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Practical Governance

Co-opetition — The New Governance Challenge

PRACTICAL GOVERNANCE

Co-opetition – The New Governance Challenge

A White Paper Based on the Proceedings from The Chairman's Society

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Preface

Ernst & Young is proud to have joined with The Chairman's Society in presenting "Practical Governance 2004." We would like to extend our sincere thanks to The Chairman's Society for providing such a unique opportunity for hospital and health system Board Chairpersons and Chief Executives to discuss the most vital issues facing their institutions and the health care industry.

As the presentations and discussions at this important meeting so powerfully illustrated, these are unique times for the nation's health care providers. For hospital and health system Trustees and Chief Executive Officers, there is an increasing urgency to understand and deal with complex public policy issues, financial constraints, and intensifying consumer expectations related to health care access, quality, and affordability.

The ***practical governance*** perspective emphasized at The Chairman's Society conference helps health care leaders go beyond the polemics and contention that difficult health care issues always generate. Instead, the attendees hear from experts about and discuss their own immediate experiences in dealing with tough issues that impact their institutions' daily effectiveness and long-term future.

My Ernst & Young colleagues and I hope that this compilation of the ideas presented about health care governance overall and "co-opetition" specifically will be helpful and interesting to the nation's health care leaders. This report is one of several Ernst & Young communications initiatives — including the recent "Straight Talk About Clinical Quality from Health Care CEOs." We are delighted to assist in publishing this rich dialogue, but the ideas are truly those of our distinguished contributors. These publications underscore Ernst & Young's commitment to helping health care leaders navigate through these challenging and important times.

Rick Wallace
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Introduction

J. Larry Tyler, FACHE
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Co-opetition:

The business practice in which organizations simultaneously collaborate and compete with other organizations.

Co-opetition is not a buzz word or fad. While it may seem like a new development in the health care industry, the term and the actual practice of co-opetition have been quite common in other industries for many years. Co-opetition recognizes that at times an organization can be more successful if it reaches out to cooperate with another organization — sometimes, a competitor — who has a product, technology, service, or geographical presence that the first organization does not.

In simple terms, co-opetition seems simple and sensible. In reality, however, it can be complex and difficult.

For the governance and management bodies of health care institutions, co-opetition is one of the more powerful trends driving change in the industry. Co-opetitive business proposals that Boards and CEOs are now being asked to consider can seem straightforward. However, the impulses and motives driving those proposals can be troubling. They often relate to physician concerns about their own financial well being, to their lack of trust in their hospitals to find ways to promote physicians' best interests, and sometimes to breakdowns in open communications.

In developing the program for Practical Governance 2004, The Chairman's Society felt co-opetition was an important issue on its own as well as an issue that could be used to explore how hospital Boards and management could work together to understand and develop approaches to building — or re-building — productive relationships with their medical families.

Indeed, a strong theme running throughout a number of the presentations at our conference is that the key to effective health care governance is mutual trust. This is certainly true in any business or professional environment. It is even more critical for organizations in an industry that is confronted by so many complex financial and economic issues. Communications and trust are multidirectional and multiple-constituency processes:

- Board Chairpersons and their fellow Trustees must know, respect, and communicate with each other in order to be credible and effective.
- Hospital Boards and CEOs must likewise communicate effectively and adopt a strong, unified approach to tough problems and challenges.
- Boards and CEOs must mutually commit to addressing the issues that concern their institutions' staffs — because these issues will impact retention, effectiveness, and, of

course, physicians' and technical staffs' natural desire to seek economic security and job satisfaction.

We believe you will find the experience-based presentations by Errol Biggs, University of Colorado; Gregory Piché, a partner with Holland & Hart LLC; James Hinton and Larry Stroup, Presbyterian Health Care Services in Albuquerque, NM; and Joanell Dyrstad, Fairview Health Services; thought-provoking discussions about how health care leaders can strengthen foundations of communications and aligned goals.

The Chairman's Society also reached out to distinguished experts to address several important external factors that deeply impact health care institutions and their governance and executive management. Recent far-reaching changes in Medicare with regard to provider payment and quality improvement are addressed by Robert Langston from Ernst & Young and Bruce Vladeck from Mount Sinai School of Medicine. And Craig Kornett, from UBS Financial Services, discusses the relationship between the quality of hospital governance and a hospital's access to capital.

One of the health care industry's leading futurists and philosophers, Leland Kaiser, added his own unique perspective on how co-opetition fits into the much larger picture of how hospitals must be willing to re-imagine their futures and deal strategically with profound change factors.

Finally, Frankie Perry, FACHE, The Chairman's Society Executive Director, was generous in sharing her first-hand, practical experience in working over many years with hospital Boards, management, and medical staffs.

The cumulative message from these presentations as well as from much candid discussion is that co-opetition is multi-faceted in terms of what it means to hospitals today. Handled insensitively and insecurely, co-opetition can be a threat; but approached in a spirit of open communication and awareness of a larger context, it can also represent win-win opportunities.

Feedback from Practical Governance 2004 has been strong and positive. We hope and trust you will enjoy reading these proceedings.

J. Larry Tyler, FACHE

Survival Strategies in an Era of Co-opetition

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The most effective governance is visionary governance. Visionary governance requires us to think in future time.

The Rules of Visionary Governance

The most effective governance is visionary governance. Visionary governance requires us to think in future time. One can think in past time — and that is important because it explains who you are. Or one can think in present time — like bailing water out of a canoe. If you think in the present, you are going to be primarily in reactive mode.

Or you can think in future time. That is an attempt to design the kind of future you wish to live in. It is an attempt to change the nature of the game. Perhaps you recall that in the movie "The Matrix" a web of machines connects to brains of people and creates an artificial reality — called the Matrix. People within it have no idea they are in it. It seems real as long as they stay within the Matrix.

I would suggest there are two ways of thinking about your future. One is to stay in the game — play by the rules. The Matrix has rules. If you violate those rules, you get crushed. Or you can step outside the Matrix itself, which means creating a new reality. This is what visionary governance is all about.

It is important to remember the rules of the Matrix player:

Rule #1 is that nothing has to be the way it is. That is because of Rule #2 — which is that reality is a social creation. Reality is a product of our imagination, desires, beliefs, habits, and past. It is created by us. If you decide to accept this perspective in your work as a hospital Chairperson or Trustee, then the most profound statement you will ever make at a Board meeting would be: "This is not an acceptable reality. It must change." If you say that and mean it, it is very powerful, because most people assume the way something is today is the way it has to be in the future. That is simply not true. The reason visioning is so important is that it creates a new reality. So in health care today, I believe if we changed our collective mindset and consciousness, half of the problems in health care would disappear.

That is Rule #3 — the only thing that has to change is consciousness, because that is what creates the world we live in. I know this is true. There is a county in the United States, with which I have been working, in which people who have money and/or insurance pay for their health care. People who cannot afford to pay go to a free clinic that is staffed by retired physicians. This simple system has almost eliminated the misuse of the hospital's emergency

room. The hospital reciprocates by providing free hospital care to patients sent over from the clinic. To me, this shows that if you change your mindset, you do not need more resources or legislation.

Classical and Spiritual Economics

So I want to talk to you today along two paths. One path is philosophical and, perhaps, idealistic. Rejecting the old matrix in favor of creating a new reality is idealistic. However, we all recognize it is difficult. The second path is to look at ways in which you can become a more effective, forward-moving contributor within the existing matrix. Make no mistake — the latter is the lesser of the two options. The better option is to unplug.

One example behind this conviction is in one community I am aware of in which two hospitals engaged in litigation over competing services for the last two years. They spent more in legal fees than it would take to provide health care to all the poor people in that community. It is important to understand that when you hoard resources, you create a shortage; when you share resources, you create abundance. Classical economics, which is taught in business school, says that if I give you a dollar, I am a dollar poorer. There is also a spiritual economics that says if I give you a dollar, we are both richer.

Classical economics, which is taught in business schools, says that if I give you a dollar, I am a dollar poorer. There is also a spiritual economics that says if I give you a dollar, we are both richer.

The way we are running health care today is a demonstration of classical economics. It is not that one is true and one is false. The tragedy is that we make key assumptions and structure reality in this way. The tragedy is assuming there are not enough resources to go around and that laws are imposed from outside rather than generated from inside of the community.

At some point in the future in America, we will have to wake from the dream and unplug. We will have to ask important questions like: How do we provide health care for everyone? How do we create an abundance of shared resources?

The reason you would not ask such questions within the matrix today is that too many people make money off of it. For example, disease is good business. If you turn on the TV, you will see 20 commercials for pharmaceuticals, but not one commercial about how to live without these drugs. Look at the medical profession. There are many who argue that the function of a physician is to make sure a patient does not get sick. Yet if we look at how reimbursement occurs, how would a physician make money by keeping people from getting sick? The sicker people are and the more high technology it takes to fix them, the more the doctor makes.

These are the rules today for playing inside the matrix. As with all rules within a well-established matrix, they are artificial and protected by vested interests. At some point, you wake up from the dream. The matrix is a kind of sleep, but when you are in it you cannot see that. In the matrix, the primary self-sustaining goal is survival. At whose cost? Everyone's and anyone's.

Let us argue that all of us fall into one of three categories:

- People who play in the matrix and do not see it.
- People who get discouraged, unplug, and leave.
- People who say "Let's make this better — and it has to be made better from the inside out because the matrix automatically destroys anyone trying from the outside in."

The only way to make a change is by committed people — like yourselves — who decide to change the rules.

The rules can be changed as long as we are willing to step outside of what is taken for granted as the necessary reality. For example, I always take Boards who are my clients on field trips. We get on a bus and visit less fortunate areas of town. We talk to people about their health care needs and about what they can and cannot afford. I have seen this result in a hospital's decision to reinvest 10 percent of its annual net profit back into the community. Today, that hospital has partnered with agencies in about 20 community programs related to community health services, education, and prevention. This hospital Board decided to challenge the matrix because it believes everyone in its community should have access to the entire health care system.

One of the fundamental roles of the Board or Trustees of a health care institution is to create a consensual new vision — one that includes physicians — of what is an "acceptable" reality. When there is a consensual vision, it becomes a reality.

So one of the fundamental roles of the Board or Trustees of a health care institution is to create a consensual new vision — one that includes physicians — of what is an "acceptable" reality. When there is a consensual vision, it becomes a reality.

Building a New Covenant

Co-opetition is a change of rules that causes changes in reality — the reality of the health care market in a specific region. The players in co-opetition are still players within the matrix, but they are engaged in new dynamics that will inevitably bring about changes in the matrix.

Co-opetition simply says that physicians and hospitals will have a flexible relationship. At times, they will be business partners working together and sharing; and at other times, they will compete and not share. This formula is common in the business world, but it is relatively new in health care. We have never had or needed co-opetition because until recently there has always been enough demand and money to go around. What is happening today is that doctors are working harder than ever, yet still have trouble maintaining their income; and hospitals are just trying to survive. So we have two parties in survival mode, which almost always means those parties will be at war. Today, many physicians and hospitals look at co-opetition as a form of warfare.

There are physicians who see co-opetition as the only viable alternative to staying in the profession. Some hospitals see co-opetition as a direct threat and react defensively: They say that

if you are a doctor on our staff and you create a freestanding center, you are off our medical staff! Or they say, you are off the important committees. This all-good or all-bad approach does not work.

Hospitals and physicians must learn that hospital-physician relationships can be more nuanced — not just win or lose and, just possibly, even win-win. Until you recognize that your interests and someone else's interests have equal value, you cannot create win-win situations. This means we both must be committed to the fact that neither of us will fail. It means both participants must search for mutual advantage and understand each other's pressures. This is called a covenant relationship — and it is based on three principles:

- Mutual obligation
- Reciprocal benefits
- Trust

Successful co-opetition requires that a hospital Board and executive management take a strong leadership position in dealing with a physician-led co-opetitive proposal. Is there a constructive way we can work with each other? What are the common values, principles, and understandings that form the basis of a win-win relationship?

Inherent in this new covenant relationship role is the willingness to commit to reconciliation. Adversarial relationships inevitably involve negotiation, arbitration, and litigation. Reconciliation is an agreement among friends to develop a new relationship based on a common value — such as the well-being of the community. A relationship based on mutual commitment to reconciliation is also one that is committed to finding a win-win formula. It says that both sides can move from *survival* mode to *thrival* mode, based on the shared belief that enough resources will be available. And of course, there is no litigation in a true covenant relationship.

Mastering the Game of Co-opetition

There is a well-known theoretical context behind co-opetition. It is called game theory. Game theory is all about recognizing that reality in any marketplace is dynamic and evolving. It is about maneuvering in this dynamic reality to beat the competition. Game theory forces you to think through the consequences of your business decisions in a broader and deeper way than was required in the more one-dimensional context of traditional competition.

Control is a key concept — it is central to competition and central to the matrix. The big difference is that in co-opetition control is shared. There is no one-way, unilateral control. In a successful business venture based on co-opetition, everything is shared — capital investment, costs, revenue, and profit. Successful co-opetition also requires understanding *who* provides *what* value to a prospective new business venture.

Hospitals and physicians must learn that hospital-physician relationships can be more nuanced — not just win or lose and, just possibly, even win-win.

There are a few simple strategies for hospital Boards and executive management to follow as the trend toward co-opetition increases. These strategies are predicated as much on awareness that the game is changing as that the ability of any health care organization to continue doing business as usual and succeeding is increasingly limited.

Most hospitals do not have a culture of innovation and entrepreneurship. They have a culture of day-to-day operations.

First — co-opetition is American! If your doctors are adventurous enough to compete with you, then you must be innovative enough to compete — as well as collaborate — with them. You need to stay ahead of the curve. Most hospitals do not have a culture of innovation and entrepreneurship. They have a culture only of day-to-day operations. Most ventures by physicians groups are based on a perceived market opportunity — not merely on a self-interested desire for profit. So hospitals need to look to innovation as a way to compete effectively.

- One obvious type of innovation is simply to improve your product lines — to invest in improving your quality. This makes a hospital more competitive.
- Another innovation is to invest in research and development — the creation of intellectual property — that can be spun out for profit. This also includes forming partnerships. You can form a partnership with your physicians for the development of forward-looking ideas; and those can lead to partnerships with technology companies for joint development of new diagnostic approaches, devices, and medicines.
- Then there is the little-used strategy of investing resources in obtaining funding from philanthropies — where, unlike government funding sources, the funding possibilities are potentially limitless and more flexible. When I work with a hospital, I try to get the Board to pass a resolution setting aside one percent of operating revenue for research and development and innovation — and the other 99 percent for operations today.

Second — co-opetition energizes hospitals to become more competitive. Competitiveness is still not an intrinsic component of a typical hospital's culture.

- A hospital needs to bulletproof its core clinical operations. If a key area — such as cardiac — is your Achilles heel, then you must invest to become competitive again. If your institution is known for long Emergency Room waiting times and for other practices that negatively impact customer satisfaction, attack those issues directly and decisively. Visit other facilities — not just in your market, but everywhere — because one of the basic steps in innovation is to plagiarize. By the way, if you are world class, you can charge anything you want! There is still a strong mindset in hospitals that all services must be paid for by third-party payers.
- Another perspective on competitiveness is to be proactive — not just reactive and defensive. Identify one or more areas in which your hospital is or could be a leader and invest in order to maintain and ideally increase your leadership. Add special features that your competitors will find difficult to match.
- Use aggressive marketing to build consumer recognition and brand dominance within your market. One mistake hospitals make is to assume their entire market is just their

immediate service area — that area within driving distance of their facility. If you are just only as good as everybody else, that is so true! If you have competitive advantage in terms of innovation, technology, staff, and track record, then you can promote your brand far beyond your immediate service geography.

Hospitals that consciously invest in innovation are generally more successful than others in developing world-class services. This gives them access to consumer discretionary spending and better access to capital, particularly from philanthropies.

Third — dealing with co-opetition requires creative and flexible management of relationships with hospital physicians.

- One approach is actually to encourage an entrepreneurial relationship between a hospital and its physicians. Hospitals can take the high road by forming a hospital-physician investor group to study possible joint ventures and consider proposals from outside investors. The strategic goal is to develop more extensive and deeper strategic partnering with physicians based on reciprocal obligations and mutual benefits. This approach recognizes that co-opetition is always preferable to outright competition. This allows all parties to co-author the rules of "engagement" — rather than force one party into a strictly defensive mode.
- When it becomes clear that physicians are determined to engage in co-opetition, the hospital should make a well-considered decision about the continuing role of those physicians on the hospital's strategic committees.
- It is important to operate in the community interest. In the larger dynamic of the matrix, the hospital will manage some, but not all, co-opetition challenges to its satisfaction. Negative public relations campaigns are not appropriate. In a sense of openness and fairness, however, the community should be kept informed about both events and the pros and cons of what co-opetition will or could mean to the community.

More than Just Survival

Hospital Boards and Trustees are rightly concerned about the unfolding dynamic and eventual impact of co-opetition on their institutions. Co-opetition is about more than just hospital survival. It is equally a strategic business issue and important public policy issue, because it impacts the availability, cost, payment, and quality of patient care and community health. Dealing successfully with co-opetition requires Board awareness and astuteness, a keen sense of where the institution is positioned on the playing field, and the strategies it must adopt to survive and thrive.

Hospitals that consciously invest in innovation are generally more successful than others in developing world-class services.

The Governance Factor: 33 Keys to Success in Health Care

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I became interested in hospital Boards when I was with a company that managed non-profit hospitals. At one point, I was in charge of 12 hospitals — and that meant attending numerous Board meetings. I could not help noticing that some of these Boards functioned much more effectively and smoothly than others — even though the Board members generally had similar backgrounds and the issues we were addressing were similar.

So I came to the conclusion it would be helpful if there were a book available that would tell new board members everything they need to know. I also thought such a book would be useful for a Board Chairperson to give to a Board member who was not functioning well on the Board. The result is *The Governance Factor — 33 Keys to Success in Healthcare* (ACHE/HAP, 2003). Much like the theme and focus of this meeting — "Practical Governance 2004" — this small book is a practical discussion of key hospital Board issues and an information resource — including a glossary of technical, medical, and financial terms. Let me cover a few of the highlights of the book — some of which are controversial in terms of how hospital Boards should be managed and the issues they should address.

Governing Board Features and Responsibilities

It is important that hospital Boards and Board Chairpersons remember the distinct nature of their role in governing a hospital. Hospital Boards sometimes lose sight of the fact that they have authority only when they are meeting. Individual Board members also sometimes forget that no one Board member has individual authority. This is important in how a Board and its members interact with each other and with the hospital CEO.

Boards are not like congress or the courts in that they do not issue majority and minority opinions. Boards must reach one conclusion on an issue and speak with one voice. If a Board member says in public that a recent specific Board decision was a bad decision, that is his fault. If he says that repeatedly about other decisions, then it is the Board's fault for not removing him from the Board. Lack of unanimity only undermines the Board's credibility and effectiveness in governing the institution.

Responsibilities of a Hospital Board

There are about 7,500 health system and hospital Boards in the United States today with about 120,000 Board members. By far, most of these are the Boards of non-profit (Tax

Exempt 501 C-3) institutions. There are numerous other types of Boards — from Academic Medical Center Boards to city, county, and district Boards whose members are elected by the voters.

It is sometimes not fully appreciated that hospital Board members have a tough and at times thankless job — along with significant responsibilities. Imagine what a help-wanted ad for a hospital Board member would need to say about difficult issues, complexity, and pressure.

Because time is a Board's most precious commodity, focus on key responsibilities is critical to its effectiveness. The hospital Board, in my view, has five key responsibilities:

First, the Board's ultimate responsibility is to envision, articulate, and focus on implementing the institution's mission, vision, and goals. Every health care institution has an articulated mission, and it is easy for the Board and the institution to stray from it. But if at the top of the agenda of each Board meeting were the hospital's mission statement, it would be easier for the Board to stay focused. It would be easier for Board members to ask, "Why are we even talking about this, when it is not related to our mission?"

HELP WANTED - HOSPITAL BOARD MEMBER

Looking for someone willing to assume a position of tremendous responsibility overseeing an organization in one of the most complex industries in America. Significant time demands preparing for and participating in numerous board and committee meetings. Ongoing education on multiple subjects required, including attendance at weekend retreats. Subject to intense scrutiny of the public, physicians and, possibly, the state attorney general's office. Little-to-no pay. Advancement opportunities comprise becoming a board officer and doing much more of the same.

Second, a Board must assume ultimate responsibility for ensuring high levels of executive management performance. The Board does this by focusing on the performance of the *only* hospital employee who reports directly to the Board — and that is the CEO. While high-level performance of the CFO, VP of Nursing, and other senior executives is critical, that is the CEO's direct concern and not the Board's.

Third, the Board must assume ultimate responsibility for ensuring the quality of patient care. When a Board gives its Quality or Patient Safety Committee stature equal to its Finance Committee, that sends a powerful message throughout the hospital.

Fourth, the Board must assume ultimate financial responsibility for the institution's financial health. This can be particularly problematic at non-profit institutions where the Board focus is more on achieving break-even, than making a profit. It is, however, important even for a non-profit to make a profit at least equal to its cost of capital — otherwise the institution risks going into a downward spiral with no operating funds to invest in the future.

Fifth, the Board must assume ultimate responsibility for itself. Effective Boards make a serious effort to evaluate their performance — often based on a written description of responsibilities and annual goals. This self-management also includes continuing education and maintaining an awareness of important industry, economic, and local community issues and trends. This self-scrutiny is led by the Board Chairperson — not the institution's CEO.

The Chairperson's Responsibilities

A hospital Chairperson has a variety of straightforward governance-related responsibilities that are defined in an institution's bylaws. However, the Chairperson plays several roles that are more difficult to spell out and even harder to evaluate. So in that context, it should not be a big surprise that there are many people who are strong Board members, but lousy Board Chairpersons.

Arguably, the most important strategic role for the Chairperson is to be a counselor to the hospital CEO on matters of governance and the CEO's relationship with the Board. This counselor and mentor role can be the key to the CEO's effectiveness in moving the institution forward. It is a role that is particularly important when the institution is in crisis and faces public and media scrutiny.

At the same time, the Chairperson must also be a counselor and mentor to Board members. This is particularly important with new and promising, but relatively inexperienced, Board members. So the Chairperson sits in a unique and often delicate position, which requires traits and skills that not all Board members have. At the same time, it is important that both a Board and the CEO are mindful that in a governance context, the Board controls the Chair — the Chair does not control the Board.

Key Issues Boards Should Address

Hospital Boards must be concerned with a broad range of issues — large, strategic issues related to the long-term state of their institutions — as well as more tactical, governance-related issues that impact their own effectiveness.

The University of Colorado's Graduate Health Administration Program recently conducted a survey of 2,500 hospital CEOs asking them what key issues they believed their Boards should be addressing. Just to get a different perspective, I then looked at a survey of public company Board members conducted by the National Association of Corporate Directors.

Both hospital CEOs and corporate Board members agreed that financial performance and strategic planning were crucial. Interestingly, hospital CEOs did not rank their Board's oversight of CEO succession planning as a top priority, while corporate directors are preoccupied with succession. Hospital CEOs saw conflict of interest as important, while corporate directors did not. In this era of concern about governance, conflict of interest, and disclosure,

Responsibilities of the Board Chairperson

- Presides over board meetings
- Designates committee chairs
- Serves as ex officio member of all Board committees
- Serves as Board's primary representative to key stakeholder groups
- Serves as counselor to CEO on matters of governance and Board/CEO relations
- Specifies annual Board objectives and approves Board meeting agendas
- Recruits new Board members, provides Board member orientation, development, and evaluation
- Assumes other responsibilities and tasks as directed by the Board

it would not be surprising to see both public (non-profit) and private sector institutions come to share exactly those concerns.

In *The Governance Factor*, I discuss in some detail a host of practical governance matters that are top-of-mind issues for hospital Boards. Board Chairpersons and their Boards really do devote thought and discussion to how and how well they work among themselves and with the institution's CEO who, in most cases, is also a Board member. Let me single out just four practical issues that have significant strategic impact on a Board and the institution itself.

Board Selection Process: There is growing consensus that the position of hospital Board member has long ago stopped being an honorific "letterhead" appointment. And a Board seat cannot be an "on-the-job-training" exercise. With today's health care issues so complex and hospital problems so serious, Board members need to:

- Commit the needed time
- Be intellectually capable of learning and understanding the issues
- Know how to be a team player
- Have the personal staying power to be effective

Boards should represent diverse professional backgrounds and skills as well as be comprised of individuals who are accomplished in their respective fields. Affluent Board candidates are often, but not always, both influential in the community and highly accomplished. Board Chairs are responsible for leading the Board selection and vetting process.

Board Member Term Limits: The most often expressed argument for specific Board term limits is to ensure that weak Board picks do not stay on the Board any longer than necessary. However, term limits deny the Board the flexibility to remove ineffective Board members prior to their term expiration. Conversely, term limits also cause the departure of invaluable, experienced Board members who are otherwise willing to continue their valuable service. My view is that instead of term limits, a Board needs a self-assessment and a discussion framework, driven by the Chairperson, that facilitates the renewal and strengthening of the Board. Chairperson terms, on the other hand, should have set limits. Ideally, those limits should be defined in the context of a Chairperson succession process designed to ensure that future Chairpersons serve for several years on major Board committees and even a term as Chairperson Designate or Vice Chairperson.

Governance versus Management — Why Boards Micro-Manage: When Boards manage — or, worse still, micro-manage — as opposed to provide governance, it can be as simple a matter as the information packets they receive prior to Board meetings. If a Board is given management information, it will tend to manage. It is the dual responsibility of the Board Chairperson and CEO to define the meeting agenda and compile relevant and appropriate information. Other dynamics are involved as well — as when directors have specialized

Top Hospital Board Issues

- Financial Survival
- Strategic Planning
- Conflict of Interest
- Quality of Care Oversight
- Board Evaluation & Education
- Community Relations
- Accomplishing Mission
- Physician Relations
- Term and Age Limits
- Board Selection Process

knowledge and keen interest in a subject — whether it is the latest cardiology technology or debt refinancing. The most effective proactive approach to minimize micro-management is for the Chairperson to provide a job description and orientation for new Board members that clearly delineates the Board, governance and the CEO's management responsibilities.

CEO Succession Planning: CEO succession planning has never been a well-known strength of hospital Boards. In today's tense health care environment, Boards need to step up to the plate with a detailed, well-considered succession planning process. Typically, a Board's Executive Committee drives the process, but the entire Board should be involved so there is unanimous buy-in in terms of a CEO departure and the naming of a successor. At least three fundamental factors are involved in hospital CEO succession planning:

- The CEO and Executive Committee must assess internal management talent and develop an executive leadership plan that invests in the development of future institution leaders. (At the same time, it is shortsighted for a Board Chairperson not to identify a potential executive search firm that could be engaged on short notice to conduct a CEO search.)
- Both an institution's mission and plans change and Boards change — so it is important that a Board Executive Committee carefully update the CEO job description and character trait description prior to initiating a formal search.
- Boards need to develop a CEO transition plan that minimizes institutional disruption, staff resignations, and damage to investor confidence.

Conclusion: Hospital Governance Post-Sarbanes-Oxley

The governance and management concerns of non-profit, for-profit, and publicly held hospitals and health care systems have rapidly aligned over the past few decades. This has been primarily because the federal and state reimbursement and regulatory apparatus has introduced complex management burdens and concerns.

Another powerful driver of that alignment is the Sarbanes-Oxley Act. This legislation, in large measure a response to cases of corporate malfeasance, sets a high bar for accountability and transparency of publicly held companies. Executive management is now more accountable than ever for full and accurate financial disclosure. Hospital Board Audit Committees are now required to be more independent than ever before and are more rigorously accountable for management's disclosures than ever before.

Non-profit hospital governance, in my view, will in the near future and for years to come also feel the impact of Sarbanes-Oxley. At the very least, the rigor of Sarbanes-Oxly governance independence will become "best practices" for non-profit Boards. State legislatures, state attorneys general, and the IRS are already considering proposals related to conflict-of-interest

and financial disclosure in the non-profit sector. Such proposals and eventual legislation will almost certainly influence lenders and bond rating agencies' reviewing practices. This is arguably a long overdue and positive movement — one that adds a new dimension to hospital governance.

Top-of-Mind Internal Board Issues

- Mission Statement
- Size
- Board Selection Process
- Term Limits
- Governance vs. Management
- New Trustee Orientation
- Physician Membership
- CEO as Board Member
- Outside Director(s)
- Board Compensation
- Board Retreats
- Chair Selection Process
- Board Meeting Frequency
- Age Limits
- CEO Success Planning
- Stakeholder Analysis

The Board's Relationship with Physicians: The MMA Opportunity

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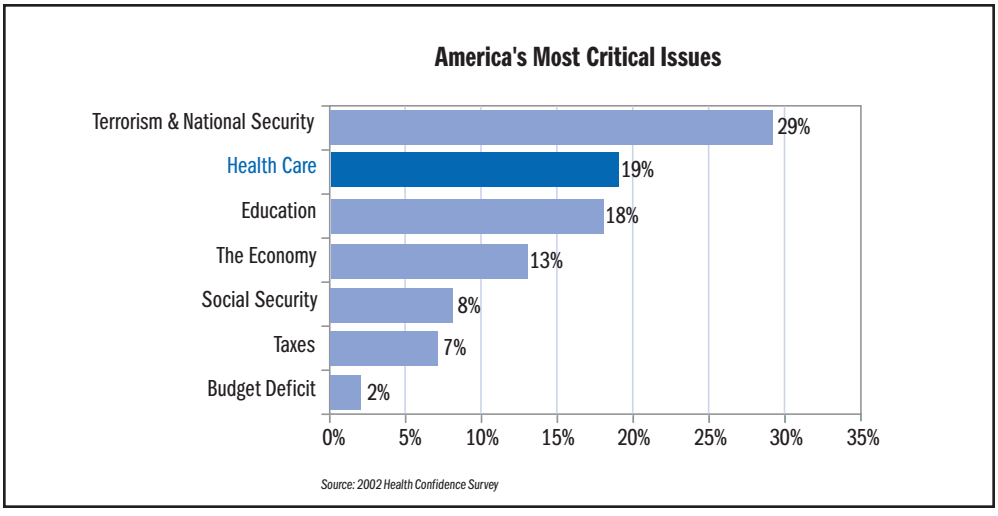
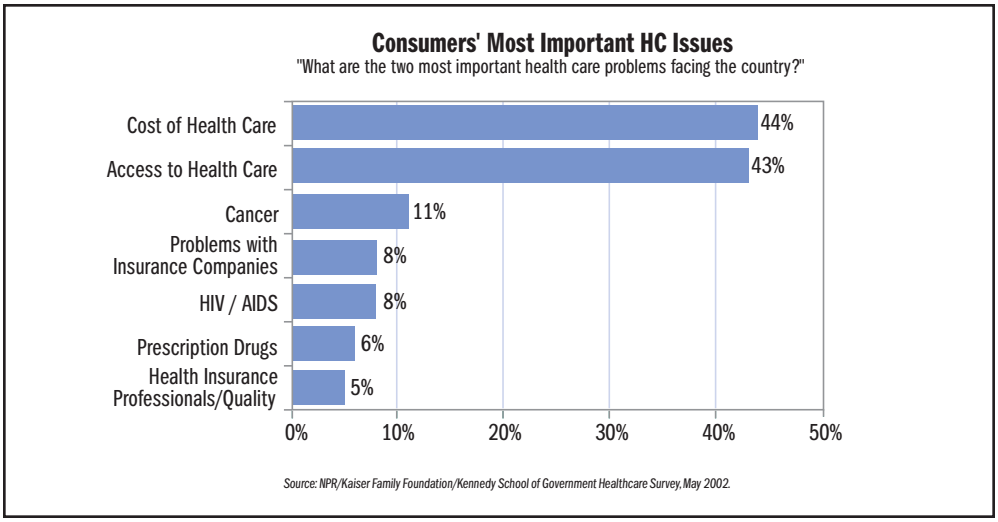
The rise of co-opetition is adding even more complexity, uncertainty, and economic pressure to the already complex and changing U.S. health care industry. To deal with co-opetition effectively, it is important for health care institution Board Chairpersons and their CEOs to understand the impact, implications, and potential opportunities of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

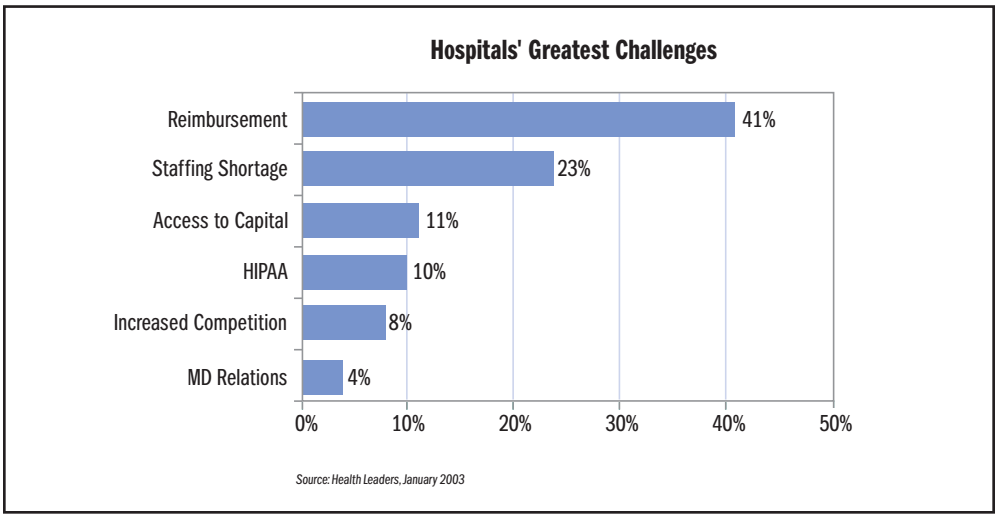
Alignment of Health Care Issues and Concerns

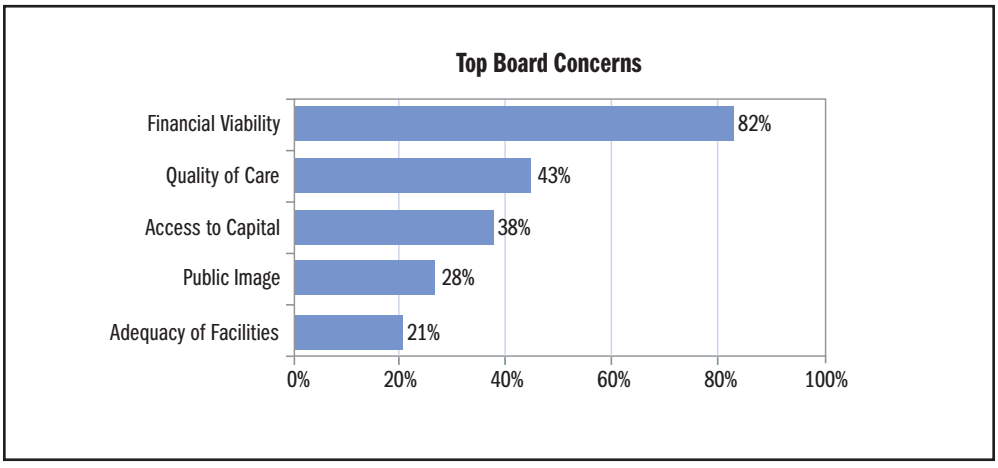
There is a strong unanimity at various levels of society about the compelling importance of health care. After terrorism and national security, a recent consumer poll found that health care was the most important issue. The 2002 Health Confidence Survey of consumers found that cost of health care and access to health care are the top of mind issues. And it is hardly surprising that hospital CEOs and Board members agree that reimbursement and financial viability are driving concerns.

Hospital Boards also believe that access to capital and adequacy of facilities are looming issues, because they are related to reimbursement. If a hospital cannot optimize its reimbursement revenue, it will not have debt capacity and access to capital, which means it will not be able to invest in its physical plant. These critical strategic issues are all interrelated. This complex web of driving factors reinforces the idea that hospital governing bodies need to be thinking in future time — and not just linearly and reactively.




Consumers' Most Important HC Issues
"What are the two most important health care problems facing the country?"
Cost of Health Care
44%
Access to Health Care
43%
Cancer
11%
Problems with Insurance Companies
8%
HIV / AIDS
8%
Prescription Drugs
6%
Health Insurance Professionals/Quality
5%
0%
10%
20%
30%
40%
50%
Source: NPR/Kaiser Family Foundation/Kennedy School of Government Healthcare Survey, May 2002.


Hospitals' Greatest Challenges
Reimbursement
41%
Staffing Shortage
23%
Access to Capital
11%
HIPAA
10%
Increased Competition
8%
MD Relations
4%
0%
10%
20%
30%
40%
50%
Source: Health Leaders, January 2003


Top Board Concerns
Financial Viability
82%
Quality of Care
43%
Access to Capital
38%
Public Image
28%
Adequacy of Facilities
21%
0%
20%
40%
60%
80%
100%

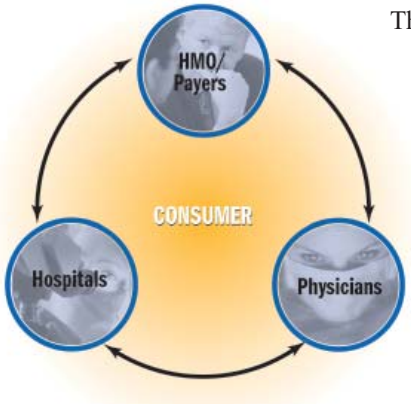
Hospital Trustees, in addition to worrying about their institutions' basic financial health, are critically concerned with:

- Physician alliances and arrangements
- Long-term strategic planning
- Quality of care and patient safety
- Employee recruitment and retention

These factors are also related directly and indirectly to the Medicare/Medicaid and regulatory apparatus and the long-term financial viability of their institutions. As we will discuss, quality is now for the first time explicitly and quantitatively linked with reimbursement. In addition, many non-profit hospitals are incorporating select provisions of the Sarbanes-Oxley Act of 2002 into their business practices. This trend will continue to be a major focus area as governance of non-profit organizations comes under increasing scrutiny by regulators at federal and state levels.

MMA and New Opportunities for Hospital-Physician Cooperation

Co-opetition, in this case, is all about a hospital's relationships and various arrangements with its physicians. Until recently, it could be said these relationships were "relatively" simple — or at least familiar — in terms of how hospitals and physicians shared different pools of money.

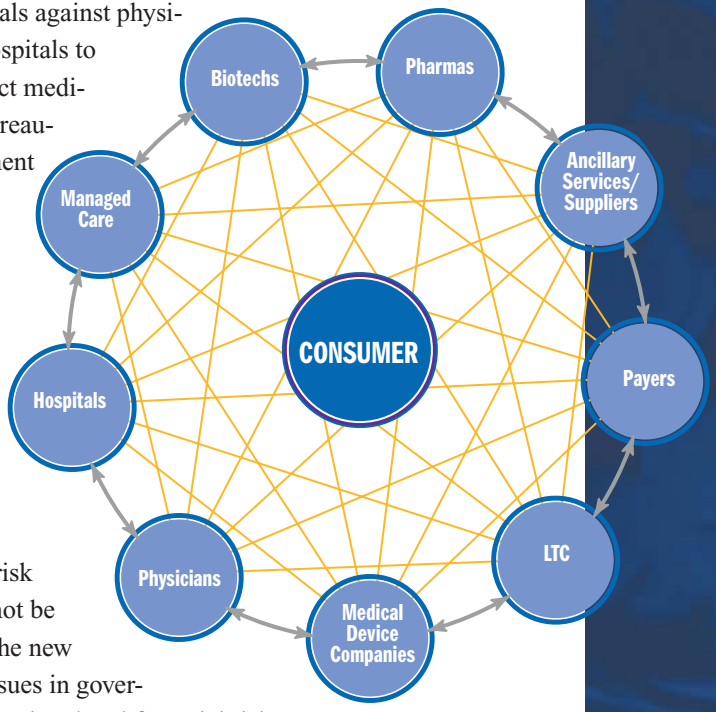


The Old Health Care Economy

The "three-legged stool" of the old *health care* economy, which is still operative to some extent, depicts a linear economic model for health care delivery and reimbursement. A far different and more dynamic model is emerging, however. A new *health sciences* economy is emerging and it is changing the way the industry sectors relate to one another. The interaction among the sectors will change in meaningful ways and the entire system will experience disequilibrium as MMA drops two huge pools of new money into the health care industry — somewhere between $400 million and a trillion or more dollars over the next ten years or so.

This disequilibrium will inevitably trigger opportunities for the different players. The challenge will be to find those opportunities and develop new relationships and ventures to capitalize on them. Hospitals and physicians will continue to be bound together, but the reimbursement morass will make it difficult to align goals and incentives. For example, cost

containment efforts will continue to pit hospitals against physicians. Financial and regulatory pressure on hospitals to improve clinical quality will continue to impact medical staff independence. And the continuing bureaucratic culture of hospitals — with no government incentives to make hospitals less bureaucratic — will only stand out in even greater contrast to the growing entrepreneurism of physicians.



It is helpful to think about these new dynamics and the new health sciences economic model in the framework of risk and risk management. As we look at the concerns about health care services and reimbursement as expressed by hospital Boards and CEOs, it is clear health care leaders are worried about risk of failure — including the risk that they will not be able make their organizations competitive in the new world. This basic concern coalesces around issues in governance risk, legislative and regulatory risk, operational and financial risk, and compliance risk. My focus today will be primarily on legislative and regulatory risk as reflected in the changes that MMA introduces.

Legislative and Regulatory Risk – Compass for Navigating Change

The landscape of legislative and regulatory risk is extraordinarily broad — and made all the more challenging by new legislation and regulatory change. This risk includes:

- Federal and legislative attacks to expose and prevent fraud and abuse
- Intense consumer pressure for a prescription drug benefit
- Financial burden of the uninsured
- Quality regulatory risk

All of these elements represent a blueprint for regulatory risk analysis. It is important to realize that these risk elements are interrelated — and that significant changes in one or more elements will reverberate throughout the entire new health sciences economic model.

Medicare reform, MMA particularly, will trigger both structural and payment changes throughout the sectors — particularly in the pharmaceutical and biotech, managed care, provider, and consumer sectors.

MMA reflects some of the intensifying pressure on Medicare to reform and evolve. The Baby Boomers are reaching retirement and will double the number of Medicare beneficiaries over the next 20 years. At the same time that both demand for services and expenditures have been escalating, Medicare has been notoriously slow in adapting to new medicine. MMA addresses this to some extent — and this will create new opportunities for innovation in health care organizations. Then there is the increasing pressure for supplemental coverage. Medicare is the only major insurance program that does not have catastrophic coverage associated with it.

Recent changes in Medicare, MMA specifically, are in part driven by what seniors want — more choices, better benefits, improved health care delivery, and improved access. The resulting Medicare drug bill, as we all know, has received extremely mixed response. Seniors did get a prescription drug benefit, but of questionable value; and there are new preventive benefits, but they have nothing to do with chronic care or preventive care. However, MMA does address access to care in rural areas of the country, giving rural institutions more money, strengthening rules about critical access hospitals, and creating demonstration projects related to changing wage guidelines for rural hospitals.

MMA is designed to trigger both structural and payment changes. These in turn will be the catalyst for behavior changes within the different sectors and will open new opportunities — opportunities that could strengthen hospital-physician relations and provide mutual financial benefits.

Pharmaceutical Issues: In the pharmaceutical sector, the most relevant structural changes in Medicare are the drug discount program, sponsored cards, and the new Medicare Part B prescription drug benefit. Two other important, more subtle, changes are in prescribing standards and intellectual property reform.

Medicare's push for a uniform prescribing standard stems from the Medicare Doctor's Office Quality (DOQ) project aimed at eventually requiring physicians to migrate to electronic medical records. This will involve adopting a standard nomenclature and new information technology for handling patient data. CMS believes this is essential for reducing medical errors and decreasing costs. Physician offices are probably among the least computerized places on the planet — and it costs money to address this. So this could be an interesting opportunity for hospitals and physicians to work together to capitalize on new MMA funding in this area.

Another potential win-win opportunity is MMA's willingness to fund demonstration projects that will lead to the development of new treatment methodologies that reduce pharmaceutical costs. For example, there is debate and competition about the relative benefits and cost advantages of self-injectible and oral drugs. These are opportunities for hospitals and physicians to work together in this area.

Blueprint for Regulatory Risk Analysis

- Fraud and Abuse
- Budget and Economy
- Medicare Reform
- Prescription Drug Benefit
- Uninsured
- Quality
- Biodefense
- Drug Reimportation
- HIPAA

Biotechnology Issues: The biotechnology sector looks a lot like the pharmaceutical sector. However, the big news is the new incentives in MMA for moving more new science through the approval system faster and cheaper. Today, even after the FDA approves a new medicine, it has to go through an entire Medicare approval cycle. To address this, CMS has created a Council for Technology and Innovation that brings the approval cycles in parallel.

On the payment side, MMA provides payments to hospitals for new treatments and products — such as radioactive brachytherapy devices — and expands payments for routine hospital care for clinical trials. These are opportunities for hospitals and physicians to work together.

Managed Care Issues: MMA invites managed care companies to come back into the business by paying about what they would pay for fee-for-service. This new approach to reimbursement gives managed care programs the opportunity to be profitable. In 2006, managed care companies will be invited to compete for business on a regional basis. MMA will establish regional plan stabilization funds within small geographic areas. There is a distinct possibility that CMS will also establish quality standards in order to qualify — so this support will come at a price.

Since 2003, when it looked like MMA would be enacted, about 50 plans have applied to the new program and another 40 plans have expanded geographic reach. With this "new" force entering the market, hospitals and physicians will feel the impact. First, managed care companies' new power in the marketplace will mean they will have stronger leverage with providers. Second, they will have an impact on the competitive dynamic among hospitals and physicians as they look at quality issues, medical regimens versus pharmaceutical regimens, access to care, formulas, and the like. So figuring out how to deal with this operational flux and this power will be a challenge for you and your physicians.

Provider Issues: MMA also affects hospitals directly and certainly affects the emerging role of co-opetition in the health care industry. The two most significant structural changes are:

- **Curb on expansion of niche hospitals**. This move will cool physician interest in such investments. On the other hand, physicians will still have money available to invest and their entrepreneurial spirit will still compel them to look for new ventures. So this could open a new playing field for hospitals and physicians to explore and pursue new for-profit ventures.
- **Quality and Pay for Performance**. Quality will be the watchword of the day. The real issue is the linkage between quality and reimbursement, and the nature of the rules and standards on quality that emerge.

In terms of provider payment changes, most of the changes impact rural hospitals. MMA improves the ability of rural hospitals to survive through a series a funding increases, including more Critical Access Hospital (CAH) payments, more disproportionate share reimbursement (DSH), and increased funding for indirect medical education.

However, most important in MMA's provider payment changes is the rebasing of inpatient prospective payment (PPS) rates. This provision is just two lines in 700 pages of legislation, but it mandates a CMS demonstration project to look at the appropriateness of inpatient prospective payment rates. The original data for the PPS is from the early 1980s, so we know that we have rates today that do not reflect today's hospital cost structure.

The worrisome open issue is whether CMS will "get it right." Will it mean more money or less money? Will they re-order money among the DRGs? How this issue plays out will present hospitals and their physicians with issues and opportunities in terms of deciding what your business is going to look like and what new businesses you will be going into and with whom.

On the non-hospital provider side, MMA calls for changes that either freeze or reduce reimbursement rates. In the next five years alone, MMA will reduce reimbursements to non-hospital providers by about $36 billion and by $90 billion over the life of MMA. Physician-owned clinics and other for-profit clinics and ambulatory surgical centers that provide high-value, high-profit services are going to experience a steady decline in reimbursement rates to levels that will not support their facility costs. Physician reimbursement rate cuts are also increasing, which will impact compensation. Between the two, physicians will start to feel pain, so this will create an opportunity for hospitals to talk with them.

Consumer Issues: MMA is ultimately driven by the mounting pressure of consumerism. Consumerism as related to the health care sector has always been based on the premise that if consumers controlled more of the money in health care, they would increasingly influence hospital strategies and capital investments. Whether this has actually been the case can be debated. Moving forward, consumers will control more health care dollars than ever:

- First-dollar coverage — i.e., deductibles and coinsurance — is increasing.
- Consumers are paying more of the premium dollar versus their employers.
- Consumer-direct health plans and Health Savings Accounts (HSAs) are becoming increasingly popular and will soon represent a significant pool of consumer-controlled money.

With MMA, CMS also addresses the enormous consumer-driven issue of quality. It is often pointed out that the entire consumerism movement is based on the explosion of data about virtually all products and services that is readily available in print and electronic media, particularly on the Internet. In the health care sector, significant quality data exists, but consumers are ill-prepared to understand what that quality data mean. Add to this the explosion of clinical information available — and a scenario forms in which the new health sciences

economic model will become increasingly consumer-centric. The impact on hospitals and their physicians will be profound.

Pay-for-performance is here to stay and will become a powerful driver of hospital and physician behavior. For example:

- New reimbursement formulas are based on a pay-for-performance formula.
- By championing the Premier Demonstration Project and National Voluntary Reporting Initiative, CMS is a driving force and will ultimately establish universal quality standards.
- Commercial Health Plans are also moving ahead with standardizing quality incentives.
- Multiple coalitions and agencies (Agency for Health Care and Quality, Leapforg Group, National Quality Forum) are also driving this effort.
- Multiple states are mirroring CMS efforts by formally encouraging and working with resident health plans to link demonstrable, quantifiable quality performance with credentializing, hospital and physician payments, and bonus payouts.

By introducing disequilibrium into the health science economic model, MMA cannot avoid becoming a significant change driver throughout all sectors. MMA seems to create intriguing new opportunities for hospitals and physicians to work together for mutual benefit. Co-opetition and outright competition will remain options, but perhaps become less and less desirable.

Hospital-Physician Relations — Critical Considerations

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One Vision, One Organization

At a conceptual level, few hospital Chairpersons and physicians would disagree with the premise that in a constantly changing economic and technological environment, hospitals and physicians must develop and use mutual trust and understanding to improve quality of care. After all, trust is the belief that those on whom we depend will meet our expectations of them. Hospitals and physicians have traditionally had trust-based relationships in which there was a common alignment of values and commitment to patient care and community well-being.

What we have come to today, however, are "distances" that are unparalleled in the history of hospital-physician relationships. At many hospitals and in many communities, trust has broken down. While both hospitals and physicians are still committed to the vision of quality care and community well-being, each sees a different path entirely to achieving the vision.

My objective is to look at how we have come to this point — and then suggest some ideas about how to rebuild those trust-based relationships.

The "Distances" Increase

Today, there is direct competition between hospitals and physicians — and that competition is turning into outright warfare. There is increasing retaliation by hospitals against physicians — sort of the "empire strikes back" against "disloyal" physicians. There are many physicians who believe hospitals have become largely irrelevant white elephants. These physicians believe the market should be the main factor in determining the future of health care — and that future includes for-profit ambulatory surgical centers, surgical hospitals, and office ancillary services.

There is a lot of very good, very cheap technology available today — such as $3 million CT scanners that can be acquired for $300,000. Combine that with growing physician interest in entrepreneurial ventures and the desire to increase or at least maintain their compensation — and a new physician business strategy develops: A wholesale chronic disease business strategy where clinical specialties with high degrees of clinical affinity ally to fully exploit the most profitable specialty areas along with a full continuum of care. Many hospital CEOs would say this strategy is an accurate snapshot of what is eating away at hospitals' bottom line today.

At the same time, and along a parallel track, hospitals are confronting a variety of looming risks:

- Hospital free cash flow and bottom line are increasingly dependent on a few clinical specialties.
- Physicians who drive contribution margin in sizeable single- or multi-specialty groups are under economic pressure and their incomes are at risk.
- With hospital capital budgets severely limited, physicians are waiting in line for their turn at clinical service enhancements.
- State regulations favor entrepreneurism and even the Stark Rules do not prohibit office ancillary services, which means that market entry is easy.
- Specialists are intensely concerned about personal income, control over their future, and getting things done in the hospital.

So as trust and productive communication continue to break down, the overall situation devolves. We are seeing retaliation by hospitals against their physicians who embark on competitive and co-opetitive ventures — everything from excluding them from leadership positions, to economic detailing, and supporting legislation to strengthen "certificate of need" requirements.

How Did We Get Here?

It is reasonable to ask about how all this happened. One could say it started when hospitals hired emergency room physician specialists. In the old days, all physicians at a hospital took a turn in ER. Physicians always met at the hospital. The hospital was the center of their professional existence and the key to sustaining a strong collegial environment.

As medical specialization increased, so did hospitals' hiring of hospitalists — staff doctors who provide general medical care for hospitalized patients. Many physician specialists reached the conclusion they did not need the hospital, because they could do business more conveniently in their offices. At the same time, hospitals still needed their specialists, but not in the same immediate and intimate terms as before.

Another factor was the evolution of the DRG reimbursement structure. The DRG introduced direct conflict of interest between hospitals and physicians, as hospitals were paid on a fixed-fee basis and physicians on a procedure basis.

There were other operative factors as well that drove the wedge between the traditional hospital-physician trust-based relationship — from managed care to better and cheaper technology. The direction has been — and still is — competition for access to and control of the patient base. There is now competition and co-opetition between hospitals and physicians over fundamental medical services.

Not surprisingly, these trends have been a catalyst for debate over the exact legal relationship between hospitals and medical staffs. Even today, the issue is still far from resolved. There is a body of case law that defines a hospital's medical staff as a subordinate administrative unit with no separate identity or legal standing. These judgments argue that a hospital's Board of Trustees has an ultimate fiduciary obligation to do what is in the best interest of the community — and that medical staff bylaws are subordinate to powers of the Board.

In contrast, other courts have ruled vigorously that medical staffs are entities onto themselves and have self-governing bylaws that, in fact, represent a contract between the medical staff and the hospital. They contend Board policies cannot override medical staff bylaws. The JCAHO similarly weighed in and held that if hospitals unilaterally violate medical staff bylaws, they are out of compliance and subject to potentially losing Medicare certification.

Judicial consensus will eventually be reached — probably to the effect that medical staff bylaws must be honored by both hospital Boards and the physicians themselves. However, neither the courts nor the legislature can dictate that bonds of trust be rebuilt.

Axelrod's Five Rules of Tit-for-Tat

- Begin cooperatively
- Retaliate if the other side is competitive
- Forgive if the other side becomes cooperative
- Be clear and consistent
- Be flexible

Building A Foundation for Cooperation and Loyalty

In some respects, it can be said that our society has lost the art of cooperation. The current chasm between hospitals and physicians is all about the breakdown of trust and cooperation. We have talked about game theory already at this meeting — and I want to suggest that cooperation is also an element in game theory. Cooperation is about behavioral dynamics. It is about understanding and anticipating how different groups of people will react to each other as they pursue different goals — often guided by different value systems and world views. Cooperation is the process of agreeing on shared goals, despite whatever differences exist.

Robert Axelrod's *The Evolution of Cooperation* is based on studies of the behavior of the Allied and Axis armies in World War I. The author talks about the natural behavioral rhythm of troops in the trenches. Despite many days of bombardment and hand-to-hand combat, there came to be wordlessly agreed-upon days of non-combat when wounds could be treated, clothes washed, food cooked — and even holidays observed. Certain rules emerged — including retaliation if either side disrupted the rhythm of off-days with an unexpected attack — and also rules of collaboration.

The deepest principle in human nature is the craving to be appreciated.
—William James

Perhaps the simple logic of building a cooperation strategy — rather than a retaliation strategy — is that the behavioral rhythm will over time tilt toward those instances when collaboration prevails over retaliation. The more that occurs, the more cooperation there will be.

The behavioral dynamics underlying cooperation are not complex — they are human and, I believe, can be re-integrated into the behavioral dynamic between hospitals and physicians. Here are a few guidelines for building cooperation and loyalty in the hospital-physician setting:

Ask what makes a physician's life more convenient. Location is everything! So get your physicians into your medical office building and invest in technology that will make their lives simpler and faster.

Invest significant time in building relationships. It is possible to counter the trends that separate hospitals and physicians, but it requires time and commitment of hospital leadership. Building personal connections among Boards, executive staff, and physicians means investing time and genuine attention. Creating opportunities to recognize the substance and quality of physician contributions is another building block of cooperation.

Engage physicians intellectually. For several decades now, it has been common to talk about the necessity of turning employees into participatory stakeholders. Arguably, hospitals have not done a good job in recent years of substantively involving physicians in planning the future of their institutions. This includes market analysis, evaluating potential opportunities, and collaborating on design of new services.

Challenge physicians to advance the institution. Jointly pursuing new opportunities to enhance clinical quality, market position, operating performance, and financial performance builds a sense of partnership and common ground. Co-opetition and competition become attractive alternatives for physicians when they feel disenfranchised from their hospitals. Jointly developing business models and business plans — in pursuit of shared financial benefits — overcomes mistrust.

Renewing the Bonds of Trust – Impasse Resolution

Conflict resolution among health care professionals and health care entities has never been a core strength. When there are differences in opinion, goals, agendas — which there always will be — hospitals need to have in place an impasse resolution process. Without that, serious differences become calcified as irreconcilable differences — and physicians go off in a different direction and hospitals retaliate.

To a degree, the impasse resolution process takes on a behavioral rhythm similar to cooperation. It calls for each side to articulate its concerns and organize them in order of importance. The sides exchange their analysis and make an honest effort to find grounds for compromise. This closing of distances between hospitals and physicians is essential to both parties' best interests and those of their communities.

The genius of leadership lies in the manner in which leaders see and act on their own and their followers' values and motivations.
—James McGregor Burns

Impasse Resolution Policy

- Delineate specific concerns
- Evaluate reasons for concerns — weighing factors such as fiduciary, professional, and organizational duties
- Weigh specific responsibilities underlying position for degrees of importance
- Exchange analyses
- Develop possible compromises
- Consult third party, if necessary

You cannot solve the problems of the present with the solutions that produced them.
—Albert Einstein

MMA's Strategic Implications for Providers

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Addressing the Structural Imbalance

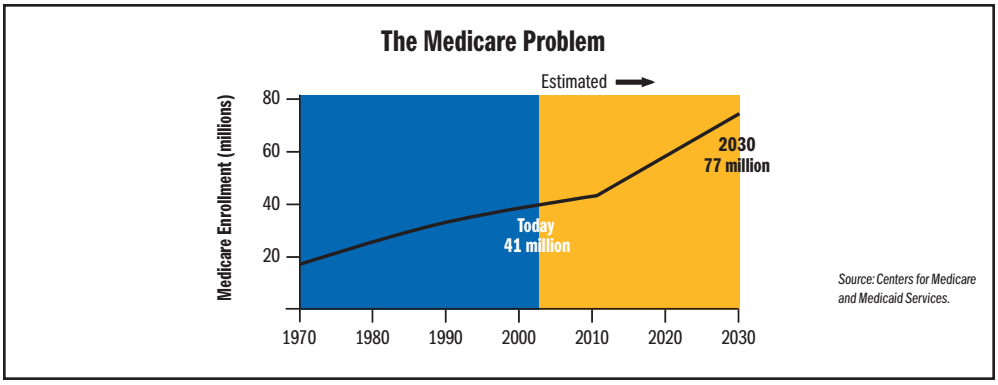
The enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) raises fundamental strategic and structural health care issues that providers must understand. These issues coalesce around three themes:

- First, Congress addressed a number of specific issues surrounding the Medicare program, but not all of them. MMA reflects the current phase of the evolution of Medicare and Medicare policy. However, there are many large issues about the future of Medicare that were left on the table.
- Second, as the impact of MMA unfolds and as Congress eventually addresses other Medicare issues, it will become even clearer that the basic theme in this legislative initiative has to do with the distribution of health care costs between the government and beneficiaries.
- Third, Congress' interest in this distribution of costs is converging with the same concern throughout the private insurance sector. So the impact on both consumers and providers will be far-reaching and ongoing.

These themes, as expressed in MMA, relate to the long-term structural imbalance between the costs of providing benefits to Medicare beneficiaries and the revenue that is expected to be available to do that. The underlying problem comes from the enormous growth in the projected number of beneficiaries between 2010 and 2030, as the number of beneficiaries will roughly double. On top of that, health care costs will continue to grow faster than the anticipated sources of revenue, whether they are payrolls or the economy as a whole.

Over time, Medicare spending is projected to exceed its income substantially. When that occurs, there are only a fixed number of things you can do:

- Cut benefits from the program.
- Privatize, which has so far involved encouraging greater participation from private plans.
- Try everybody's favorite pet solutions for health care, which I call "magical thinking."
- Cut provider payments.



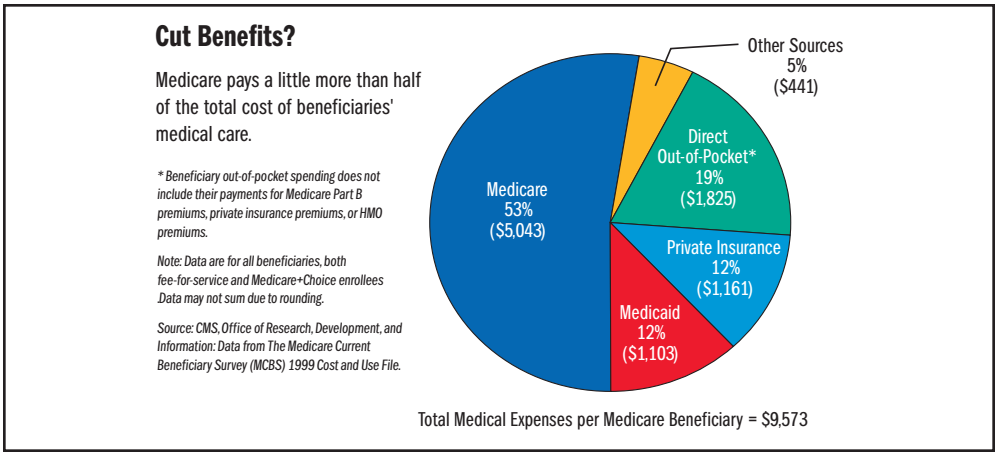
- Increase revenues.
- Shift the share of shared Medicare costs away from the government and in the direction of beneficiaries.

MMA reflects Congress' willingness to legislate innovative "magical thinking" approaches and, certainly, to shift more of the cost burden to beneficiaries. (Of course, another logical approach when spending exceeds income is to increase income — but this was not a permissible discussion topic in last year's debate, but I suspect it will come back sooner or later.)

Cutting Meager Benefits

Arguably, cutting beneficiary benefits is as least as straightforward an approach to fixing Medicare as cutting provider payments. However, the problem with this approach is that benefits are already markedly meager. Today, the tax-supported part of Medicare is paying barely half of beneficiaries' total health care expenses. This certainly does not come close to reasonable expectations about what health insurance should provide.

In contrast, for a long time now, the private health insurance industry has set a rule of thumb that it will pay 75-80 percent of a household's total average health care expenses with the



rest paid out-of-pocket by the household. In contrast, even after the new MMA drug benefit is added, Medicare will be paying just 57-58 percent of beneficiaries' health expenses. That is not surprising when one considers that Medicare still does not cover vision services, renal services, dental care, most long-term care services — and perhaps most critical — does not provide a catastrophic coverage ceiling on beneficiaries' out-of-pocket liabilities.

The Myth of Private Sector Superiority

If cutting beneficiary benefits is not the solution, neither is reducing costs through shifting emphasis to private health insurance. Despite much Washington rhetoric about cutting government bureaucracy and investing in private sector innovation and market efficiency, health care privatization does not work. In fact, the cost of Medicare, per enrollee, on average, has actually gone up slightly more slowly than the cost of private health insurance. In part, this is because the fastest growing cost component of private insurance has been prescription drugs, which Medicare has not covered.

An even stronger factor is simply Medicare's superior market power with its ability to set prices it pays providers by fiat. In essence, it is the economies of scale associated with having 40 million "customers." Ironically, MMA's encouragement of private plan participation has added over $50 billion to projected Medicare costs over the next 10 years. So I've never quite understood the logic of saving money by inducing people to enroll in more expensive private plans.

The Power of Magical Thinking

MMA also reflects the appeal of new bright ideas — a multitude of magical thinking. As the administrator of the Health Care Financing Administration (HCFA) for over four years, I learned that in the prevailing climate, it is not often sufficient for a new idea or service to be valuable in and of itself. In order to convince Congress to incorporate it into Medicare, its supporters must claim their ideas will save Medicare money.

I point this out because MMA has about 300 pages of magical thinking involving everything from competition to prevention to disease management to quality. Most of these initiatives are worthwhile and even noble. They may produce significant benefits for Medicare beneficiaries and for society in general. However, the notion that they will save Medicare significant money over time is inconsistent with experience and logic.

For example, consider prevention and disease management. Prevention is a good thing and disease management can be a good thing if it is done right. Medicare beneficiaries should get a complete history and physical when they turn 65. But in terms of Medicare's financial imbalance, the implications are more subtle. Effective prevention and disease management contribute to fewer hospitalizations, but also to greater longevity. The reality is that the longer people live and the longer they are enrolled in Medicare, the more money it costs

Medicare over time. Of course, Congress should encourage investing in the longevity of citizens; however, no one should misleadingly justify the funding of miracle thinking on the grounds of saving Medicare money.

I feel the same about clinical quality. It is popular these days to talk about the cost effectiveness of higher quality. Experts argue that quality saves money because it means less re-work, shorter patient stays, and better long-term results. But the same experts then ask for additional funding to support quality initiatives. Whether or not a much higher quality health care system would be more expensive or less expensive has not yet been demonstrated.

Reduce Costs Through Provider Cuts?

Cutting provider payments is certainly effective in addressing the imbalance between Medicare spending and funding. We took this approach with the Balanced Budget Act — and Congress quickly realized this approach is politically unpopular. A key structural political issue is that just as the burden of paying for Medicare falls relatively equally on taxpayers everywhere, so do cuts in provider benefits adversely impact providers in every Congressional district.

So it is not surprising that MMA provides for increased payments to certain kinds of providers — rural hospitals, in particular — and reduces payments for other programs, such as direct medical education. However, it is entirely likely that by 2006 or 2007, whoever is president will be proposing major provider payment cuts as a way of dealing with the enormous structural deficit in the federal budget.

The Feasibility of Shifting Medicare Costs to Beneficiaries

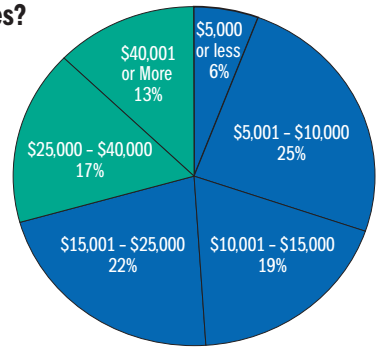
Despite arguments to the contrary, increasing the beneficiary cost burden is engrained in the new legislation. This is arguably ironic, because most Medicare participants just do not have very much ability to take on more Medicare cost.

Increase Costs to Beneficiaries?

Seventy percent of Medicare expenditures are on behalf of individuals with annual incomes of $25,000 or less.

Note: Data may not sum due to rounding.

Source: CMS, Office of Research, Development and Information Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File



Indeed, over 70 percent of all Medicare expenditures are on behalf of individuals with annual income of less than $25,000. A household headed by someone 65 or older has on average roughly half the income of a household headed by someone 65 or younger. The median per capita income of people 65 and older in the United States is about $15,000. So when one considers that this population is already bearing half the cost of its health care, there is not much opportunity to find many more dollars to pay for still-higher Medicare costs.

Nonetheless, MMA does contain provisions that will increase the cost of health care to the elderly — and this will certainly have an impact on providers over the life of the bill. For the great majority of Medicare beneficiaries, the new drug benefit will pay less than half of their total drug expenses. When the additional premium is factored in, the total drug benefit will cover only between 25–30 percent.

There are other MMA provisions that are less discussed, but are consistent with the philosophy of capping the government's liability and letting beneficiaries pay more. The most significant example is the Part B deductible, which has been fixed at $100 since 1991. This increases to $150 in 2006 and is indexed every year thereafter.

Public and Private Convergence

It is important to realize that even though what is happening with Medicare drug legislation is a series of relatively small steps, they are entirely consistent with what is happening in the private health insurance market. There is a true convergence of philosophy and vision here.

There is an ongoing very substantial growth in out-of-pocket expenditures in private health insurance. The so-called consumer directed plans, health savings accounts, and other euphemisms for shifting cost to beneficiaries are spreading like wildfire in the private market. Economists justify this by saying it is important for consumers to have more "skin in the game." Of course, the impact of out-of-pocket liability in a household with an income of $150,000 is very different from that in a household with an income of $50,000. The two households will likely have quite different health care utilization rates and patterns.

Providers are already seeing the impact of these changes in the private health insurance sector in at least two ways:

- Some of the national chains — both for-profit and nonprofit — are reporting bad debt expense in 2003 double that of 2002. Hospitals are increasingly confronting patients who are nominally insured, but have a $500 or $800 out-of-pocket expense for each outpatient procedure. Not surprisingly, these bills are getting harder and harder to collect. This will be the case with Medicare as well.
- National chains are also reporting a reduced demand for postponable or discretionary surgical procedures — such as certain outpatient orthopedic surgical services.

So at least in the short term, there are these and other operational effects that providers will need to manage.

A Work in Progress

Despite MMA and other efforts to reform Medicare, we must not conclude there is a political consensus or a reduction in political polarization on long-term Medicare issues. Having lived through the Balanced Budget Act experience, I remember vividly that in 1997 both the HCFA actuaries and the Congressional Budget Office were predicting that the proportion of Medicare beneficiaries involved in private plans — which in 1997 stood at 16 percent — would go to 30 percent by 2005. It is now just 11 percent. We were wrong about many other things as well.

As Yogi Berra once said, it is easier to predict the past than it is to predict the future — but the issues surrounding Medicare and the necessity of still further future policy change are pretty much certainties.

The Twists and Turns of Co-opetition — Some Basic Principles and Lessons Learned

Larry Stroup, Chairman
James H. Hinton, President and CEO
Presbyterian Health Care Services
Albuquerque, NM

Building a Unified Front – Chairman's Perspective

One of the chief issues Boards of hospitals and hospital systems will face over the next few years is the niche hospital — the freestanding specialty hospital. This is a business venture that is usually owned and sponsored by physicians, some of whom are also leading physicians within a hospital and who, therefore, are competing against their own hospital.

Over the past few years, Presbyterian Health Care Services has had several opportunities to partner with some of our physicians on new business ventures. One of the interesting things in retrospect is that our reaction to those opportunities was not the same each time. Each proposed deal was different and we responded differently — and I believe, fairly, to each one.

As an engineer, there is a part of me that believes the world can be reduced to numbers and equations. So it occurred to me it might be possible to develop an equation that would contain all the factors that needed to be considered in evaluating those co-opetition opportunities. All the factors could be weighted, which would make it possible to reach an objective, quantitative decision. Our ultimate decisions reflect to some degree this quantitative approach to making a judgment in each case.

It is also important to point out that I am not the one making this presentation. The President and CEO of Presbyterian is doing that. The process of evaluating proposals to participate in niche ventures was a management process — not a governance process. This is an important distinction that has been voiced at this conference — and I certainly agree with it.

The reason I am here is that these situations can be so explosive that the Board needs to know ahead of time what the hospital is doing. When a situation "blows up," the Board and the institution itself are exposed to intense public scrutiny. It is critical for the Board and management to build a unified front and present it to the public.

Realities of Co-Opetition – The CEO's Perspective

Co-opetition and the rise of non-hospital niche players is a fact of life in the health care industry. Some of these ventures can succeed, although it is perhaps too early to tell how well and for how long. Other niche ventures, however, can introduce disharmony and even

acrimony. Coming out of several co-opetition experiences, let me distill Presbyterian's experiences into a few principles and lessons learned that will, hopefully, be instructive for other health care institutions in the future.

For hospitals confronted with opportunities to participate with their physicians in niche business opportunities, there are no really good options. Physician-backed co-opetition or entrepreneurial impulses are ultimately attempts to dilute a hospital's business — and they will not go away. Once they start, it is death by a thousand cuts.

The best approach is to avoid extremes in judgment and commit to making objective decisions that, to the extent possible, speak for themselves in terms of the business case. In this way, it is possible to avoid, or at least minimize, negative publicity in the community and minimize damage to hospital-physician relationships.

Board Involvement: It is important for hospital management and their Boards to look ahead, rather than be caught unprepared to deal with niche proposals. The first step is to educate the Board about the co-opetition trend, and then provide criteria that management and the Board agree to use to evaluate incoming niche proposals. With each opportunity, it is helpful to share with the Board the results of the analysis and due diligence. In other words, surprises are not welcome.

Let me also add that in dealing with these niche opportunities, which can be so difficult and contentious, the Board Chairperson and other Board members have a unique opportunity to provide support and counsel to the CEO.

Opportunity Analysis: At Presbyterian, we have identified key external factors that would be likely to encourage or discourage niche plays. For example, we think the fragmented health insurance market puts pressure to blunt the niche plays, because individual insurers do not need niche players as much. On the other hand, if a geographic market has a concentration of large single-specialty physician groups, niche plays are more likely. Such groups have the sophistication, patience, and indispensability to drive for these new business entities. On the other hand, a high hospital concentration puts downward pressure on niche plays.

Market Analysis

FACTORS	ALBUQUERQUE MARKET	NICHE PLAYS
Health Insurance Market	Highly fragmented	↓
Physician Market	Large single-specialty groups	↑
Hospital Concentration	High concentration	↓
Indispensable Insurance	Yes – PHS	↓
Indispensable MDs	No	↑

Board Involvement in Co-Opetition Opportunities

- Learn about co-opetition trends and features
- Review criteria and approach for evaluating opportunities
- Share analysis and due diligence findings with Board
- Consider involving Board members at key points in discussions
- Make a recommendation to Board and gain approval

Principles

- Sense of partnership
- Cost and quality performance
- Service to all patients — payers and clinical groups
- Comprehensiveness
- Financial feasibility
- Community benefit

Presbyterian has also distilled a few key principles we believe should be used to evaluate how well a niche proposal aligns with our health system's mission, philosophy, and culture. A proposal's financial feasibility, its immediate and longer-term impact on our institution, and the likely cost of high-quality service delivery are critical considerations.

We also look at whether the opportunity aligns with our vision of comprehensiveness of care to our constituency. For example, if the potential new venture could not ensure a commitment to serving its share of uninsureds, it would be inviting a "first-class" versus "steerage-class" service model, which we find unacceptable. Or if the business plan excludes a clinical group, such as pediatrics, that would also be out of alignment with our mission of full service to individuals, families, and the community.

Decision-making and Deal Implementation: Early elimination of low-impact or unfeasible proposals through a first-round proposal filtering process is important to minimize management distraction as well as media exposure to the negative decision, should knowledge of the proposal reach the media and community.

For proposals clearing an initial feasibility threshold, a second filtering analysis and deeper due diligence are required to reach a go/no-go decision. Throughout this process, Board and management communication and alignment are critical, particularly if a no-go decision on a high-profile niche proposal is likely to trigger sustained media attention, medical community polarization, and community debate.

For go-ahead proposals, a variety of deal design issues must be addressed — and these are fairly straightforward. However, establishment of "out" clauses within the formal deal structure is important. Often overlooked, or at least unappreciated, is the likelihood that physician-led initiatives will have a much shorter timeframe than that of a participating hospital. Physicians will retire and will most likely want a buy-out mechanism in place to withdraw their equity. On the other hand, hospitals have a much longer timeframe — an indefinite timeframe — in terms of their commitment to serving their constituencies. As the physicians predictably retire and technology changes, the hospital representing the health system in the community is usually the one facing the task of taking back the services offered in the co-opetitive venture.

Conclusion

Hospital Board of Trustees and senior management need a united view on dealing with co-opetitive niche ventures. Generally speaking, I believe most hospitals will continue trying to avoid becoming involved in such ventures. If that is not possible, then the key principles to follow are:

- Understand your market.

- Conduct a thorough analysis to determine if the opportunity is compatible with the hospital's mission.
- Ensure Board input and buy-in along the way.
- Commit to finding the answer that is "right" for the hospital and the community.

Co-opetition: Impact on Debt Financing

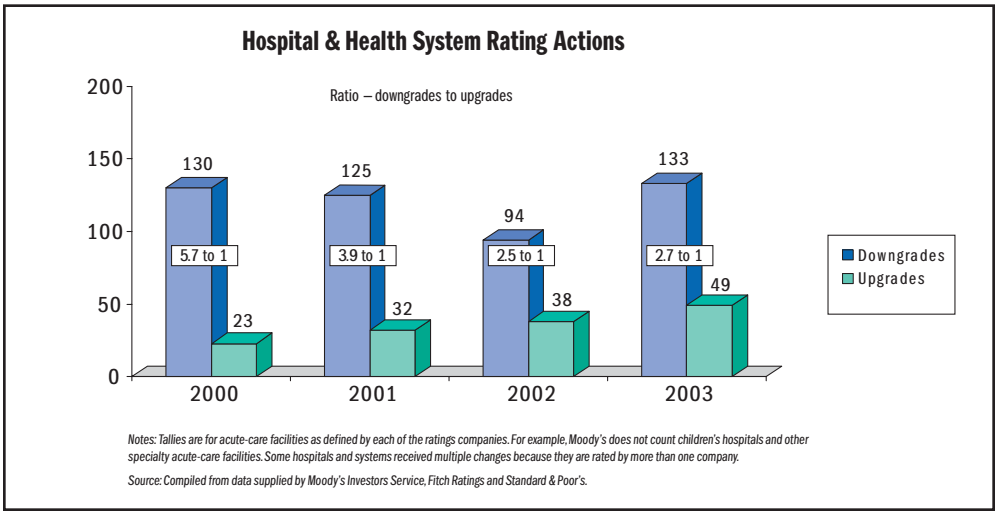
Craig Kornett
UBS Financial Services, Inc.
New York, NY

Key Concerns of Analysts and Investors

Governance and management are the most important factors today for health care industry analysts who evaluate hospital and health care system debt. One of the big concerns is the acumen of Boards. Analysts are concerned that a hospital's management may be able to get approval and start to implement various plans that the Board may not fully understand. This includes "co-opetitive" joint ventures with physicians groups and other outside investors. To the extent that any such ventures affect a hospital's top line or bottom line or its competitiveness is always a concern to analysts and investors.

It is important that Boards know how to ask the tough questions and then also be able to understand the answers. This is not advocating that Boards should micromanage. However, management decisions are ultimately the Board's decisions. It is important that analysts are comfortable with a Board's ability to understand changing health care industry dynamics and trends — such as co-opetition — because those dynamics will invariably impact their institution's financial performance, debt position, and ultimately, its future success.

Without question, the hospital sector is the most volatile sector within public fiance. With downgrades continuing to outpace upgrades by wide margins, the entire hospital sector has essentially been "downgraded" from a higher level in the late 90's, and most analysts expect that this trend will continue.



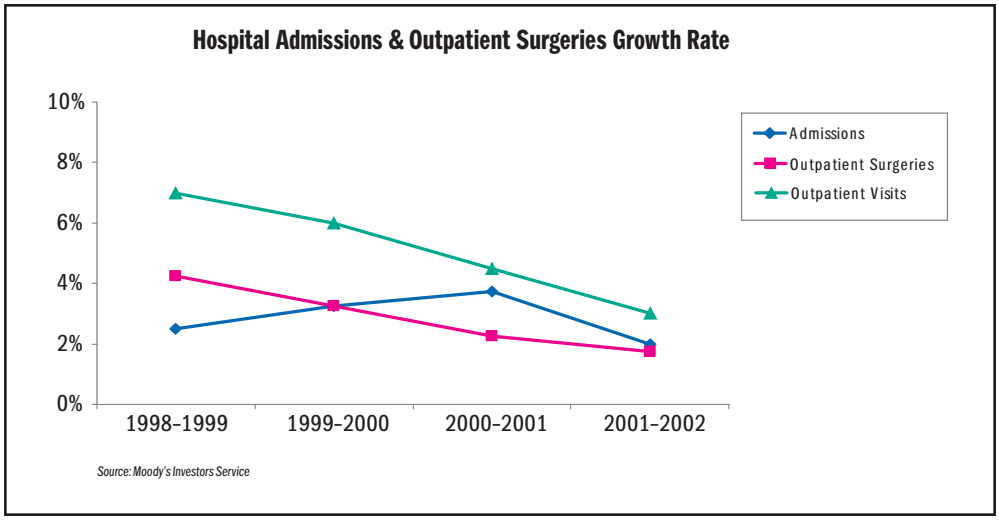
Notes: Tallies are for acute-care facilities as defined by each of the ratings companies. For example, Moody's does not count children's hospitals and other specialty acute-care facilities. Some hospitals and systems received multiple changes because they are rated by more than one company.

Source: Compiled from data supplied by Moody's Investors Service, Fitch Ratings and Standard & Poor's.

Driving bond ratings downgrades have been declining operating performance, leading to poor profitability levels and subsequent lower liquidity. Margins have improved a bit — to two percent in 2002 — but this is not enough to provide for adequate capital maintenance of a hospital's physical plant and infrastructure and invest in strategic opportunities.

The Big Driving Trends

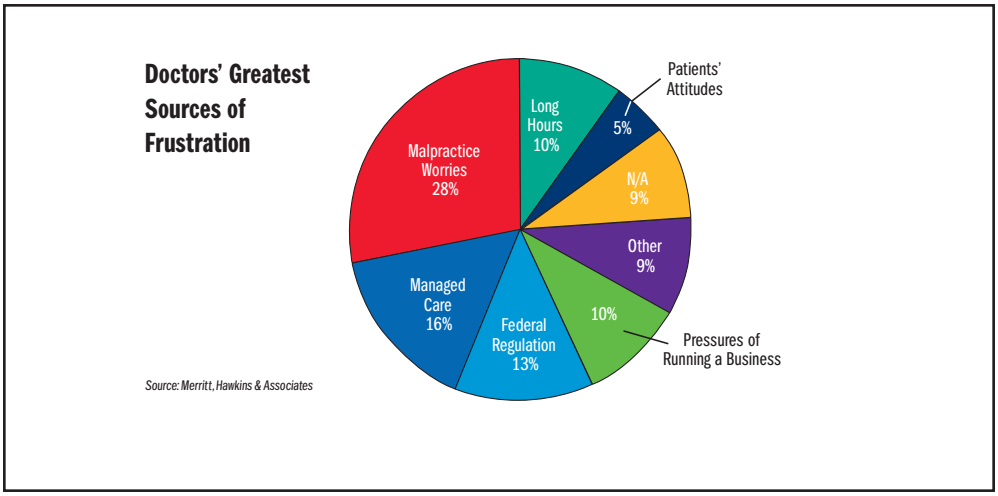
There are a variety of key health institution operating trends that drive revenue and profitability as well as contribute to a growing sense of unease among physicians and their willingness to try new for-profit ventures. For non-profit and for-profit hospitals alike, hospital volumes have been declining — including admissions, outpatient surgeries, and outpatient visits. A lot of this patient volume is no longer hospital-based, but has moved to for-profit specialty clinics.



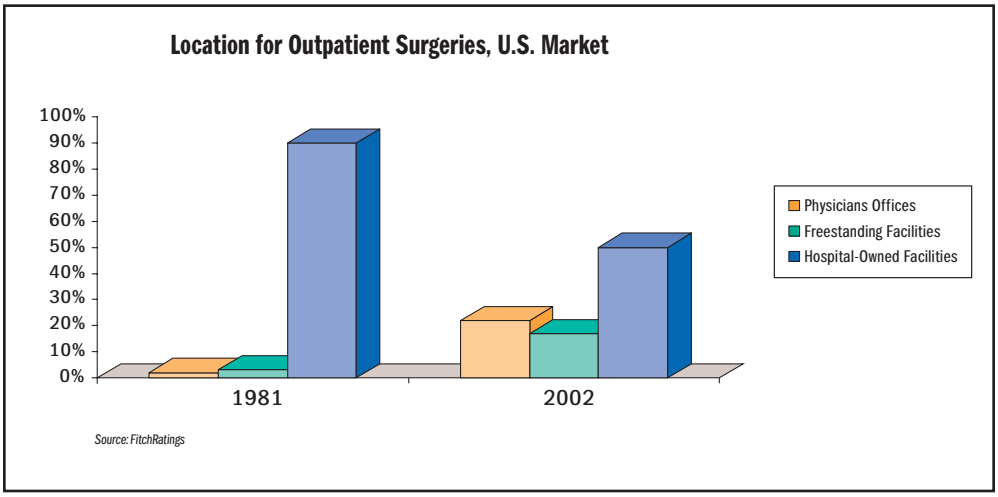
The multiple impacts of this trend are clear: At hospitals with physician employees, the bottom line is that on a fully allocated accounting basis, hospitals lose about $88K annually per employee physician. Not surprisingly, physicians are worried about earning less money.

Physicians are certainly adversely affected by such factors as denied or delayed managed care reimbursements as well as the increasing pressures and costs of running a business. The strongest negative factor by far, however, is the continuing costs of malpractice insurance premiums. Much more severe in some parts of the country than others, overall premium growth over the past decade has been twice that of the growth of physician income.

Over the past two decades, improvements in technology, drugs, and procedures have driven the shift from inpatient to outpatient (or ambulatory) surgical procedures. This trend has been profitable for both physicians and for-profit institutions. However, a parallel shift has also occurred. Two decades ago, over 90 percent of outpatient surgeries took place in hospital-



owned facilities; today, that is down to less than 60 percent — with about 30 percent taking place at physician offices and freestanding facilities.



This is an alarming trend for all hospitals, and particularly for non-profit hospitals. Driven by obvious for-profit tendencies, freestanding, for-profit enterprises along with physician practices have targeted the most profitable specialties (cardiac, orthopedic, surgical). They are effectively competing with traditional hospitals for the most profitable business and for patients with the "best" reimbursement potential. So competition between hospitals — particularly non-profit hospitals and co-opetitive niche players — is an increasingly important issue as it relates to hospitals' long-term financial viability.

Congress and federal agencies have been tracking these industry trends and, looking at the big picture, have become concerned about the long-term ability of non-profit health care institutions to deliver high-quality services. In parallel, there has been increasing legislative,

regulatory, and consumer concern about conflict-of-interest issues. So the current moratorium, introduced in the Medicare Prescription Drug, Improvement, and Modernization Act, on the opening of specialty hospitals could put at least a temporary break on the co-opetition trend.

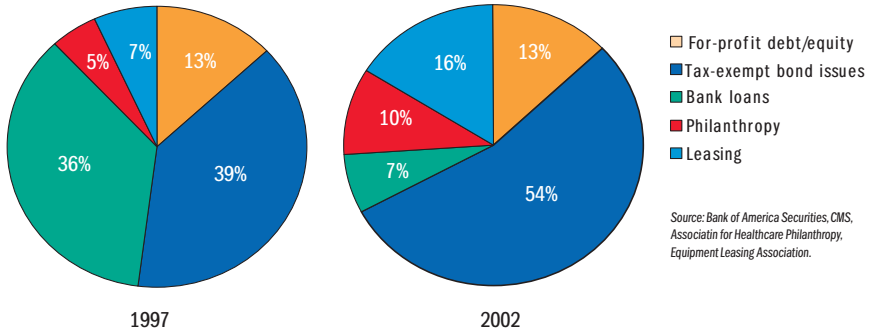
Because rating agencies have a longer-term horizon, this moratorium is considered a relatively short-term event. The agencies are taking a wait-and-see position. However, non-profit hospitals can take this pause as an opportunity to evaluate proactive outreaches to their physician communities. Rather than stay in a reactive — and usually defensive — mode in dealing with co-opetitive pressures, hospitals can develop scenarios for new kinds of win-win ventures that would not result in loss of hospital revenue or market share or further place pressure on operating profit margins. These approaches could include:

- Creating a single-signature hospital-physician apparatus for managed care contracting
- Outsourcing of physician back-office operations to a hospital
- Sharing "carve-outs" of speciality services within the hospital business framework.

Coming Full Circle – Pressures and Risks of Capital Needs and Capital Access

Health care industry analysts have a growing concern about the non-profit sector's ability to fund its capital requirements. As most non-profit hospitals struggle to improve their profitability, they usually cut capital expenditures. This deferment of maintenance and modernization is looming as a major industry issue across the country.

Percentage of External Capital from Various Sources



Source: Bank of America Securities, CMS, Associatin for Healthcare Philanthropy, Equipment Leasing Association.

As it has for several years, the tax-exempt municipal bond market will continue to be the most popular, most effective, and generally lowest cost-of-capital for hospitals. Of course, successful issues in this market usually require an investment grade — and that subjects hospitals to constant scrutiny of their performance and ability to navigate through complex industry issues, market trends, and all kinds of uncertainty.

Hospital Partnering Strategies for Improving Physician Compensation, Satisfaction, and Loyalty

- Managed care contracting
- Back office functions
- Joint ventures
- Expansion of service
  - ORs, ERs, diagnostic services
  - Specialty hospitals within hospitals

This comes full-circle back to the issue of hospital governance. Of the 5,000 hospitals in the United States, about 600 are currently tracked and rated by the rating agencies. The rating agencies and mutual funds that buy hospital debt have many concerns:

- Ability to fund needed capital improvements and new investments
- More bad debt expense
- Increasing onus on employees in terms of higher co-payments and higher deductibles — which means more bad debt
- Labor shortages in key areas, particularly registered nurses
- Competition — which includes pressure on physicians to be entrepreneurial as their salaries become more constrained and insurance premiums increase

These are common issues across virtually all of the hospitals that are tracked and rated. Evaluations and ratings are the direct outcome of how effectively hospital management guides its organization through these issues, and of how convincingly hospital Boards respond to questions about these issues.

When analysts prepare their evaluations and ratings, they look at hospital governance, which is admittedly one of the most subjective and most difficult things to judge. They look at all kinds of quantitative and non-quantitative information in order to assess Board acumen and, therefore, the long-term strength of the institution.

- What information do Board members receive from management?
- What are the key financial ratios the Board uses to track the hospital's financial health?
- Do Board members really understand what is going on?
- Does the Board ask tough questions and, more importantly, understand the responses?
- How are Board members continuously educated on the constantly changing environment of health care?

When Boards have that "deer-in-headlights" look when asked questions from a credit analyst, the rating agencies understandably become worried, fearing that the governance aspect of the organization is lacking. Experience shows that, nine times out of ten, when a hospital experiences a precipitous decline in operating performance and sees its credit rating decline, the causes are typically more internal than external. The Board's ability to work with hospital management to navigate through important issues such as co-opetition and competition is critical to ratings, access to and cost of capital, and long-term success.

Tenets of Effective Board Chairmanship

Joanell M. Dyrstad
Fairview Red Wing Health Services
Red Wing, MN

Being an effective Board Chairperson is all about building specific relationships that are based on specific values. The relationships on which Board Chairpersons should focus are with other Board members, the CEO, physicians and other providers, and the media. The specific foundations of those relationships — the values that will make those relationships strong and productive — are respect, trust, and communication.

Chairpersons and Board Members

Respect: For a Board to be effective, Board members need to feel free to express their opinions and contribute their ideas. The Chairperson's role is to manage the dynamics so that Board members do not feel intimidated by the CEO or fellow Board members who may have longer tenure on the Board, stronger opinions, or just a louder speaking voice.

If a Board has been carefully chosen, one of its inherent strengths will be the diversity of its members in terms of professional expertise, experience, and perspectives. This certainly includes listening to the views of physician members from inside or outside the community. Respecting and harnessing this diversity is one of the Chairperson's key challenges.

The Chairperson also needs to respect the Board's time, because it is all volunteer time. There is an art to running a good meeting — and it includes starting and ending a meeting on time, and publishing a full schedule of meetings and other Board engagements.

Trust: The confidentiality of Board discussions is a basic element of the Board's effectiveness and credibility with the hospital staff and the community. The Chairperson needs to establish confidentiality as a basic operating requirement.

Rigorous management of conflicts of interest has always been important, but never more so than in today's environment of transparency and full disclosure. If the Chairperson or another Board member has a conflict related to an issue, it should be acknowledged up front. The Chairperson also needs to ensure that annual conflict-of-interest statements are on file.

The Chairperson must also ensure the Board is educated about and sensitive to HIPAA guidelines on confidentiality regarding any and all aspects of patient information. This includes information related to the interaction of any hospital staff member with any patient.

Communication: It is important that there is open communication between the Chairperson and CEO and between the Chairperson and other Board members. The Board's authority is vested in the decisions of the entire Board — and not one individual's decision.

The Chairperson must take the lead in providing orientation for new Board members and not relegating it to the CEO or management team. The Chairperson should provide the briefing on the institution's background, mission, culture, and current top issues. Then it is the CEO's responsibility to meet with new members to cover the annual strategic plan, financial plan, and quality initiatives.

Continuing education for the Board should be a formal policy and commitment. This includes briefings by hospital department heads and key staff on such issues as new technologies, new initiatives, government relations, and the investment climate.

Chairperson and CEO

Respect: There is nothing less pleasant or more counterproductive than a disagreement in front of the Board between the Chairperson and CEO. If the Chairperson has issues with certain CEO decisions, they should not be expressed at Board meetings where it will always sound like second guessing. Instead, the Chairperson should create an off-line opportunity to discuss the issues — and make a commitment to work with the CEO to identify and resolve concerns. If this does not happen, the Chairperson risks not having a trust-based relationship with the CEO, which can undermine the effectiveness of the Board overall and damage the institution.

Another side of this issue can be instances where the Chairperson and the CEO are long in office and have developed the habit of making decisions without fully involving the full Board. This risks Board dissatisfaction, lack of trust, and sideline board meetings in the parking lot before or after official Board meetings.

Trust: No hospital today can be effective over the long term if its Board Chairperson and CEO do not have a trust-based, "high-performance" relationship. The basic nature of hospital governance is such that there must be an alignment of Board and CEO values, goals and objectives, and overall willingness to work together. Specifically how a CEO implements those goals and objectives is a management issue.

It would not be a bad idea for Chairpersons to ask themselves a series of questions about their relationship with their CEO. (The assessment questions provided here are inspired by Elizabeth Becker Reems' article, *Synergy in Motion — The Board Chair and CEO Relationship*, reprinted in The Excellent Board: Practical Solutions for Health Care Trustees, American Hospital Association, 2003.) Candid responses to these ten questions will help you evaluate the relationship.

Chairperson — CEO Relationship Assessment

- We have taken time to get to know one another on a personal level.
- We check on the relationship and occasionally ask each other how we are doing.
- We take time to discuss difficult issues and are open about our thoughts and feelings.
- We have attended educational programs together away from the hospital.
- We accept each other's idiosyncrasies.
- We are clear about our roles and responsibilities.
- We talk several times a week and always in advance of a difficult or potentially explosive hospital issue.
- We let each other know when we have done something that was "out of line."
- We respect each other, including our differences, and our perspectives.
- We forge ahead to resolve problems, even when the solutions are uncomfortable to implement.

Communication: Chairperson-CEO communication has several dimensions. First, it is important to clarify roles. Chairpersons with forceful personalities and strong convictions must be careful not to cross the line between governance and management. This is certainly critical as it relates to staff issues. Another even more practical concern is who acts as the hospital's public spokesperson in a crisis or on a high-visibility issue. Certainly, this is primarily a CEO role, although the press will track down Chairpersons and other Board members if the issue is sufficiently newsworthy. It is imperative that all individuals speaking on behalf of the institution deliver a consistent, well-considered, but brief, statement.

Second, because they are often active in business, civic, and philanthropic affairs, Chairpersons can be a CEO's eyes and ears and provide helpful feedback from the community.

Third, a Chairperson can be a valued confidant, mentor, and sounding board to the CEO. This is certainly one of the hallmarks of a trust-based, open-communication-based relationship. A perceptive Chairperson is often aware of the CEO's leadership strengths and needs as a leader — particularly during crises. The best Chairpersons are also sensitive to events going on in the CEO's personal life that may impact normal performance.

Physicians and Providers

Respect and Trust: A hospital's medical community is obviously a core asset — and each of its members must be shown respect by the Board. This is particularly the case with physician Board members and the Chief Medical Officer, who may be an ex-officio Board member. Respect for physicians' views is important in terms of their deep day-to-day, visceral involvement in many critical health care issues. Because of that personal stake in issues, physicians'

views can be passionate and less-than-objective — but they must be heard and respected nonetheless. The bottom line is that outstanding patient care is always THE shared goal and commitment.

Communication: In my experience, it is a constructive idea for Board Chairpersons to accept invitations to attend hospital medical staff meetings. This "down-in-the-trenches" perspective on daily clinical operations can provide Chairpersons with knowledge and perspective that benefit Board deliberations. Similarly, inviting a hospital's medical leadership to annual Board retreats can result in increased common understanding and warmer personal relationships among the Board, CEO, and physicians.

The Bottom Line

Respect, Trust, and Communication go to the hospital's bottom line ...

- Patient Satisfaction
- Employee Satisfaction
- Financial Performance
- Community Pride

Media

Respect, Trust, and Communication: As mentioned earlier, the CEO is the most appropriate lead spokesperson for the hospital. However, when a Chairperson and other Board members are well-known community members who have had interaction with the press in other contexts, it is a near certainty that the media will seek them out for comment. So it is important for the hospital to have an unambiguous plan and method in place that includes informational briefings for the Board and even a written statement that refers all questions to a hospital spokesperson. This careful planning and message coordination extends to high-visibility situations such as medical staff sanctions, lay-offs, litigation, and violent crime on hospital premises.

Self Awareness of the Board Chairperson

At the end of the day, successful Board Chairpersons who leave an enduring legacy to their institutions are those who knew themselves — their strengths and weaknesses, their biases, and when it was time to leave.

Particularly important for new Chairpersons is being aware of their limitations. This includes lack of experience with financial, medical, and regulatory terminology; important industry issues; and even public speaking and managing meetings. Self-awareness for Chairpersons with a proclivity toward micromanagement and the willingness to address that trait are critical to successful tenure.

In today's troubled health care environment, the position of Chairman of the Board is no longer an "honor roll" position. Hospital Boards are being challenged by regulators and the community to play deeply meaningful roles in helping their institutions deal with serious and complex issues. The bottom line is that respect, trust, and communication are the most powerful navigational points for successful, effective hospital Board Chairpersons.

Speaker Profiles

Errol L. Biggs, Ph.D., FACHE, is Director, Center for Health Administration; and Director, Programs in Health Administration, at the University of Colorado, Denver. Dr. Biggs works extensively with hospitals and medical group practices to improve governance of those organizations. He also teaches governance in both the graduate program and the Executive Program in Health Administration at the University of Colorado. Dr. Biggs has been involved in both the investor-owned and nonprofit hospital industry, having been the CEO for 12 years of large teaching hospitals.

Joanell M. Dyrstad is currently a Trustee of Fairview Health Services, in Minneapolis, MN; and immediate Past Chair of Fairview Red Wing Health Services in Red Wing, MN. Ms. Dyrstad was Lieutenant Governor of Minnesota from 1991-95, and Mayor of Red Wing, MN, from 1985-90. She has been Chairperson of the Minnesota Mayors Conference and Chairperson of the National Conference of Lieutenant Governors.

James H. Hinton is President and CEO of Presbyterian Health Care Services (PHS), based in Albuquerque, NM. He received his BA in Economics from the University of New Mexico and his Masters in Health Care Administration from Arizona State University. He served as Chief Operating Officer of PHS from 1992 to 1995, when he became CEO. Mr. Hinton is also Chairman of the Presbyterian Health Plan Board.

Leland R. Kaiser, Ph.D. is an educator, consultant, author, and speaker specializing in bringing change to the American health care system. Dr. Kaiser holds an appointment as associate professor in the graduate program in Health Administration at the University of Colorado, Denver. He has held positions as a hospital administrator, trustee, research and development director, graduate program director, and professional psychologist. Dr. Kaiser has graduate degrees in clinical psychology, medical care administration, social psychology, and higher education.

Craig Kornett joined UBS Financial Services in December 2003. Prior to that, he spent seven years at Fitch Ratings, where he was a senior director and lead analyst covering more than 50 hospital and health care system organizations. In 2001, Mr. Kornett became the sector head for hospital ratings at Fitch, managing a portfolio of more than 200 hospital ratings. Mr. Kornett has spent 15 years in a variety of positions in health care, including directing strategic financial planning for North Shore Health System, a then 10-hospital system based in Long Island, NY, and at The Brooklyn Hospital Center, a then 701-bed hospital in Brooklyn, NY. Mr. Kornett also spent five years as a management consultant in the health care practices of two major accounting firms, Coopers & Lybrand and Ernst & Young. Mr. Kornett received his B.A. from Lynchburg College and his M.B.A. from Fordham University.

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Larry Stroup is President and owner of Provider Services Group and of The Stroup Company, a real estate development company based in Albuquerque, NM. He has served on the Presbyterian Health System Board since 1987 and has been Chairman of the Board since 1993; he also serves on the Board of the Presbyterian Health Plan. Mr. Stroup is past president of the Albuquerque Homebuilders Association and past executive committee member for the Albuquerque Chamber of Commerce. He has a BS in Civil Engineering from the University of Illinois.

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Bruce C. Vladeck, Ph.D., is a nationally recognized expert on health care policy, health care financing, and long-term care. He served four years in the mid-1990s as the Administrator of the Health Care Financing Administration of the U.S. Department of Health and Human Services, where he directed the Medicare and Medicaid programs. Dr. Vladeck is Professor of Health Policy and Geriatrics at the Mount Sinai School of Medicine, Director of the Institute for Medicare Practice, and Senior Vice President for Policy of Mount Sinai-NYU Health. He also served ten years as President of the United Hospital Fund of New York and was Assistant Commissioner for Health Planning and Resources Development of the New Jersey State Department of Health. He received an undergraduate degree from Harvard University and masters and doctorate degrees from the University of Michigan.

The Chairman's Society

The Chairman's Society is dedicated to providing health care Board Chairmen and Chairmen-Elect with high-quality educational experiences and practical resources that will enhance their leadership effectiveness. Our programs are predicated on the belief that Chairmen Officers benefit from education in a collegial environment where they can learn not only from experts in the field but from others who have Board Chair experience. Membership in the Chairman's Society and participation in its programs are by invitation-only.

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