of driving quality and cost efficiency (value) and are rewarded for this through the sharing of savings with payers. More recently, CINs have also been formed by physicians and hospitals to drive high-value healthcare delivery. However, the term CIN usually refers to ACOs that contract with commercial payers or directly with employer-sponsored health plans as

opposed to those that contract with one of Medicare's shared savings programs also referred to as ACOs. While this nomenclature can be somewhat confusing, the basic principles underlying both ACOs and CINs are the same and going forward this article will refer to both as CINs.

## Key Components of a CIN

As mentioned, the overarching purpose of a CIN is to drive higher value in the healthcare delivery system. To accomplish this, CINs must include several key components:

1. **Legal structure.** Most CINs are set up as single or multi-member, limited liability corporations owned by their physician or hospital sponsors. This structure has proven to be simple to create and very flexible as the CIN operates as either a for-profit (the usual case) or a not-for-profit entity.
2. **Governance structure.** Physician leadership is key to the success of a CIN for the simple reason that physicians have the most proximate control over the quality and cost expenditures in the healthcare system. Additionally, one of the critical criteria that the FTC looks for in determining whether an organization meets the definition of being clinically integrated is the degree to which it is physician led. While hospitals and physicians often both participate in CINs and hold seats on the governing board of these organizations, physicians are usually in the majority on both the board and the various subcommittees of the board.
3. **Management structure.** A CIN is generally managed by a small group of full-time employees who work in close collaboration with a set of board-appointed subcommittees, made up of key physician and hospital CIN participants. These subcommittees focus their activities on the following areas:
  - Quality and cost efficiency
  - IT infrastructure
  - Finance and payer relations
  - Accountability
4. **Business operations.** As with any start-up, a CIN must have a sound business plan that can quickly lead to its profitability and financial stability. While most CINs initially rely on investments from their sponsors, grant funds from governmental or non-governmental agencies, and dues from their participants to get off the ground, ultimately the CIN must become financially self-sufficient. The key to achieving this status is for the entity to negotiate viable contracts with payers, providers, or employers. Usually, these contracts are value-based. However, some CINs also enter into fee-for-service contracts and then leverage their ability to identify and eliminate non-value-added costs to preserve margins in a fee-for-service market where reimbursement rates are declining.
5. **Clinical operations.** Ultimately, the CIN must have a way to re-tool the frontline clinical enterprise so that it reliably produces high value

as opposed to just producing high volume. Management tools, such as lean value-stream mapping of common care processes and procedures, time-driven activity-based cost accounting, process management automation technology, and data-driven process improvement methodologies are essential to making this happen. Merely reorganizing the providers into a CIN or ACO will not change long-standing clinical practice patterns. For these to change, there must be a systematic approach to transforming the delivery system from a volume to a value production model. Note, this does not mean that healthcare production can ever ignore volume, as the aging of the population and expansion of affordable health insurance will likely ensure high demand for services into the foreseeable future. That said, those providers who can deliver both high-volume and high-value care delivery will indeed succeed in the healthcare marketplace of the future.

6. **Care management infrastructure.** CINs will likely become more involved over time with population health management. To do so, they will need to augment their clinical operating system with a care management infrastructure that can deliver population health management services. Care managers include chronic disease managers, care coordinators, health educators, social workers, pharmacists, nutritionists, and others. These professionals will need to be organized into physician-led teams that can then be deployed where most needed. The patient-centered medical home (PCMH) model is an example of where team-based care is already happening. Thus, the primary care and some specialty components of a CIN need to strongly consider implementing this model as they take on more population health management responsibilities. Reimbursement models are also changing to incentivize the PCMH model and other primary care innovations as exemplified by the all-payer Comprehensive Primary Care Plus (CPC+) model that is being introduced in several regions of the country.
7. **Compliance.** It should be noted that bringing together disparate providers into a CIN is fraught with compliance issues, mostly related to antitrust concerns. Despite this difficulty, many of these organizations have now been formed, and regulatory agencies, such as the FTC and the Department of Justice, now consider the benefits of clinical integration to be a legitimate justification for allowing groups of providers who are not all employees of the same entity to jointly contract for services. It should be noted, however, that any group of providers who intend to form a CIN need to seriously consider hiring outside legal counsel experienced in this area who can guide them through the somewhat arcane rules and regulations related to this process.
8. **Marketing.** As stated, a clinically integrated provider network will be at a distinct advantage

once the reimbursement climate transitions from a predominantly volume-based model to a more value-based model. Nevertheless, CINs will need to demonstrate through a well-thought-out marketing plan to payers, providers, and employers their proven capabilities to deliver higher value. CINs also will need to time their transition from a volume-based production system to a value-based production model to not find themselves in front of or behind their particular market as this change takes place. CIN development and the timing of it is not a one-size-fits-all process. Each market will require CIN developers to tailor their approach and timing to make sure they are optimally successful.

## Conclusion

CIN formation is a critical first step for any group of providers who wish to succeed in the coming value-

based healthcare marketplace. Key takeaways for hospital board members to know about clinical integration and CIN development include:

- Successfully developing a CIN requires attention to the major components that make up these organizations and carefully timing the conversion with the move of the local market toward a value-based reimbursement model.
- A systematic approach, guided by those experienced in this process and by those who understand the legal ramifications of clinical integration, can accomplish this transition process while minimizing disruptions in ongoing operations and maximizing the success of transforming the system into a more value-based delivery model.
- In the end, the volume-to-value shift accomplished through the development of a CIN will benefit patients, providers, and even payers.

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## General Industry Influence on Executive Compensation in Not-for-Profit Healthcare

*By Jose Pagoaga and John Collins, Sullivan, Cotter and Associates, Inc.*

**T**raditionally, when not-for-profit (NFP) hospitals or health systems needed to fill a CEO or other executive position, governing boards either hired from within or looked to other healthcare organizations to find appropriate candidates.

Today, changes within the healthcare industry have caused the talent market for some executive roles to expand beyond NFP healthcare peers and, indeed, beyond the healthcare sector and into general industry. There is a melding of the talent markets as NFP healthcare organizations increasingly compete with for-profit (FP) organizations to recruit executives.

This shift has significant implications for healthcare executive compensation and its oversight. Compensation of NFP executives is increasingly influenced by compensation practices in the FP sector. In light of this growing influence, governing boards must assess the executive compensation policies of their organizations and determine the extent that policies should reflect FP compensation models, keeping in mind the differences in overall philosophy, business strategy, and capital structure between an NFP healthcare organization and an FP business entity.<sup>2</sup>

<sup>2</sup> Not-for-profit healthcare refers to hospitals and health systems; for-profit also includes pharmaceutical, biotechnology, insurance, and other healthcare-related entities.

## Market Trends and Pressures

For the past several years, mergers, acquisitions, and other partnerships have resulted in larger and fully integrated NFP and FP health systems, which sometimes parallel the size and complexity of Fortune 500 companies. Some of these NFP health systems recruit executive talent from FP industries to oversee their larger, more complex operations and corporate functions that affect the whole enterprise. Likewise, the reverse is true, although to a lesser extent. For example, as the demand for healthcare management and care delivery expertise grows, traditional FP healthcare insurers increasingly look to NFP healthcare as a source for talent.

As operating margins get tighter, systems seek new sources of revenue and are venturing into nontraditional businesses, such as health plans, innovation centers, retail medicine, biomedical engineering services, consulting services, and pharmacy benefit management. The operating characteristics, market forces, and capital structure of these businesses will likely lead the NFP parent/partner organization to seek out leaders with experience in these businesses and to source them from FP organizations, including healthcare and non-healthcare sectors.

## Compensation Considerations

Taken together, these market trends and pressures should give boards and compensation committees of

NFP health systems reason to consider the influence of the FP sector and whether compensation policies should be adjusted accordingly.

Issues to consider include:

- Whether to use FP peer companies in setting compensation levels for NFP health system executives.
- How to treat the equity portion of the FP compensation plan when the NFP peer group includes FP companies.
- Whether the NFP executive compensation model should be altered to reflect FP influence, such as the use of long-term incentives.
- Whether executive compensation for nontraditional healthcare businesses requires a different compensation model with performance metrics that are aligned to the maturity of the business and the owner's long-term objectives with respect to value creation and liquidity.

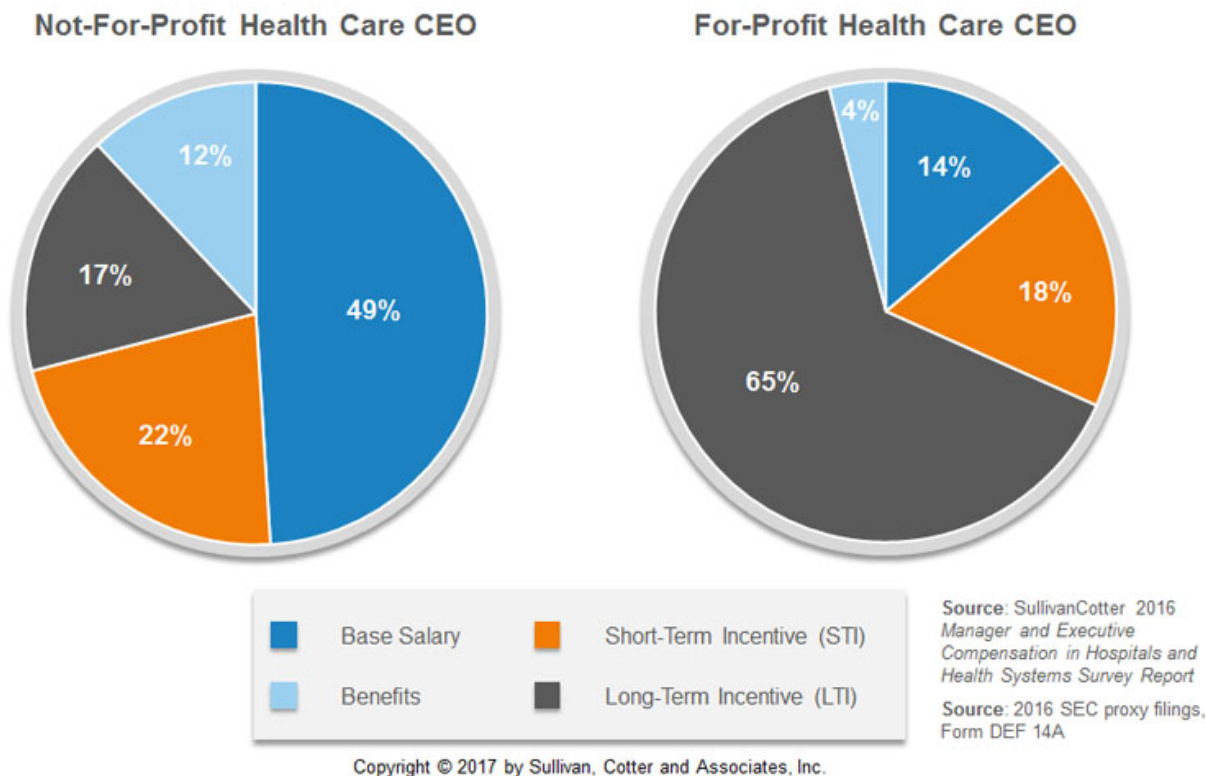
### NFP vs. FP Compensation

When deciding whether to include FP companies in the NFP peer group to set compensation levels, boards must first carefully consider what is being

compared. A comparison of CEO compensation models illustrates the fundamental differences between NFP and FP pay. CEO compensation in NFP health systems is mainly delivered through base salary. By contrast, most FP healthcare and general industry CEO compensation is delivered through equity awards, which carry greater risk and have a stronger emphasis on performance than the cash-based compensation common in NFP organizations.

According to a 2016 SullivanCotter research study on healthcare CEO compensation, base salary and benefits comprise 61 percent of compensation for the average NFP health system CEO, while the same components comprise just 18 percent of compensation for the typical FP healthcare CEO (see **Exhibit 1**). At the same time, long-term incentives comprise just 17 percent of an NFP CEO's compensation, while they comprise 65 percent of a FP CEO's compensation—almost all of which consists of equity awards. Moreover, the value of total direct compensation for FP CEOs dwarfs that of their NFP CEO counterparts. Smaller long-term incentives in NFP models are made up through richer benefits programs, especially supplemental retirement plans, which are less prevalent in the FP market.

### Exhibit 1: Not-for-Profit vs. For-Profit CEO Compensation Comparison



The potential value of equity compensation depends on market factors and, therefore, carries greater risk than cash compensation. Awards are commonly tied to stock price performance to align with shareholder expectations and are often modified based on relative total shareholder return versus peers. Equity is also paid through shareholder dilution and, therefore, does not impact cash flow the way cash delivered in long-term incentives in NFP models does.

Given their organizations' charitable missions, NFP CEOs do not have the same opportunities as FP CEOs to drive value creation, and their compensation models reflect a more conservative risk-reward philosophy and less volatile compensation package than that of their FP counterparts.

As a result, compensation committees must carefully consider whether to include FPs in their peer group (for CEO and other executive roles) as doing so has the potential to drive up compensation. Because of such fundamental differences, compensation committees should exercise caution when considering FP compensation levels in peer group comparisons and recognize that a dollar of NFP pay is not equal to a dollar of FP pay because the associated risk is not the same.

## Remember the Mission

As the NFP and FP markets for healthcare talent continue to meld, the FP sector will continue to influence NFP executive compensation models. Governing boards and compensation committees must consider how this influence will affect the organizations they govern and whether, in turn, to adjust executive compensation policies to address this influence.

Just as the inherent differences between NFP and FP executive compensation should not be overlooked, compensation committees must also ensure that any changes to compensation policies do not affect mission sustainability. Keep in mind that as long as FP businesses are controlled subsidiaries of an NFP parent, the compensation of key executives may be subject to the same regulatory risks as other key executives of the NFP health system. Ultimately, it's all about determining the right compensation model that will drive behavior of leaders to effectively manage and grow the business in a manner consistent with the overall goals and strategic objectives of the healthcare organization.

*The Governance Institute thanks Jose Pagoaga, Managing Principal, and John Collins, Principal, Sullivan, Cotter and Associates, Inc., for contributing this article. They can be reached at [josepagoaga@sullivancotter.com](mailto:josepagoaga@sullivancotter.com) and [johncollins@sullivancotter.com](mailto:johncollins@sullivancotter.com).*

## Restructured Compensation Models

As the talent market for certain executive roles within NFP health systems expands and overlaps with the FP sector, some systems are restructuring their executive compensation models to reflect FP industries' influence. A few examples include:

1. A large NFP health system that incorporated FP healthcare and related companies in its peer group for selected roles.
2. An NFP health system that started an FP pharmacy benefits management company has made phantom equity grants (cash plans that pay according to value creation) to the FP benefits management company executives so they can share in value created over time.
3. An NFP teaching hospital that is granting stock option awards to the executives leading a new independent innovations company that will ultimately be a public FP entity.
4. NFP health systems that have incorporated FP innovation subsidiaries have started carried-interest incentive plans (cash plans that pay according to repayment of invested capital plus interest) akin to private equity and venture capital plans.
5. An NFP health plan that is being acquired by an FP insurance company has adopted the same severance, retention, and parachute protections that FP companies utilize.

## Questions to Consider

1. How is the growing influence of the FP sector affecting your organization's executive talent strategy?
2. Has your organization begun to source executive talent from the FP sector? At equivalent career levels?
3. Is your organization losing talent to the FP sector?
4. Should FP companies be used as compensation peers for key executives in your NFP health system? If so, how should equity compensation among FP peers be factored into pay comparisons and pay decisions?
5. Should NFP health system executive compensation pay models be restructured to align more closely with executive compensation found in the FP industry? Does this affect all executives, executives in roles common to both (e.g., CHRO), or only the executives of new FP health system ventures?
6. How can your entity adopt FP practices to monitor incentives to identify and mitigate potential risks to the overall strategic goals, reputation, and cultural values of the organization?



# Board Chairs and CEOs Need to Get Serious About Philanthropy

By Bill Mountcastle, Health Giving

Research from Moody's Investors Service reports that the cost for hospitals to earn a dollar of revenue is 97 cents. With our healthcare business model facing uncertainty and changes, hospitals will now be forced to navigate an even more difficult environment. Despite these toughening circumstances, board chairs and CEOs must remain eager to enhance the patient experience, develop new treatments, lower costs, and find additional revenue to support growth.

Fortunately, philanthropic investment offers hospitals the opportunity to raise a dollar of revenue at an average cost of just 31 cents. Because of this, we are seeing best practice hospitals turn to philanthropic investment from grateful patients and their community leaders to boost sagging bottom lines, improve overall credit ratings, and fund facility upgrades and expansion. To secure this vibrant revenue source, leadership will need to get serious about partnering with their philanthropy office or foundation.

In today's environment, it is essential for the board chair and CEO to be champions of their hospital's fundraising efforts and lead the charge for philanthropic investments. It's no longer enough to set budgets and goals. They need to advocate for the organization with corporate donors, individual donors, and through special events to help grow their base of supporters and dollars. The board chair and CEO must, among many other things, be the "Chief Philanthropic Investment Managers" for their hospitals. They need to be willing to roll up their sleeves and engage with their philanthropy offices.

The best board chairs and CEOs call on their leadership skills and focus on the five important actions discussed in this article.

## 1. Benchmark Philanthropy Performance Against Best Practice

Just as they would with any other investment, best practice hospitals build specific expectations for philanthropy into their strategic and financial planning. Board chairs and CEOs should require accountability metrics from their philanthropy offices to help understand everything from the overall effectiveness of fundraising campaigns to individual major gift officer performance reviews. Board chairs and CEOs need to champion this "fundraising as a science" approach by implementing key performance indicators and holding leadership accountable for delivering on them.

In addition to benchmarking against expectations, leadership should benchmark philanthropic investment performance against the leaders among similarly sized or recognized organizations. Measuring against these peer organizations will

generate new ideas for improving the performance of philanthropy.

## 2. Make the Pursuit of Philanthropic Investment a Team Sport

To raise more philanthropic dollars, raise the profile of philanthropy within your hospital. The board chair and CEO set the tone for the rest of the board and C-suite leadership, so lead by example. Recognize philanthropic investment as a significant contribution to the bottom line. Make sure that the philanthropy office leader has a seat at the executive table and share how philanthropic investments are driving successes throughout the hospital.

But remember philanthropy is a team sport and it is essential to engage all parts of the organization. Bring board members, leadership volunteers, clinical staff, and hospital administrators together with fundraisers, marketing, and strategy to create coordinated plans for engaging top community philanthropists and grateful patients. Promote and encourage cooperation from the physicians and clinical leaders. Proactively work together with the full board in a dedicated partnership to advance philanthropy. The full board's engagement, input, and commitment to philanthropy are essential. Also utilize your organization's collective strengths and relationships to develop strong proposals for major philanthropic investors. Establishing this teamwork culture for philanthropy will open more doors and ultimately raise more philanthropic dollars.

## 3. Talk to Your Top Philanthropists

Board chairs and CEOs will always have to make tough decisions about how to invest their time. But if they want to grow all possible revenue sources, they need to get serious about raising philanthropic investment. To do this, they should be devoting time to building strong relationships with the hospital's current top philanthropists. While the exact amount of time a board chair or CEO should spend engaging philanthropic investors is fluid, one solid rule is that the board chair should have, at a minimum, four meetings with top potential philanthropists each year. In addition, the CEO should have at least one of these meetings each month. These modest time commitments are not too much to request of your highest leaders, and over the course of a year, they allow hospital leadership to gain a broad understanding of the community.

These meetings with top philanthropists will prove to be significant, as hospital leaders have a unique ability to connect with these philanthropists, ask questions, gain insights, and eventually identify opportunities for continued philanthropic investment at your institution. Hospital leaders should first thank

these philanthropists, but also be certain to ask for feedback. Are they having a gratifying donor experience? Do they feel the hospital is making an impact and the community is experiencing an ROI from their giving?

Current philanthropists will tell you why they invested in the hospital and its people. And knowing why they invested is vital to developing future strategies for securing philanthropic investment. The hospital's current philanthropic investors will also explain what value they derive from supporting the hospital's efforts. Giving motivations can be entirely different from the motivation to seek medical care at the hospital. Current top philanthropists may also have a list of suggestions on how the hospital can do better. Focusing on understanding challenges with passion is a winning management plan in any business, but especially a service business like healthcare.

After board chairs and CEOs have meetings with top philanthropic investors, make sure time is scheduled with the philanthropy office to recap all that was learned and identify any necessary next steps. Use this new knowledge to build stronger proposals for future philanthropic investment and ultimately a stronger hospital as well.

#### **4. Motivate, Inspire, and Spotlight Philanthropy Success**

Fundraising is a high-pressure effort, and maintaining motivation, energy, and drive is incredibly important for success. That's why excellent leaders are not passive about inspiring their organizations and communities. They appreciate their power to motivate and maximize potential. Dr. Toby Cosgrove, CEO and President of the Cleveland Clinic, told his community: "I've seen the powerful effect of giving on both donors and recipients. Sick children, adults, and the families who love them flourish under the favor of generous givers. Scientists are energized. Doctors, nurses, and other caregivers are inspired." Model this excitement, passion, and optimism. Talk about a bright future, and how your hospital contributes to it. Share the powerful stories that help crystallize philanthropy's impact at your hospital. And be certain to celebrate and recognize success. Sincere, personal praise from the board chair and CEO can be an incredible motivator. While public recognition for success can be

spontaneous, it is also possible to build a system and culture that regularly recognizes philanthropic investment to the hospital.

#### **5. Ask Often How You Can Help Drive Philanthropic Investment**

Ask not what your team can do for you, but what you can do for your team. Be a servant leader. The key principles of servant leadership are leading people by setting the vision for them, trusting and empowering them, then serving them by removing obstacles and getting out of their way. Good leaders listen. Great leaders ask questions, gather information, and offer to help.

When it comes to philanthropic investment, board chairs and CEOs should have questions-only conversations with their philanthropy offices. For example: How can I help you? Are there certain aspects of our relationship with this top potential philanthropist I could be particularly helpful with? Are there questions I should directly ask the potential philanthropist?

The fundraiser may know specific ways they would like you to be involved, but may not tell you this without you asking, "How can I best help with this relationship?" Know that what you may think is unimportant, the fundraisers may view as critical. Respect them in their arena. Remember that they're in the field, not your C-suite office. Be grateful, demonstrate your leadership, and show the gift officer in the philanthropy office that you genuinely value the work they do.

#### **Conclusion**

Many hospital leaders have little or no experience raising philanthropic investment. That means that while they must set the vision and plan, they also must listen to fundraising staff and learn from their expertise when making decisions. While hospital leaders shouldn't micromanage or do the philanthropy office's work for them, getting involved with securing philanthropic investment for the hospital, collaborating with gift officers, and sharing their strategic vision all help to boost philanthropic investment, increase revenue, and deliver growth.

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## Upcoming Events



### [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



Leadership Conference  
September 10–13, 2017  
The Broadmoor  
Colorado Springs, Colorado

*More information and registration  
coming soon.*

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## New Publications and Resources

[Board Leadership Succession Planning](#) (Intentional Governance Guide, March 2017)

[The Healthcare Transformation Frontier: Insights from the 2016 Forum on Consumerism and Transparency](#) (Conference Proceedings, February 2017)

[Combining Medical Staffs in a Multi-Hospital Setting](#) (Webinar, February 2017)

[Health Insurance Exchanges, Implications of Policy Uncertainties, and How They Are Interlinked](#) (Article, February 2017)

[BoardRoom Press: Volume 28, No. 1](#) (BoardRoom Press, February 2017)

[Continuous Governance Improvement](#) (Intentional Governance Guide, January 2017)

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