GOVERNANCE THOUGHT LEADERSHIP SERIES

Texas Healthcare Trustees

The Wide Angle Lens: New Perspectives for Governance

Providing education, resources, leadership development to inspire excellence in health care governance.

The ongoing transformation of the health care industry and individual pieces of that transformation have been well covered by media and experts. During a time of so much noise in the industry, it is important to step back and analyze the larger macro trends. These larger themes are contributing to the industry's fundamental disruption, at an accelerating pace, and should be a part of the conversation at the hospital governance level with a greater sense of urgency.

The purpose of this piece is to step away from the day-to-day dialogue and explore five specific macro themes that may be getting less attention in the conversation.

1. Leadership Transition Redefines Institutional Strategies

Today, health care organizations often articulate a focus on succession planning and evidence formal succession plans of one kind or another. However, the prevalence of external searches for key executive talent, including important c-suite positions, seems to demonstrate that the internal succession board is less than optimal. The 'succession plan' may resemble a wish list, rather than a well-planned succession that is a routine in-process activity.

It is a unique time for the industry's talent succession as more tenured, long-standing senior executives are reaching the end of their careers. This issue is further complicated by claims that talent pipelines are generally weak across the country. Both factors have contributed to a willingness and interest on the part of institutional leadership to explore non-traditional executive talent in some instances.

A landscape is emerging where new executive leaders from non-traditional venues and experiences are active succession candidates. Two examples of this increasingly popular types of candidate is the physician CEO and CEOs who come from non-health care industries.

The emergence of the physician CEO is reflective of increasing recognition that clinical leadership is required throughout the c-suite, and not just in the more traditional Chief Medical Officer role. Another forward-looking example is the selection several years ago of Carlos A. Migoya as CEO of Jackson Health System in Miami. Prior to his selection, Mr. Migoya was a local banking executive with significant community and political relationship equity. Under Mr. Migoya's leadership, Jackson has achieved a crucial level of financial sustainability and closed important public capital financings to fund the System's critical infrastructure needs. It seems reasonable to associate an important level of the 'turnaround' of Jackson with the deep banking acumen and community equity.

The strategic, operational and financial perspectives of these emerging types of executives will of course have been shaped by individual experiences, and will be expected to incorporate and execute from those perspectives as they take the helm. These non-traditional experiences (and accompanying playbooks) may serve as accelerators and disrupters that will shape the health care landscape.

2. New Purchaser Expectations

Fundamental to the risk capability point-of-view is the concept that the current transformational dynamic is not really being driven by "industry reform" as typically characterized; rather, the catalyst is fundamentally new purchaser expectations, with the "purchaser" defined as federal and state governments, employers, and (crucially) individuals. Purchaser expectations are creating momentum towards a new U.S. health care industry paradigm with unprecedented speed.

The intent of federal and state governments is well-publicized but institutional urgency and pace are not often keeping up with the expectations of governmental purchasers, especially how that shift is being perceived by the public. Emerging Alternative Payment Model frameworks put pressure on the provider community, not only in strategic APM planning for the future, but on current revenue streams as mandatory programs take hold. Frequently providers and others are trying to understand why their volumes are exceeding plans yet per-unit revenues are dramatically down. The impacts of governmental APM frameworks are a crucial component of that equation.

In the private payer market, the Affordable Care Act did not drive employers to forego offering traditional health plan coverage to their employees. In fact, the number of employers offering health plan coverage in 2015 is similar to the number in 2005. What is different, however, are the emerging new

expectations of employers regarding "value," which itself has multi-faceted definitions and can vary by employer. Sophisticated human resources leadership and complex cost dynamics are moving to the CFO's desk, driving an emerging new corporate financial understanding (and questioning) of the traditional insurance marketplace. This has spurred new levels of collaboration with local leaders in health care benefit program initiatives, and more robust dialogue that is insistent with respect to value development and delivery.

Governmental and commercial purchasers increasingly expect a retail experience as part of their definitions of value. Regardless of the retailing metaphor to describe what access to health care should be "like," the real experience for most Americans still falls short.

Two key factors – cost-shifting to individuals and technological adaptability – will drive a demand for an enhanced retail experience from health care organization at a pace that is currently not being anticipated by the industry in general. Emerging strategies to deal with this demand are in their infancy in the context of the overall health care economy. Strategies that relate to urgent care and retail pharmacy are informative. For example, the ability of retail pharmacists to be one of the prominent faces of a new retail experience is profound – the average American lives within five miles or less of the nearest community pharmacy, and yet:

- Approximately $300 billion is wasted each year by patients not taking their medications (13 percent of total health care costs).
- Chronically ill patients who take their medications save the health system up to $7,800 annually per patient, yet roughly 50 percent of all chronically ill patients stop taking their medications within the first year of starting such therapy.
- Up to 70 percent of hospital readmissions are related to poor medication adherence, estimated to cost $100 billion a year outside of hospital readmission penalties.
- Approximately 50 percent of all adult patients experience a medical error post-discharge and up to 23 percent experience an adverse event related to a prescribed medication.

These are well-socialized statistics. Yet the current levels of market-specific urgency and pace are not consistent with the opportunities the retail pharmacy presents as critical access point for population health in a new retail paradigm. The pace will likely increase with respect to disruptive strategies that create a transformed retail experience in order to harvest almost 15 percent of "bad spend" in the health care economy.

Finally, the traditional commercial payer will increasingly find it challenging to deliver value in this transformed health care landscape. Large and undifferentiated networks, disruption of the traditional broker framework, niche and segmented product/service challenges, and a need for a "Google-like" innovation response are driving the commercial payers to re-evaluate and re- construct their business models in real time and experiment market-to-market. This isn't to say the payers will go away – there is certainly a "too big to fail" component here that can't be ignored. Rather, the disruption emerging here represents significant opportunities for the direct provider-to-purchaser relationship to emerge without the involvement of the traditional payer in a new value paradigm.

3. Acute Care Capacity Becomes Commoditized

The commoditization of acute care capacity has important disruptive implications for health care systems and provision of care in every market. Declining inpatient utilization is emerging from a wide variety of population health, APM and "right-time right-place right-care" implications.

Population health, while still to some degree defined differently by different stakeholders, is becoming not only a central part of the health care lexicon but representative of multiple paths to a crucial goal of healthy communities. That goal has been relatively undefined and largely aspirational until recently; now, the emergence of population health baseline goals are central to the goals of many different constituencies. These are important societal matters at their core, as the effective management of chronic conditions, medication compliance, access to services, and personal responsibility for health will have a positive impact on quality of life for community members and the overall sustainability of the health care economy.

The research indicates that:

- The U.S. spends up to one-third of its health care dollars on medical services that do nothing to improve health and can even be harmful.
- Only 20 percent of health is determined by clinical care while 80 percent is determined by health behaviors and other non-clinical-care factors, so related other determinants need to be addressed in order to improve health.
- Shifts to APMs require that health systems consider the relevance of their value proposition and create new capabilities to deliver value against new purchaser expectations.

As well, technology and the rapidly increasing leverage of both "big" and "little" data to shape wellness and care paths is disproportionately impacting the need for traditional inpatient bed capacity. This is not to any degree strictly an EMR dialogue, although the ability to access and mine warehoused patient data in properly connected and populated EMRs is obviously important. Through the wider lens, this is a discussion about both speed and confidence in evidence-based medicine that defines tighter paths and dramatically reduces clinical variability and, therefore, cost. For example, the emerging transition of IBM Watson Health as a practical population health and clinical management platform is facilitating this transition. New technologies, leveraged against exabytes of relevant data, will provide speed and confidence to clinical decision making and may in the future not only supplement but may supplant direct clinical care in the traditional sense. The implications for traditional inpatient utilization are clear.

Finally, there remains a focus on retaining a fee-for-service mentality and continuing to plan provider economics around a core FFS model. The need to demonstrate ROI on significant facilities capital investments will necessarily drive market pricing down for these heavy, volume-dependent economic commitments.

The greater emphasis on the broader continuum of care should result in a focus on coordinating both wellness and care activities to reduce unnecessary medical care, reduces costs and improves quality. More innovative health systems are actively working to develop models designed to make traditional bricks and mortar inpatient capacity less relevant to delivery models. More advanced pharmaceuticals are rendering traditional inpatient stays less necessary and more advanced outpatient facilities and modalities are limiting the need for inpatient admissions.

These trends are not, as in the dialogue of the 1990's, "managed care" impacts on inpatient utilization. This is a focus on doing the right thing that deemphasizes the need for inpatient capacity and will create a supply and demand scenario that will necessarily commoditize inpatient capacity to an important degree. The concept that inpatient capacity will be subject to EBay-like auction is not wild-eyed; in Kaiser Permanente markets where KP doesn't have inpatient capacity, there is already a bidding process for defined "buckets" of inpatient capacity that KP contracts for, and anecdotal observation proves that pricing at the margin for that capacity is already the rule versus the exception.

4. The Traditional Ecosystem is Disrupted

Interest in the transformation of U.S. health care has never been higher. There are many reasons for this level of interest – some of them altruistic, some of them deeply personal, and all of them important. However, there is one interest that should be acknowledged and requires deeper system-wide consideration – that which is driven by entrepreneurial and economic considerations and will deeply disrupt traditional infrastructure and other operational platforms and modes.

The U.S. has a $3 trillion current health care economy that is largely unsustainable with incredible opportunities for improvement. The transformational environment has never been more encouraging and accepting of new solutions to help achieve. There is material economic opportunity to be harvested by creating and driving these solutions. As an example, every 25 basis points of "savings" on the $3 trillion health care spend is approximately $7.5 billion, which stated in revenue terms would place a disrupter who could harvest that level of opportunity squarely within the Fortune 400. This simple example demonstrates the dramatic levels of potential return that are available to disruptive innovators.

Given the economic stakes, it seems sensible that capital deployment will continue to align with greater urgency against the innovation required to harvest this economic opportunity. Scaled capital deployment will increasingly accelerate the "innovation engine," which itself will drive many of the changes to the landscape.

The business model transitions will require non-traditional stakeholders to intervene to bring order to these shifts. The dynamic mergers and acquisitions environment, which can involve physical mergers and more virtual partnerships and service consolidations, is ripe for order-making. The current "musical chairs" environment can result in less-than-thoughtful integration and deployment plans, and an innovator (with or without technology) can position itself as moderating transformational disruption and increasing the odds of success and, thus, anticipated return on investment. Both financing transformational activity and meeting/exceeding ROI expectations is risky business and likely requires incremental, non-traditional players to further assure success.

5. The Need for Greater Governance Sophistication

This level of institutional disruption calls for wholesale review of many health care organization governance models, to ensure that they are properly responsive to the transformational dynamic. This is a provocative and complicated topic, as health care organizations are deeply tied to the community and a diverse set of stakeholders.

Unfortunately, wholesale transformation of business models in a step-change environment requires levels of acumen and responsibility on the part of governance that have traditionally been the exception across the country. The need for governance that can both intellectually engage and confidently act with transformational agility around enterprise risk, capital deployment, strategic affiliations, clinical enterprise optimization, and revenue portfolio design – just to name a handful – is a remarkably challenging topic.

As health care business models undergo transformation, governance models need to not only match that transformation in urgency and pace, but should actually be well in front of the transformational dynamic to ensure the confident and responsible oversight of health care institutions.

Considerations for Governance

In order to provide the type of guidance and governance that health care organizations need to adjust for major paradigm shifts requires a nuanced understanding of key issues. However, beyond specific issues, it is crucial that hospital boards and leadership have a wide-lens perspective of macro trends that resulting from that change. The hope of this overview is to provide a summary of those macro trends from shifting payer expectations, changing faces of leadership, and market considerations for a new industry ecosystem.

There is a lot to keep up with in health care. Texas Healthcare Trustees is here to help our members, trustees of hospitals and health care systems throughout Texas, with resources that will help to stay up-to-date on important information that can impact how they lead their organization. THT's Governance Thought Leadership Series is one of many resources THT has available for health care board members. To learn more about this series and to view other tools and resources available, visit **www.tht.org**.

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