# Deciding Upon Success: Governance as a Long-Term Solution for Integration

*White Paper*

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## INTRODUCTION

Even before the advent of health reform and its ever changing impacts on provider groups, hospitals/health systems and private practices alike have put forth significant efforts toward strategic planning. Now, with the combination of regulatory challenges and the continuing downward economic pressures, a distinct insecurity has been mounting within physician groups, hospitals, health systems and payers. In recent alignment and clinical integration transactions, we sensed heightened levels of anxiety coupled with excitement as distinct provider organizations decided to "team up" and forge ahead on mutually agreeable grounds to combat an uncertain healthcare backdrop. In many cases, these recent engagements entailed renegotiations of existent contracts wherein the arrangements needed to be elevated to account for recent changes in healthcare such as expensive information technology systems, value-based reimbursement models, greater emphasis on quality measures, pressures to reduce costs, increasing consumerism, and looming changes around new coding methodologies.

With the face of care delivery drastically and rapidly evolving, three notable trends have become very apparent in the alignment space:

1. Succession planning is a growing consideration (for physicians and administrators alike)
2. Independent physicians who are seeking to align with a hospital partner are more preferential toward maintaining oversight of their entity's day-to-day functions
3. Hospitals/health systems are finding themselves at a chasm between delivering the best care to their patients and the ability to elicit enough input and services from the medical providers caring for those patients

These trends are indicative of the increasing importance of *governance* as a vehicle for establishing a workable, responsive and long-term partnership. In general, governance is the process by which an entity's overarching decisions are made and its strategic direction, short- and long-term goals, and the monitoring of same are achieved. While connected, governance and management have significant differences. The former is the process by which an organization's purpose and guidelines for operations are determined whereas the latter focuses on the administration of those pre-established policies through day-to-day functions. The monitoring bodies and the authorities of same under governance and management are also quite different. Typically, governance is performed by a Board of Managers/Directors ("Board") charged with the task of handling the business affairs of the entity, which encompasses key decision making as it relates to strategic planning, financial stewardship, establishing and enforcing accountability, operational guidance, etc. Sub-committees under the Board may also be included in a governance setting to provide the Board with recommendations for consideration across various areas. Conversely, management is enforced by a group of administrators, typically led by a chief executive officer.

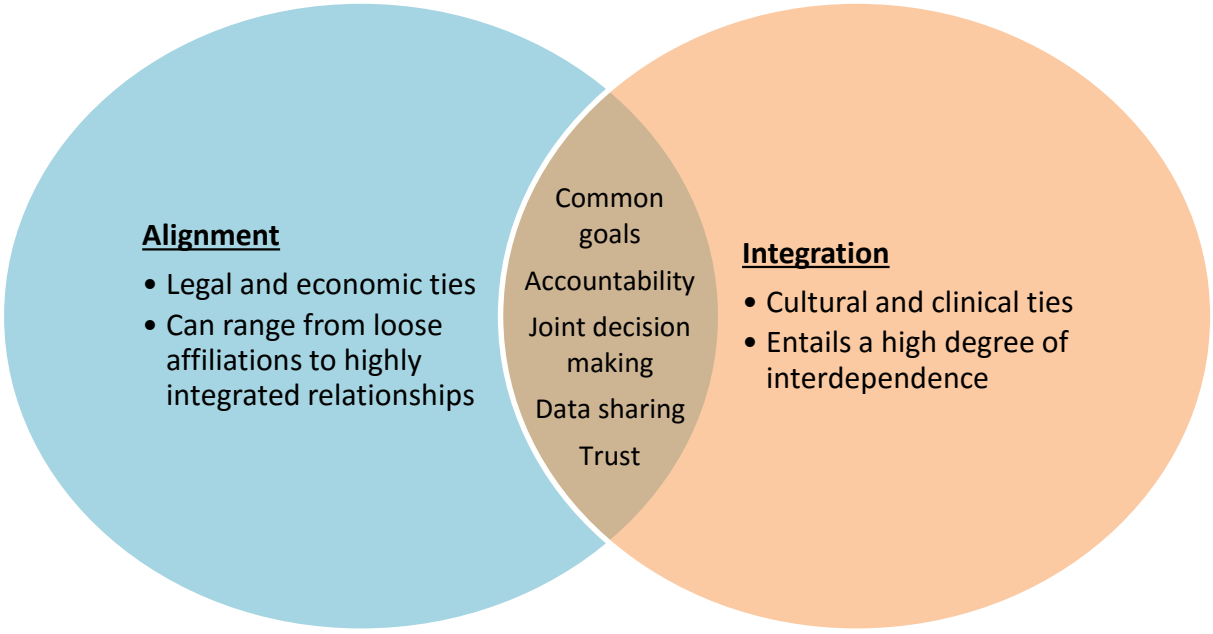
Despite their differences, both topics fall under the same category during the development of an effective transaction structure. Thus, the focus of this paper is on the myriad ways governance models can be organized to transform a viable alignment model into a fully functional and sustainable integrated strategy. Before this discussion can take place, however, we first briefly explain the differences between alignment and integration.

## ALIGNMENT VS. INTEGRATION

"Alignment" and "integration" are often used interchangeably in literature, but in practice, they are two very different schools of thought. Alignment is the strategy that legally and economically binds at least two distinct groups to work together. On the other hand, integration is a term often associated with healthcare in the 1980s and 1990s when health systems built integrated networks to counteract impending capitation models. Today, however, integration refers to the formation of high functioning provider network systems tightly tethered by cultural and clinical ties. These integrated, collaborative systems can include just independent physicians or a combination of both hospitals and private practices that share relevant clinical data in virtually real-time in order to coordinate care, make necessary patient care decisions and improve the system through feedback loops.

Alignment models span the continuum of various integration levels depending on how culturally and clinically bound the various affiliated parties are. They are not mutually exclusive and, often, alignment precedes integration (both clinical and financial) and, thus, sets the foundation for the successful operations of a clinically integrated model. The figure below provides a snapshot of the differences and overlaps in the two concepts.

**Figure I: Alignment and Integration**



More involved (or more integrated) forms of alignment call for the synchronization of each group's operations, strategic plans, relations, and overall delivery of care. This type of an operational model can be achieved through "traditional alignment" strategies that entail full levels of integration (i.e., employment). However, even under this scenario, a long-term plan is necessary to evolve the traditional model to a contemporary one. More specifically, there is a substantial need today for providers (whether traditionally aligned or not) to form collaborative, clinically integrated models. The objective is to not only bring primary care and specialty providers closer together but bring physicians into the fold when making certain major decisions that impact the *value* of care being provided. The challenge lies in shifting a responsive strategy from being a short-term plan to a long-term solution. In technical terms, this entails bridging the gap between traditional alignment (short-term) and clinical integration (long-term).

## WHY GOVERNANCE?

Arguably, governance is second only to compensation when it comes to structuring a successful transaction between affiliating parties given that it is often a complex area to discuss and build consensus around. This is especially the case when an alignment transaction involves a group of private physicians and a hospital partner as these physicians are used to a high level of independence and autonomy, which they often prefer to maintain post-transaction; however, this could clash with the hospital's existing by-laws and potentially threaten the prospective partnership. Thus, governance is a matter that is often discussed at the outset during transaction structuring not only due to its level of significance but also for its level of intricacy.

More externally, the need for strong leadership, both clinically and administratively, in every provider organization is exacerbated by an aging physician workforce. Thus, the imperative for grooming "junior" physicians to become leaders can also be addressed through an effective governance structure.

Looking ahead to the development of a long-term strategy, which we recommend, includes the development of clinically integrated models [such as accountable care organizations (ACOs) and clinically integrated networks (CINs)]. The success of these "contemporary alignment models" rely on the positive interplay between the physician and administrative leadership. This interplay can be fostered by an effective governance structure that allows for joint decision-making, high levels of trust, communication, and group-minded discussions.

Coker recently worked with a 20-physician, single specialty private practice with a longstanding affiliation with a local health system. While the practice itself was a separate legal entity, the physicians and staff were employed by the health system but both the individual physicians and the private practice entity operated with as much independence and autonomy as physicians of a traditional private practice model. With the group's contract with the hospital nearing expiration, Coker was engaged to provide assistance with re-negotiations such that the go-

forward model would be acceptable from both an economic and non-economic standpoint. The truly distinguishing feature of this engagement revolved around the strong emphasis placed by the practice shareholders and its administrators on the maintenance of their internal governance structure. In some respects, the governance issue ranked higher than compensation in terms of importance to the physicians. This result supported our observation of governance, or the ability for physicians to make decisions that impact their ability to deliver valuable patient care, precipitously growing in significance in current and future transactions.

A number of considerations exist when developing a governance structure for a particular provider organization. Rarely is there a "one-size-fits-all" model, and the final structure will depend on a host of issues. Some factors include the type of organization, (i.e., hospital, private practice, employed physician network, independent practice association, clinically integrated network, etc.), the number of decision makers, the tenure/commitment levels of existent decision makers, expectations of parties, determination of "reserved powers," etc. The following list presents the foundational elements of all sustainable governance models that are applicable to virtually all healthcare organizations:

- Efficiency
- Scalability
- Flexibility
- Simplicity
- Transparency
- Integration
- Synergism
- Equal satisfaction (or dissatisfaction) for all members

While the above qualities are conceptually understandable and straightforward, the application of these components during the structuring and implementation of the actual governance model can pose some challenges. Although these characteristics encompass the overall vision and strategy of an effective governance structure, they should flex depending on such things as leadership styles, size of entity, culture, current structure, and future directions. Thus, a relatively simple concept can quickly snowball into a more intricate and sensitive issue that may never move past the planning stage unless all parties involved are brought "to the table" to openly and constructively discuss the issue of governance with the ultimate goal of deriving a mutually agreeable model. This will entail deciding upon the specific decision making areas of each party and the parties collectively, how these decisions will be made and by whom, how will an accountability/checks and balances system be established and enforced, and how will the overall model be implemented.

To clarify this potentially complex matter, the subsequent sections provide an overview of common governance structures. We offer explanations on how these models apply to various

organizational types, and how they can be utilized to take a short-term plan to the "next" level and, ultimately, support the long-term strategy. It is important to note that governance is a valuable feature to every organization but in provider groups, it is especially impactful due to the interplay between physician and administrative leadership. For this reason, we maintain a focus on provider organizations throughout the remaining sections of this paper.

## Governance in its Many Forms

Similar to a compensation or income distribution model, governance models can take a variety of forms. For virtually all provider organizations, a Board structure has prevailed but for many, the Board's role evolved over time as the increasing need to control healthcare costs triggered the incorporation of clinical expertise in the decision-making process. Nonetheless, key differences in how these decisions are made exist across organizational types. For example, in a hospital setting, major decisions are often escalated up a vertical "chain of command" prior to being finalized and implemented. For other organizations, particularly those that rely on a more rapid decision-making process (such as private practices), a flat (or horizontal) organizational framework has been more common. Here, the decision makers also take part in the day-to-day management of the entity.

In present day, these concepts of vertical, horizontal, shared, and transformational governance are all existent. However, what is likely different today than historically is the creation of the "hybrid model" that intertwines the above concepts into simultaneous application. The following models reflect these views across a continuum but stratify each against the appropriate organizational/alignment model.

### The Federated Governance Model

The Federated Governance Model is a "pod-like" framework that offers limited authority of any one party over the other parties or the full entity. This model is most appropriate for a merged entity of private practices where each independent practice operates exclusive of one another.[1]

In this model, each practice entity (or pod) has full control over its own management structure. A Board may exist that oversees the strategic direction of **all** pods and thus, could consist of all shareholders of each practice or an equal number of shareholders from each practice. The Board has the task of setting the strategic direction of the organization but has limited ability in terms of executing its decisions down to the pod level.

An advantage of this model is the limited number of changes that must occur when adding or removing a pod from the overall entity. However, when considering the development of a long-

[1] Typically, this model is known as a "legal-only" merger where each separate entity comes under one tax ID number and are thus, legally merged; however, limited to no consolidation of operations occurs.

term strategy, this structure does not support the key tenets of an integrated model and creates challenges for members to share a similar vision and mission for the overall organization. Thus, this governance structure would likely not benefit an organization that is targeting clinical integration in the future.

**Figure 2: Federated Governance Model**


### THE COMMITTEE-BASED MODEL

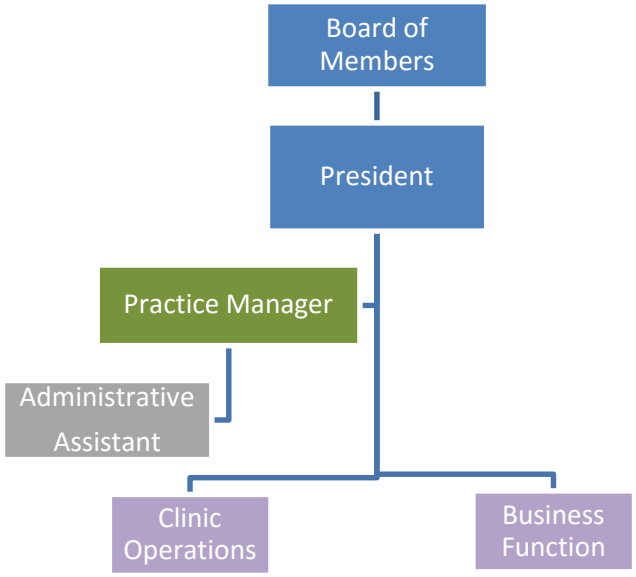
The broadly titled Committee-Based Model refers to the variations in structuring an organization's decision-making vehicle as a chain of committees under an overarching Board. Depending on the size (both in terms of members and affiliated entities) and type of organization, the volume and forms of committees will change. We explain the three main types of the committee-based structures below, offering three alternatives based on the size and number of specialties within an organization.

#### *Alternative One: Bifurcated Model*

As illustrated by Figure 3, this committee-based model represents one of the least complicated internal governance structures that is most applicable to small, single-specialty private practices. This structure is simple in that there are minimal layers between governing bodies, and the sole notable distinction is a separation of clinical operations from administrative functions, resulting in a bifurcated committee structure. This layout is not deemed appropriate for multi-specialty practices or hospitals/health systems that need to oversee and control various operational areas within one entity.

The bifurcated model has utility for small practices in less progressive markets that may desire to implement a corporate-like governance structure that is reflective of its current capacity. This model is certainly scalable; however, it can quickly become obsolete if it does not evolve as the organization and the market change.

**Figure 3: Bifurcated Committee-Based Model**




*Alternative Two: Operational Sub-Committee Model*

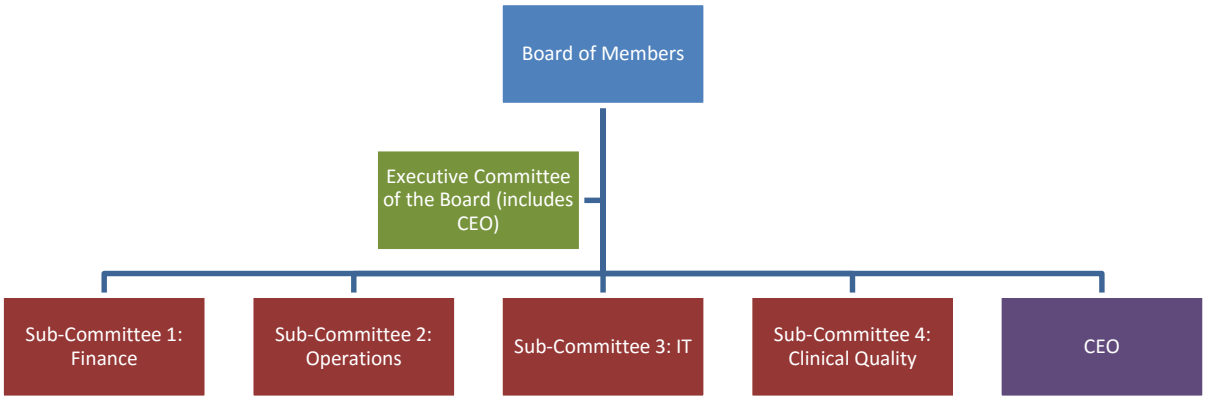
This second, committee-based option is more commonly seen in larger single and multi-specialty private practices as well as some employed physician networks (EPNs). This model has several committees, including an Executive Committee (EC) of the Board. The EC usually includes a group of Board members assigned to officer roles and the CEO. In addition to the EC, several other sub-committees that lead different aspects of the business and its operations (e.g., finance, IT, clinical quality, etc.) exist. A Board or EC member can lead these sub-committees, which most often act in an advisory role to the Board/EC.

This model is quite common and has several advantages including scalability and applicability to virtually all types of organizations. For example, a completely private practice entity could apply this model as easily as an EPN. This model also allows a diverse group of individuals to partake in the overall governance of their organization (as opposed to just shareholders). Simply put, a sub-committee, while led by an individual Board member, could include a membership of non-physicians, non-shareholding physicians and less tenured members who are all interested in a specific business area. Not only does this afford the opportunity to solicit buy-in from a diverse group of constituents, but it also allows for the grooming of less tenured individuals to

eventually take on leadership roles and work with administrative staff in tandem to decide upon and implement initiatives respective to their committee's designation.

Lastly, the operational sub-committee structure allows for significant flexibility in that committees and/or members may be added on an "ad hoc" basis depending on the types of decisions that need to be made or the initiatives in consideration. While the EC along with the finance, clinical quality and payer relations sub-committees are usually standing, permanent governing bodies under the Board, other sub-committees may be temporary and established on an as needed basis (e.g., an Information Technology sub-committee may be formed if the organization is considering a new electronic health record system).

**Figure 4: Operational Sub-Committee Model**

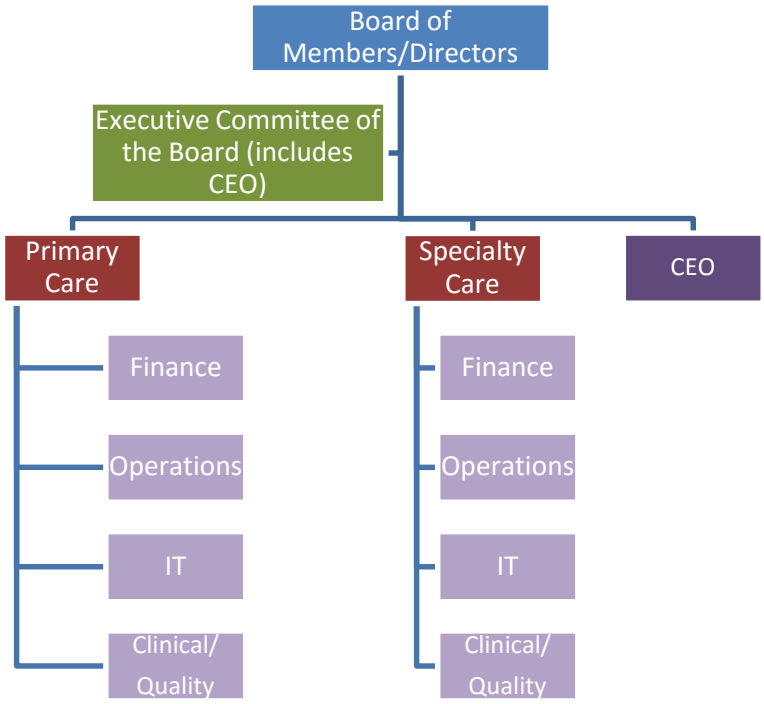



*Alternative Three: Specialty-Specific Committee Model*

The third committee-based alternative is applicable to large multi-specialty practices, independent practice associations (IPAs) and EPNs. This model is similar to Alternative Two in that the operational sub-committees are maintained; however, the main difference is a division between primary and specialty care for the sub-committee structure.

This model is not commonly recommended as it may create too much of a clinical divide between the primary care physicians and specialists of an organization. However, from a strategic and operational standpoint, the needs of both provider classes vary; thus, this structure would allow governing bodies to manage and monitor those needs accordingly. Nonetheless, for purposes of transitioning an organization from traditional alignment to clinical integration, this model would be beneficial for the short-term but should be modified to support certain key tenets of clinical integration (such as collaborative and collective clinical processes) in order to be efficacious. The following illustration models the specialty-specific committee-based structure.

**Figure 5: Specialty-Specific Committee-Based Model**




For any governance structure that utilizes sub-committees, several areas should be addressed by the Board as it relates to the size of the committees, the leadership of each (i.e., chair/co-chair), voting structure and overall membership composition. From our experience, the optimal sub-committee size is between five to seven members that represent a cross-section of areas of expertise and tenures. Within a sub-committee, a formal voting process may be unnecessary as the majority of decisions are likely to be consensus driven. However, in the event consensus cannot be reached, a majority vote may prevail or the issue/decision may be escalated to the EC or the Board.

Myriad benefits are offered by a sub-committee model, which can be applied to smoothly transition a traditionally aligned group of providers into a clinically integrated network of providers. However, the success of such models (and their ability to transition an organization from aligned to integrated) is predicated on a culture of collaboration, transparency, engagement, and open communication (some organizations allow non-governing members to attend Board or sub-committee meetings to provide input on key issues without participating in the actual decision making/voting for same). These governance structures may be ineffective for an organization that is lacking in any one of the above areas.

## HYBRID INTEGRATED STRUCTURE

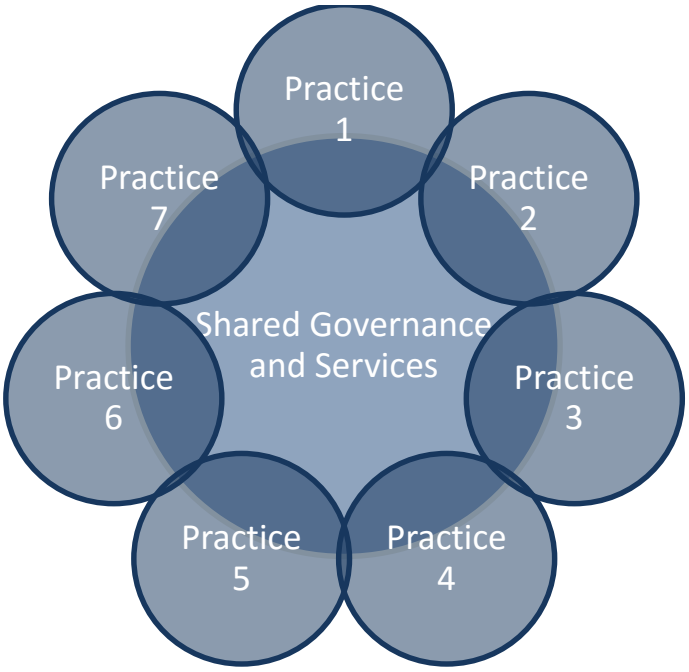
The hybrid integrated framework has a shared central governance structure and management services. This model is appropriate for legally merged entities or moderately aligned provider organizations, such as IPAs or hospitals and private practices  bound by joint ventures or management agreements.

The hybrid structure entails representation from each of the groups that make up the provider network within an "advisory board" that then reports to a higher Board structure consisting of all shareholders (or a subsection of shareholders). This model blends the federated "pod-like" structure with an operationally integrated structure. This structure allows each separate entity to continue operating as-is in regard to day-to-day functions and management activities while sharing governance over specific decision-making areas.

Shared governance and services tend to be in the areas of strategic planning, common information technology (i.e., electronic health record and billing) systems, contracting strategies, and expansion/growth strategies. The shared governance areas are overseen by the advisory board that recommends initiatives and plans for Board approval.

This model is helpful for groups that plan to clinically integrate at some point in the future when their organization and/or local market is more suitable. In the interim, they are "testing the waters" and acclimating to working collaboratively. This model is not entirely supportive of a full operational merger (i.e., when two or more parties consolidate all key operational functions of their once disparate businesses, such as billing/collecting, payer contracting, human resources, etc., into a centralized source) due to delineations in management that exist across each participating provider group. Therefore, it should be considered as a short-term solution and not a long-term strategy.

**Figure 5: Hybrid Integrated Model**




### Fully Integrated Model

The Fully Integrated Model is the "end game" structure that should be the terminal goal for all organizations that wish to remain responsive to the turbulent healthcare landscape. Thus, this model is applicable to virtually all provider groups, particularly large groups that are utilizing full forms of alignment currently (i.e., hospital employment, operational merger or professional service agreements).

The fully integrated structure has a central governing body or bodies for all affiliated groups in the network. One centralized monitoring Board and EC determine the strategic, financial, and high-level business functions of all entities. The sub-committee structure may be utilized to infuse further delineations in authority and decision-making. However, the Board will have reserved powers in this scenario and will have the ultimate "say-so" on decisions relating to strategic planning, joint contracting, large capitalizations, system-wide clinical initiatives, etc.

This model is advantageous for its inherent integrated functionalities, which allow for the achievement of economies of scale. However, it is susceptible to deficiencies if it omits groups that wish to have a voice in decision-making. When structuring a model of this nature, it will be pivotal to solicit and ensure reasonable levels of buy-in from the various groups within the network prior to the approval of enterprise-wide decisions/initiatives. This buy-in process may result from working through joint management committees and/or a diverse Board membership.

**Figure 6: Fully Integrated Model**

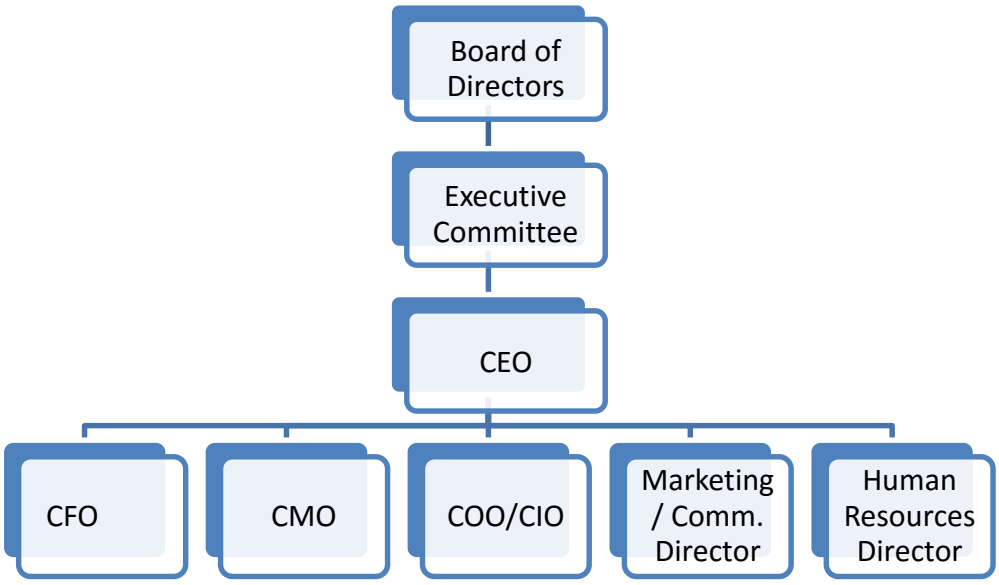

Given the broad nature of this model and the particular needs of the various types of provider organizations, this governance structure can be arranged in a number of ways. This section outlines two common alternatives for the fully integrated model.

*Alternative One: Fully Integrated Executive Model*

This choice represents a Board–EC–management team model. In many aspects, this model is the most corporate-like of all those described. However, this is a simple organizational map for entities/networks that want to apply an executive-based structure to their governance model. The Board and EC's tasks are essentially the same as those described above. The C-suite roles would then be the frontline facing administrative team that oversees the day-to-day functions of their divisions and the implementation of their respective initiatives (as directed by the Board).

This model is advantageous due to its commonly known structure and easy to apply arrangement. Nevertheless, this model is lacking in enterprise-wide involvement (as was possible using the sub-committee structure) and relies heavily on the placement of highly qualified and effective individuals within the C-suite roles. The deficit in enterprise-wide engagement, however, can be mitigated through effective management, communication and collaboration by the executives, particularly the chief medical officer.

**Figure 8: Fully Integrated Executive Model**

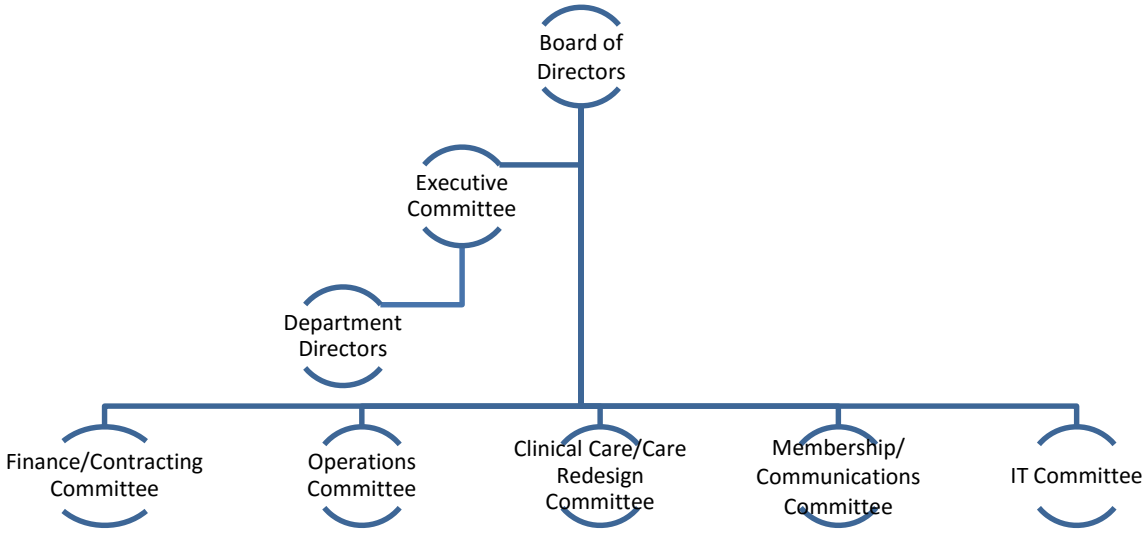



*Alternative Two: Fully Integrated Physician-Led Model*

This alternative represents a Board–EC–*physician-led committee* model. This structure is similar to the management team model described above in that the executive leadership remains existent; however, greater emphasis is placed on the physician-led aspect in this structure than the Fully Integrated Executive Model alternative described above. More specifically, the executive structure explained above is retained through the utilization of "Department Directors" who work in tandem with physician leaders who serve as the chairs of the network's operational committees.

Thus, this model strikes a sustainable balance between physician involvement and administrative oversight. Further, it is a model that can be used to groom junior physicians to take on more involved leadership roles over time. Due to the highly collaborative nature of this framework, it is an appropriate governance structure for clinically integrated models such as ACOs and CINs as well as integrated EPNs and operationally merged private practices.

**Figure 9: Fully Integrated Physician-Led Model**




When deciding on the optimal governance model for your enterprise, it is always useful to have a framework in mind that can accommodate the various nuances of the organization. All of the models described/illustrated within this section are intended to serve as viable conceptual frameworks for all types of traditional and contemporary alignment strategies. However, the value of a structure is dependent on the process by which it is vetted and implemented. Thus, the following section will provide some guidance on successfully conducting the planning and implementation components of effective governance structuring.

## Operationalizing the Framework

The final planning and implementation stages of governance development are dependent on the actual junction at which the organization/enterprise is currently. Meaning, a single specialty private practice that wishes to apply the Bifurcated Committee-Based Model will experience a vastly different planning and implementation process than a CIN that is targeting the Fully Integrated Physician Led Model. Nonetheless, both entities should have similar long-term strategic goals with the timeline being dependent on their individual markets and financial/operational capacities.

To normalize the variances in methodologies across organizational types is a complex process. The following six areas represent "tips and tricks" that can be applied by virtually all provider groups, at any stage in development, to ease the implementation process.

1. **Set Short-Term and Long-Term Goals**

   Setting goals is an important step in building and maintaining a governance model that will be useful across the lifespan of the organization itself. To establish reasonable and attainable goals, an organization (through its founders or an established Board) must

first develop an overall vision that answers these questions: What are we? Who do we serve? What are our services and standards of care? An organization that answers these questions will establish its identity within a community, and this will drive the development of specific short-term and long-term goals. The governance model should uphold these goals and in most instances, the Board will be tasked with developing and monitoring these strategies and goals. At this point, some of the short-term goals should be reflective of the ongoing shift from a predominantly fee-for-service (FFS) market to blend of FFS and value-based reimbursement. These goals should be reasonably attainable with the resources currently available (i.e., financial funding, technology, staffing, etc.) and should be measurable, such that the governing body or bodies can monitor progress.

Similarly, goal setting should also occur at the lower level governing bodies. For example, the Finance Sub-Committee could be tasked with setting, monitoring and meeting cost reduction goals for their organization. Likewise, the Clinical/Quality Sub-Committee could be tasked with developing, monitoring and achieving patient outcome goals. These relatively small steps add up to macro-level changes that drive the organization to think and operate in a "value-generating" manner and also prompt organization-wide efforts to achieve them, which then, ultimately, narrows the gap between an aligned entity and an integrated system.

**2. Physician Involvement**

Currently and likely in the future as well, physician involvement is a non-negotiable when it comes to the sustainability of a governance model, and more importantly, the survivability of an organization. The imperative to significantly reduce the cost structure is applicable to *all* provider groups regardless of type, size, wherewithal, etc., and the parties most capable to control the cost of care are those caring for the patients. Thus, despite the governance framework chosen, some vehicle for soliciting clinical buy-in should be incorporated. In most instances, clinicians are represented at the Board level. While this is undoubtedly valuable, clinical expertise should be integrated throughout all levels of governance in order to drive improvement in both clinical quality and efficiency (i.e., advance the value proposition).

This is not to say that clinical representation should be the predominant component of any governance model. Rather, the key to a sustainable model will be to achieve an appropriate balance between the administrative and clinical aspects. In various cases, particularly those that consider alignment between hospitals and private practices, some physicians may be able to offer both clinical and administrative expertise. This expertise is a significant area of opportunity and one that organizations should capitalize upon, especially in a clinically integrated scenario. A model that brings these individuals into the decision-making fold should be a consideration.

Lastly, physician involvement in decision-making relates a positive message of respect, trust, and value, which is important, particularly as many private physicians are still openly wary of hospital partnerships. With the "reserved powers" provision, the hospital may retain final say-so over certain areas. However, including provider counterparts in the governance model strengthens the overall alignment relationship, facilitates the establishment of common strategies and goals as well as the achievement of same. These all move the organization/partnership closer toward integration.

**3. Develop a Transition Model to Respond to the Changing Healthcare Landscape**

Today's providers are asking themselves some unprecedented questions, such as, are we equipped enough to accommodate large influxes of patients as the number of Americans with access to health insurance increases? Will cuts in Medicare reimbursement affect the overall reimbursement rates we are receiving from commercial payers? Will we be able to sustain our current operations under reduced reimbursement? Will the push to reduce costs end up costing more?

These concerns and many more are not only valid but necessary to consider when developing a new governance model amidst the changing healthcare landscape. It is imperative that hospitals be prepared to deal with the expected, and unexpected, changes over the next several years during the implementation of the Affordable Care Act ("ACA").

A strong governance structure should allow governing bodies to make decisions quickly when needed[1]. In these instances, the "flat" model is of great utility as is the management committee structure (i.e., joint decision-making body between multiple partnering entities). Thus, when structuring the overall governance structure, there is value in mixing a vertical governing model with a horizontal decision-making structure. Simply, certain governance structures can maintain the corporate-like Board with sub-committee layout, but allow lower level governing authorities to make necessary decisions readily. Essentially, this applies when they impact the quality of patient care (i.e., purchase of new equipment or hiring of new staff), provided that they do not violate the Board's reserved powers.

**4. Develop a Diverse Board Membership with Strong C-Suite Support**

Throughout this paper, we have alluded to the Board and its purview, composition, effectiveness, etc. However, the Board is a crucial governing body both for obvious and elusive reasons. In addition to setting, overseeing, and assessing the organization's strategic direction, the Board has other duties in support of the entity and its long-term sustainability. It is responsible for reviewing and approving the strategic plan, monitoring the legal compliance (from a high-level standpoint), maintaining connections with the community to foster public accountability, providing financial oversight,

ensuring quality improvement and advancing the mission, vision and goals of the organization.

The Board members "wear many hats" and thus, its composition should be representative of a wide array of expertise that can handle the breadth of issues on which it will need to decide. In most instances, the Board is composed of clinical, financial, legal, and community representatives as well as shareholders. Board members are often elected, although some may be appointed and typically serve for limited terms (i.e., two to three years). The Chair of the Board may rotate on an annual basis. These rotations in both members and the Chair are necessary to maintain, particularly for large organizations in order to infuse the Board with the necessary diversity in perspective, which can certainly benefit long-term sustainability.

In organizations where succession planning is an imminent consideration, the Board membership should be representative of senior and junior members. In addition, a diverse specialty mix of both primary care providers and specialists should be incorporated as much as possible.

For organizations comprised mostly of providers (i.e., private practices, IPAs, etc.), there is a need to ensure the administrative leadership consists of fully qualified individuals that are knowledgeable of the local and regional markets as well as the constructs of fee-for-value and clinical integration. Capable leadership qualities apply most to the CEO who holds a dual role, serving as an executive decision-maker and as a frontline administrator.

**5. Operational Control**

During these times of rampant consolidation, hospitals are acquiring outpatient facilities in part for the economic benefits they may potentially offer. In many cases, hospitals are not fully equipped to manage the operational component of these facilities and rely on the partnering entity's physicians to have authority over such things as staff, equipment utilization, operating budgets, etc. When these types of transactions transpire, the goal is to develop a governance structure that allows the hospital's governing authorities to maintain their preferred reserved powers while the new partnering entity's physicians retain control over the acquired facility's operations. Often, this scenario is a mutually beneficial arrangement, especially if the acquired entities were operationally efficient prior to transaction close.

**6. E-Commerce and Information Technology**

With each passing day, consumerism and patient awareness of value-based care are rising. Instead of being passive recipients of care, patients are quickly joining the ranks of progressive and educated consumers of care. Through implementation of electronic

health records ("EHR") and practice management systems, physicians, nurses, staff, and patients now all have the ability to communicate with each other, whether it regards lab results, questions about various symptoms, scheduling appointments, or finding the right physician for a patient's medical needs. Technology in healthcare is becoming more of a necessity and those that are not taking the steps to incorporate and utilize IT systems and telemedicine techniques in a meaningful way will quickly find themselves behind the curve.

Both directly and indirectly, the governance structure should embrace technology to facilitate communication, promote collaboration, and progress the organization toward clinical integration. The role of IT within a governance structure is to ease the process for setting strategies, managing risk, delivering value, and monitoring performance[2]. At the different levels of a governance structure, the meaning and relevancy of the data provided through IT varies. At the highest levels of the governance structure, the use of IT should be for strategic purposes and oversight. For example, in order to ascertain the organization's performance and the need for changes in strategy or capitalization, the Board may review dashboard reports generated by the IT system's capability to continuously aggregate of financial data and set against pre-established cost metrics.

Within the various sub-committees, IT is still a relevant matter. For example, a Clinical Quality Sub-Committee would be remiss if decision making occurred without the proper review and vetting of relevant clinical data (i.e., patient outcomes, satisfaction, experience) at both an individual physician and organization-wide level. Without the utilization of the appropriate systems for data collation and analytic tools, the efficiency of governing bodies may be significantly hampered. Thus, in the developmental stages of the governance structure, IT should be considered primarily in the context of which types of reports/data should be reviewed by each governing body in order to be effective. However, during implementation phase, IT has more relevance and should serve as a tool to improve the governance structure's impact on the overall organization.

This section outlines various considerations when developing the appropriate governance structure for a provider organization. Overall, the best governance model for an organization will depend on its long-term strategy (i.e., remain independent, align with a hospital, pursue clinical integration, grow and then sell, etc.). This is especially pertinent for existing organizations that are seeking to revise their current model or engaging in re-negotiations with their affiliated partner(s). Nonetheless, in terms of vehicles for deciding upon the optimal structure and vetting the components inherent to the structure, a "Working Group" process is often recommended and utilized by Coker. This medium entails the establishment of a core representative group of key physician and administrative leaders from the various parties in consideration, which then serves as the ongoing decision making *advisory* body for the overall enterprise. The complex and sensitive nature of some of the topics call for engaging

independent, objective advisor to facilitate the meetings. A qualified advisor will ensure that all considerations are factored, thoroughly vetted, and decisions are made from an educated position.

Coker has been successful in a number of instances in using the above Working Group process to establish mutually agreeable transactions (inclusive of the governance structure). Coincidentally, the process utilizes the fundamental tenets that are advocated for and most often seen in effective and sustainable governance structures.

## CONCLUSION

In consideration of current healthcare trends wherein major payers (both public and private) are continuing to channel increasing levels of funds toward value-based programs, clinical integration is often the recommended "terminal goal" for all organizations regardless of alignment status. Thus, in this scenario, we would recommend the "end game" governance model be the Fully Integrated Physician Led Model; however, the process to get to such a model may be gradual with the utilization of different yet complementary models (such as the Operational Sub-Committee Model) at the outset to ease the transition process. As long as the final governance structure is supportive of the underlying alignment strategy and overarching long-term strategy, each model described herein can be tweaked to apply to virtually all provider organizations. Thus, there is seldom a "right or wrong" structure, but as articulated herein, not all models are created equal and consideration of several key areas should be given during the development stage.

It is undeniable that governance is one of the most crucial components of an organization's overall structure. An ineffective governance structure may jeopardize the success of an organization and/or their relationship with their partners. As we near a point in time where several new or renewed alignment transactions are slated to occur, it is opportune to assess the current governance model. The objective is to ensure it incorporates the functional elements that will allow it to serve the organization, as a whole, in the short-term as well as translate into a long-term solution that is responsive to value-based care for all parties involved. The financial and non-economic risks of not investing the time and effort to develop a robust governance structure at this time are too great.

## REFERENCES: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