El Camino Health

AGENDA
GOVERNANCE COMMITTEE OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS

Tuesday, February 2, 2021 – 5:30pm
El Camino Hospital | 2500 Grant Road Mountain View, CA 94040

PURSUANT TO STATE OF CALIFORNIA EXECUTIVE ORDER N-29-20 DATED MARCH 18, 2020, El CAMINO HEALTH **WILL NOT BE PROVIDING A PHYSICAL LOCATION FOR THIS MEETING**. INSTEAD, THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION MEETING VIA TELECONFERENCE AT:

1-669-900-9128, MEETING CODE: 369-007-4917#. No participant code. Just press #.

PURPOSE: To advise and assist the El Camino Hospital (ECH) Board of Directors ("Board") in matters related to governance, board development, board effectiveness, and board composition, *i.e.*, the nomination and appointment/ reappointment process. The Governance Committee ensures the Board and Committees are functioning at the highest level of governance standards.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Peter C. Fung, MD, Chair		**5:30 – 5:32pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Peter C. Fung, MD, Chair		**information** **5:32 – 5:33**
3.	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes on issues or concerns not covered by the agenda.* b. Written Correspondence	Peter C. Fung, MD, Chair		**information** **5:33 – 5:36**
4.	**CONSENT CALENDAR** *Any Committee Member or member of the public may remove an item for discussion before a motion is made.* ***Approval*** a. Minutes of the Open Session of the Governance Cmte Meeting (10/13/2020) ***Information*** b. Article of Interest c. FY21 Pacing Plan d. FY21 Board Action Plan Status	Peter C. Fung, MD, Chair	*public comment*	**motion required** **5:36 – 5:38**
5.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 5**	Peter C. Fung, MD, Chair		**information** **5:38 – 5:43**
6.	**PLANNING BOARD EDUCATION: UNDERSTANDING SYSTEMNESS AND PROMOTING SYSTEM ALIGNMENT** **ATTACHMENT 6**	Dan Woods, CEO		**discussion** **5:43 – 6:03**
7.	**DRAFT RESOLUTION 2021-02: Delegating Authority to the El Camino Hospital Board Finance Committee AND REVISING THE ECH COMMUNITY BENEFIT GRANTS POLICY AND FINANCE COMMITTEE CHARTER** **ATTACHMENT 7**	Gary Kalbach, Vice Chair	*public comment*	**possible motion** **6:03 – 6:23**

A copy of the agenda for the Regular Committee Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting.
In observance of the Americans with Disabilities Act, please notify us at (650) 988-7504 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
8.	**FY21 BOARD MEMBER COMPETENCIES** **ATTACHMENT 8**	Peter C. Fung, MD, Chair	*public comment*	**possible motion** **6:23 – 6:38**
9.	**PLANNING APRIL 2021 EDUCATION SESSION** **ATTACHMENT 9**	Cindy Murphy, Director of Governance Services	*public comment*	**possible motion** **6:38 – 6:48**
10.	**ADJOURN TO CLOSED SESSION**	Peter C. Fung, MD, Chair	*public comment*	**motion required** **6:48 – 6:49**
11.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Peter C. Fung, MD, Chair		**information** **6:49 – 6:50**
12.	**CONSENT CALENDAR** *Any Committee Member or member of the public may remove an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2:* a. Minutes of the Closed Session of the Governance Cmte Meeting (10/13/2020)	Peter C. Fung, MD, Chair		**motion required** **6:50 – 6:51**
13.	**ADJOURN TO OPEN SESSION**	Peter C. Fung, MD, Chair		**motion required** **6:51 – 6:52**
14.	**RECONVENE OPEN SESSION/ REPORT OUT**	Peter C. Fung, MD, Chair		**information** **6:52 – 6:53**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
15.	**ROUND TABLE DISCUSSION** **ATTACHMENT 15**	Peter C. Fung, MD, Chair		**discussion** **6:53 – 6:55**
16.	**ADJOURNMENT**	Peter C. Fung, MD, Chair	*public comment*	**motion required** **6:55pm**

Minutes of the Open Session of the
Governance Committee of the
El Camino Hospital Board of Directors
Tuesday, October 13, 2020

Pursuant to State of California Executive Order N-29-20 dated March 18, 2020, El Camino Health did not provide a physical location for this meeting. Instead, the public was invited to join the open session meeting via teleconference.

Members Present	**Members Absent**
Ken Alvares**	None
Peter C. Fung, MD, Chair**	
Gary Kalbach, Vice Chair**	**via teleconference
Michael Kasperzak**	
Christina Lai**	
Peter Moran**	
Bob Rebitzer**	

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session of the regular meeting of the Governance Committee of El Camino Hospital (the "Committee") was called to order at 4:31pm by Chair Fung. A verbal roll call was taken. Mr. Rebitzer joined the meeting at 4:34pm during Agenda Item 5: Report on Board Actions. Ms. Lai joined the meeting at 5:12pm during Agenda Item 8: February 2021 Board Retreat Planning. All other Committee members were present at roll call. All Committee members participated via videoconference pursuant to Santa Clara County's shelter in place order. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020 and N-29-20 dated March 18, 2020.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Fung asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were noted.	
3. PUBLIC COMMUNICATION	None.	
4. CONSENT CALENDAR	Chair Fung asked if any member of the Committee or the public wished to remove an item from the consent calendar. No items were removed. **Motion**: To approve the consent calendar: Minutes of the Open Session of the Governance Committee Meeting (8/4/2020) and for information: FY21 Pacing Plan; Board and Committee Recruitment Update; Article of Interest. **Movant**: Kasperzak **Second**: Kalbach **Ayes**: Alvares, Fung, Kalbach, Kasperzak, Moran **Noes**: None **Abstentions:** None **Absent**: Lai, Rebitzer **Recused**: None	***Consent Calendar approved***
5. REPORT ON BOARD ACTIONS	Chair Fung described the Board meeting on September 23, 2020 where the Board reviewed its Self-Assessment and the development of a Board Action Plan. Discussion topics included governance of a health system, diversity in Board membership, and delegation. Mr. Rebitzer noted that the Board also discussed meeting effectiveness; there has been progress, but there is more work to do.	

DRAFT

6. FINAL PLANNING FOR OCTOBER 2020 JOINT BOARD AND COMMITTEE EDUCATION SESSION	Ms. Murphy described the revised agenda for the Joint Board and Committee Education Session, including a panel discussion with Board and Committee members with strategic planning experience. Ms. Murphy asked for feedback on the format and for any suggested panel questions. The Committee discussed 1) panel size (about four total people from Board/Committee members), 2) importance of the moderator, and 3) education of audience via the panel. The Committee reviewed the purpose of the session and proposed discussion topics: - Lessons learned and pitfalls to avoid in strategic planning processes - Novel approaches and creative techniques (*e.g.*, business games) - Strategic planning in other industries - What does a successful process for ECH look like? - What questions do the Board and Committee members want answered during the strategic planning process? The Committee suggested that the panelists should focus on process rather than content. Mr. Rebitzer cautioned that the strategic planning process should start with the question, not the answer. Ms. Murphy confirmed that the event is scheduled for October 28, 2020.	
7. FY21/22 BOARD EDUCATION PLAN	Ms. Murphy described the development of the proposed Education Plan topics, including areas identified on the Board Self-Assessment and recent publications from The Governance Institute. Chair Fung suggested adding education on diversity. The Committee expressed concerns about one proposed topic, the Role of the Board in Employee Engagement, which could muddle the distinction between management and the Board and between employee engagement and culture. Mr. Moran suggested replacing #7 with diversity. Mr. Kasperzak discontinued participation in the meeting at 5:00pm. Committee members expressed concerns about adding items to already busy Board agendas, especially when efforts have been focused on streamlining meetings. Ms. Murphy noted that there could be articles of interest in the packets with 10 minutes for discussion at each Board meeting. The Committee discussed augmenting the Governance Committee's more process-based agendas with these substantive topics and determining how the Committee can educate or offer educational opportunities to the Board in these areas. **Motion**: To incorporate these eight items into Governance Committee agendas for the coming year to address the Committee's understanding and how to support the Board and other stakeholders on these topics and replacing Item 7 (the Role of the Board in Employee Engagement) with education on diversity. **Movant**: Rebitzer **Second**: Fung **Ayes**: Alvares, Fung, Kalbach, Moran, Rebitzer **Noes**: None **Abstentions:** None **Absent**: Kasperzak, Lai **Recused**: None	***Education Plan to be incorporated into Governance Committee work***

8. FEBRUARY 2021 BOARD RETREAT PLANNING	Ms. Lai joined the meeting at 5:12pm. Dan Woods described the proposed agenda related to understanding system-ness and progress on the strategic planning process. Mr. Woods and the Committee discussed joint presentation from consultants and executives and engaging physician leadership in the process. Board members on the Committee suggested including leaders or representatives from the employed medical groups in the conversation at the retreat. **Motion**: To have the February 2021 Board Retreat on understanding system-ness and promoting system alignment and to discuss the participants further. **Movant**: Fung **Second**: Alvares **Ayes**: Alvares, Fung, Kalbach, Lai, Moran, Rebitzer **Noes**: None **Abstentions:** None **Absent**: Kasperzak **Recused**: None	***February 2021 Board Retreat topic approved***
9. POLICY AND PROCEDURE FOR ADVISORY COMMITTEE NOMINATION AND SELECTION	In response to Ms. Lai's question, Ms. Murphy explained that the Committees send recommendations to the Board for approval of community member Committee appointments. The Board does not interview or consider additional candidates. **Motion**: To recommend that the Board approve the proposed changes to the policy and procedure. **Movant**: Moran **Second**: Lai **Ayes**: Alvares, Fung, Kalbach, Kasperzak, Lai, Moran, Rebitzer **Noes**: None **Abstentions:** None **Absent**: None **Recused**: None	***Revised policy and procedure approved***
10. GOVERNANCE COMMITTEE SELF-ASSESSMENT RESULTS	The Committee discussed their Self-Assessment and overall Committee operations and performance: 1. **Frequency and duration of meetings** are appropriate. 2. **Membership**: Some members commented that the Committee is slightly larger than optimal and that many were not in favor of active recruitment at this time. The Committee also discussed the diversity of the candidate pool and the desire to have diverse experience and philosophy to generate productive discussion. 3. **Information and Education**: The Committee voiced support of more robust orientation and continuing education (including ways to refresh for existing members). Ms. Murphy described the most recent Committee member onboarding, which included an overview of the Strategic Plan with staff and Committee leadership. 4. **Effectiveness and Efficiency of Committee Meetings**: Members highlighted succinct meetings and discussion, good decision making, and useful guidance from well-prepared packets and focused summary memos. **5.** **Bi-directional communication with the Board**: Chair Fung described the development of the Report on Board Actions.	
11. ADJOURN TO CLOSED SESSION	**Motion**: To adjourn to closed session at 5:40 pm. **Movant**: Kalbach	***Adjourned to closed session at 5:40 pm***

	Second: Moran **Ayes**: Alvares, Fung, Kalbach, Kasperzak, Lai, Moran, Rebitzer **Noes**: None **Abstentions:** None **Absent**: None **Recused**: None	
12. AGENDA ITEM 15: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 5:42. Agenda items 12-14 were addressed in closed session. During the closed session, the Committee approved the Minutes of the Closed Session of the Governance Committee Meeting (8/4/2020) by a unanimous vote in favor of all members present by teleconference (Alvares, Fung, Kalbach, Lai, Moran, Rebitzer). Mr. Kasperzak was absent.	
13. AGENDA ITEM 16: ROUND TABLE DISCUSSION	The Committee reviewed the effectiveness of the meeting. Mr. Woods commended the camaraderie and collaborative spirit of the Committee. Ms. Murphy asked that Committee members send her proposed questions for the panel discussion and noted that she and Mr. Woods will work with Chair Fung and Vice Chair Kalbach to finalize the set for the October 28, 2020 meeting.	
14. AGENDA ITEM 17: ADJOURNMENT	**Motion**: To adjourn at 5:45pm. **Movant**: Lai **Second**: Kalbach **Ayes**: Alvares, Fung, Kalbach, Kasperzak, Lai, Moran, Rebitzer **Noes**: None **Abstentions:** None **Absent**: None **Recused**: None	***Meeting adjourned at 5:45pm***

Attest as to the approval of the foregoing minutes by the Governance Committee of El Camino Hospital:

____
Peter C. Fung, MD
Chair, Governance Committee

Board Recruitment

AN INTENTIONAL GOVERNANCE GUIDE: TRENDS, TIPS, AND TOOLS

A Governance Institute
Online Toolbook
Spring 2015

About the Authors

Sean Patrick Murphy is President and CEO of the TanAlto Healthcare, a professional corporation dedicated exclusively to healthcare, with a focus on leadership, governance, strategy, and innovation. TanAlto provides unique resources that allow healthcare providers and systems to think big, but act fast—to respond rapidly to the changing delivery system, in a fashion not unlike "smaller, start-up companies." His interdisciplinary team includes former healthcare executives, health lawyers, pharmacists, educators, healthcare technology experts, and healthcare business executives experienced in both the equity and public markets. Mr. Murphy is a former Senior Vice President and Corporate General Counsel to a large, New Jersey integrated healthcare system. He received his J.D. from Rutgers University School of Law and his M.H.A. from the George Washington University.

Kathryn C. Peisert is Managing Editor of The Governance Institute. She has been in healthcare governance for 12 years, and is responsible for all of The Governance Institute's content development for publications in print and online, DVD/video programs, Webinars, e-learning courses, and conferences. In her role she helps to research and identify recommended board practices and key healthcare governance challenges and issues for the nation's hospital and health system boards.

Previously, she served as Editor with The Governance Institute, and prior to that as Permissions and Copyright Editor for Roxbury Publishing Company, now a division of Oxford University Press. She has authored or co-authored articles in *Health Affairs, Journal of Health & Life Sciences Law, Prescriptions for Excellence in Health Care,* and *Healthcare Executive,* as well as numerous articles, case studies, and research reports for The Governance Institute. She has a bachelor's degree in communications from UCLA and a master's degree from Boston University.

The Governance Institute

The Governance Institute provides trusted, independent information and resources to board members, healthcare executives, and physician leaders in support of their efforts to lead and govern their organizations.

The Governance Institute is a membership organization serving not-for-profit hospital and health system boards of directors, executives, and physician leadership. Membership services are provided through research and publications, conferences, and advisory services. In addition to its membership services, The Governance Institute conducts research studies, tracks healthcare industry trends, and showcases governance practices of leading healthcare boards across the country.

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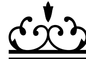

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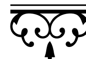

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Introduction and Background

Five years ago, The Governance Institute published its signature publication, *Intentional Governance: Advancing Boards beyond the Conventional*.[1]

The premise and concept of Intentional Governance are straightforward: if we want a better, high-performing, accountable governing board, we need to take deliberate "intentional" action to achieve this goal. Success rarely happens by chance. This is true for most things in life: athletes, students, business corporations—even marriages. It usually requires time, willingness, focus, and effort.

The same goes with governance. If we want to build and achieve a talented, highly effective board, it takes work and intent. First, we must want it: aspire to have a high-performing, better governing board. Then, we must act: take the deliberate, willful, "intentional" action steps to get there. We define Intentional Governance as: deliberate and intentional processes addressing board structure, dynamics, and culture that enable the board to realize its highest potential. The examination is about who is on the board and why; it is about how directors interact with each other and how they interact with management; it is about how the board uses its time, how it establishes its priorities/agenda, and how it measures its effectiveness. It is about governing with intention.

Intentional Governance: Seven Essential Elements

Intentional Governance is the byproduct of a simple, but important question: what makes an effective board? During our research, we identified seven essential elements of governance, each an essential part of the organization and operation of a "good board." These seven elements include:

1. Board recruitment
2. Board structure
3. Board culture
4. Education and development
5. Evaluation and performance
6. Continuous governance improvement
7. Leadership succession planning

This Intentional Governance Guide addresses the first element, board recruitment. Each guide in this series is designed to provide takeaway tools and assist readers in developing customized Intentional Governance plans related to each of these seven essential elements.

1 Sean Patrick Murphy and Anne D. Mullaney, The Governance Institute, 2010.

Exhibit 1. Intentional Governance Spectrum

Board Recruitment

Of all the seven elements or "pillars" of Intentional Governance, none has changed or gained importance in these last five years as much as board recruitment. These changes represent and indicate the increasing recognition of governance as a significant force during this time of "change management" in healthcare. The importance, and challenge, of recruiting the very best board talent is now almost universally recognized in healthcare.

Board recruitment is the first element of Intentional Governance and for obvious reasons. A good board starts with good directors who are not only willing, but able to guide the board and oversee the healthcare organization, and to take governance, and its duties and responsibilities, seriously: to build and operate a high-performing board.

In *Intentional Governance,* we recommend that governing boards consider developing a "board recruitment plan" and that such a plan address and include important factors when recruiting directors, including considering both the board's needs and the underlying healthcare organization's needs for leadership talent (based on the strategic plan); evaluating seriously the training, education, and experience of each director (in relation to board and organizational needs); the value of conducting a "stakeholder analysis" to make certain the board's and director's composite skillsets are sufficient to fulfill and discharge duties and obligations to stakeholders; and, finally, maintaining diverse community representation. All together, this activity requires ongoing talent management.

Intentional Governance Assessment: Board Recruitment

Please indicate your level of agreement with each item.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know/not applicable
The board considers the organization's needs first when recruiting directors (i.e., correlates the organization's current and future plans with directors' competencies and skills such as risk, clinical integration, quality and safety, etc.).						
The board seeks directors with specific competencies and skills based on current/future board needs.						
The board has written requirements for training/education experience for potential directors.						
The board considers the various needs and perspectives of key stakeholders (patients, employees, the community) when recruiting directors.						
The board has adequate representation from the community and strives to maintain community representation.						

Intuitively, one need not reflect deeply to consider the overall importance of board recruitment; after all, a board is only as good as its directors and the starting point for this is, without doubt, board recruitment.

A New Demand for Board Talent

The value of board talent and "strong, effective governing boards" became manifest in these past five years. Healthcare organizations are not merely paying "lip service" to the importance of board recruitment. There has been a dramatic shift in both attitude and practice about board recruitment, some of which is a result of the following.

Strategic Competitive Advantage

Governance Institute research conducted in 2010 and 2012[2] showed that boards were beginning to recognize the need to transform themselves and search for new and different talent in response to the changing healthcare delivery system. Healthcare organizations gain a strategic competitive advantage by having a strong governing board.

Human Capital/Talent Management

Healthcare organizations (like other industries) recognize the value of human capital as the most significant organizational asset. Hospitals and health systems recruit fiercely for the best talent, from CEO and senior management to rank-and-file employees. However, this was not always the case, and the need to recruit fiercely in the same way for board members is becoming ever more intense.

A Shortage of Board Talent

Governance Institute and other research indicate an ongoing shortage of people willing to serve on boards.[3] Perhaps more importantly is that governing boards are increasingly reporting difficulty in retaining board members as well. Together, these converging trends are troubling as they suggest a potential "systemic problem." These include:

- Have hospitals and health systems lost their community engagement?
- Do people value their community hospitals as they have for years, as an indispensable, charitable asset?
- Are people just getting too busy to find time to serve on their local hospital boards?
- Have healthcare governing board meetings changed to meet the times? Are the meetings vibrant, engaging, and fully taking advantage of technology?

2 The Governance Institute conducted surveys of member CEOs and board members from non-profit hospitals and health systems across the U.S. in 2010 and 2012, results of which were published in *Intentional Governance (2010)* and Sean Patrick Murphy, *Board Recruitment and Retention: Building Better Boards Now…and for Our Future* (The Governance Institute, 2013).

3 *Board Recruitment in the Non-Profit Market* (research study), Booz Allen Hamilton, 2002; *2014 Nonprofit Trends to Watch,* National Council of Nonprofits, 2013.

Wanted: Younger Directors

Healthcare organizations are increasingly recognizing a need to recruit younger talent, which is becoming more difficult due to many reasons, including more dual-income families that are struggling to balance family and workplace demands.

Technology and Governance

The next generation of board talent will want more: using technology to have "meetings without meeting." CEOs, governing boards, and board leaders who identify and embrace generational diversity today will likely recruit and retain the very best directors tomorrow.

Multi-Generational Boardroom

The "internal" demographics of healthcare governance are also changing as we begin to embrace "multi-generational" governing boards: board members who sometimes have different values and who sometimes think and learn differently.

Responding to the Demand for Board Talent

Many healthcare organizations have begun to experience the "board talent shortage" and are responding in a variety of ways:

1. **Board talent pool**: Many healthcare organizations are generating "board talent pools," often in the form of advisory boards, and also populating board committees with non-board members. This can be a source to develop talent—the organization benefits from their talent and skills and the non-director becomes familiar with the organization and how it conducts business. Some healthcare organizations invite advisory board members to attend certain board meetings (sometimes on a monthly rotating basis). Some also encourage former board members (some of whom had to leave due to term limits) to stay on the advisory board so that the organization can continue to keep seasoned, valuable former board members engaged. Finally, a board talent pool may provide another important valuable benefit: to act as a "community bridge" as hospitals and health systems shift focus to value-based, patient-centered care across the population.
2. **Directors without borders**: Several organizations are now more actively going outside and beyond their "traditional service areas" to recruit talent. Almost 30 percent of healthcare boards are going, or are planning to go, outside their service area to recruit new board talent. Just like recruiting for executive management, it can be beneficial to look beyond the local region to find the best directors.
3. **Seeking professional help:** Another trend is for hospitals and health systems to engage professional search firms to vet candidates and recruit people with the board's needed skills and competencies.

4. **Compensating directors:** Another slow but consistent trend is director compensation. Once almost unheard of, more organizations today are able to make the argument that the combined shortage of directors and increased demands on the board (legal and otherwise) help justify the decision to compensate hospital and health system board members for their time and efforts. (Note: hospitals and health systems that are considering board compensation should work with trained consultants and legal counsel to remain legally compliant.)

With these trends and challenges in mind, we turn to the steps boards can take to develop an effective board recruitment plan.

Board Recruitment and Development Plan

The board should not be looking at a generic "prescription" or list of board member skills and competencies and then attempt to fill the board with those who fit the prescription. Every organization is different and the needs of each organization are unique. The board should take care to focus its recruitment and development efforts by looking at the needs of the organization *first,* by identifying the organization's needs as a whole (considering the mission, vision, and strategic plan, how the organization is performing against goals, areas of weakness, etc.). This is where the board's strategic planning process intersects directly with board recruitment.

Strategy and Innovation: Does Your Board Have the Right Stuff?

Strategy and strategic planning is nothing new to healthcare. However, for many years, hospital and health systems were "immune" to several important and basic market forces. Today this is no longer the case and the strategic requirements of the industry can be especially problematic for hospitals and health systems that follow the hospital-centric strategic planning patterns of the past. While hospital infrastructure, growth initiatives, and quality and financial performance remain exceedingly important, hospitals and health systems have to face some serious questions about the future, both in terms of the hospital's/health system's role in an accountable care environment, as well as the impact of emerging technologies, care coordination, "new competitors," and population health.

The organization's strategic plan and vision ultimately become the foundation upon which the board considers the kinds of competencies it will need to see the plan out and enable the organization to reach its long-term goals.

Strategy Questions to Consider

What is our core business? Do we need to or should we reconsider this?

Have we looked at our hospital/health system mission statement in the past year? Based on our core business (and if that has or will change), is our mission statement still relevant or do we need to update it?

Does population health "compete" with the acute/post-acute enterprise? What is or will our role be in the population health management of our community relative to other providers in our community?

What market share-related concerns regarding population health issues should be on our radar (i.e., reduced inpatient volume, productivity measurements, risk-based payment contracts, etc.)?

How do we deal with the bottom line while being in the business of caring for the sick and injured and simultaneously decreasing demand for existing/inpatient services?

Are there new competitors entering or preparing to enter into the market that can disrupt our pace and plans to promote population health, while we continue to plan for and provide acute/post-acute care?

Do we have the board talent necessary to compete with others that are entering or already in the population health market?

Most hospitals and health systems are inundated with important and significant issues that impact and relate to our traditional "lines of business," such as acute/post-acute and outpatient care. For most hospitals and health systems, the questions are: Can we continue to provide quality and safe healthcare and compete and simultaneously "move fast enough" to claim some of the revenue that goes to those that plan to care for the healthy?

These are serious, thought-provoking issues that lend no obvious answers. Simply put, we are in the midst of a significant era of "change management"—yet, most hospitals and health systems have little time to digest the rapidly developing changes in healthcare, not to mention plan for them.

This is the core of the board recruitment issue—boards need more diverse skills, talents, and perspectives than they may have needed in years past in order to become agile and change in a smart manner to place the organization in a competitive position. Some of the new skillsets cutting-edge boards are recruiting for today are discussed below.

Second-Curve Competencies

The primary focus and benchmark of progressive healthcare governance today are board competencies, followed closely by a less appealing, yet very real, demand for accountability. What competencies—often referred to now as "second-curve competencies"—do governing boards need to lead in this time of change? The answer of course will be different for each organization.

Board Competency Questions to Consider

Are we looking seriously at "global-market" developments and their potential implications for our organization and local market? What is an appropriate, proactive response to these potential scenarios?

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Healthcare technology and innovation start-ups are moving and developing at a historic pace. Do we need an innovation expert on our board or employed by the organization to keep up?

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How will healthcare changes affect our hospital or health system—in the near term, and potentially the long term?

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Is our healthcare world growing faster and larger than we thought? Are we ready to embrace uncertainty?

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Who is looking toward the future, to protect and advocate for one of our community's most important assets—its hospital or health system?

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CEOs and boards come and go—but the visionaries are the ones who have left the legacy most of us take for granted: our hospitals, physicians, nurses, and healthcare providers. Who is looking out for the next generation?

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Based on the answers to these questions, what second-curve competencies are missing on our board?

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It is dangerous for anyone to generically "prescribe" second-curve competencies without considering hospital and health system strategy. That said, here is a list of some second-curve competencies, subject to your particular organizational strategy:

- Population health and chronic disease management
- Change management (including Lean/Kaizen-type culture implementation and continuous quality improvement)
- Technology (especially "small" such as e-health and wearables, and social media)
- Innovation (both small company and corporate)
- Banking (change management and strategic cost management; investment bankers with healthcare expertise)
- National healthcare experts (vision and expertise on a national scale)
- Corporate governance (national expertise in for-profit corporations)
- Systems management: experts on systems of care and reliability processes, and people who can move and change systems quickly
- Strategy and strategic planning (healthcare and national)
- Actuaries/risk-management
- Healthcare entrepreneurs
- Visionaries
- Medication management
- Team builders: people who can build board and management teams

Essential Planning Tool: Board Talent Management Matrix

Creating a board talent management matrix is a great way to ensure that the board will have the competencies it needs going forward. This matrix can be the basis of any board recruitment and development plan.

Exhibit 2. Board Talent Management Matrix*

Board Talent Risk Assessment	# Vacancies: ______ Skills lost: 1. ______ 2. ______ 3. ______ 4. ______	Satisfaction Survey: _____ % directors satisfied _____ % directors agree board is effective	Problems identified in one-on-one meetings with board chair: 1. ______ 2. ______ 3. ______ 4. ______	Employ search firm? Pros: ______ ______ Cons: ______ ______	Actions/deadlines: 1. ______ 2. ______ 3. ______ 4. ______

Talent Needs Based on Strategic Plan	Mission statement (updated?): ______ ______ ______ ______	Strategic goals (short term): 1. ______ 2. ______ 3. ______	Strategic goals (long term): 1. ______ 2. ______ 3. ______

Board Member Competencies & Gaps	Skills needed based on strategic plan: 1. ______ 2. ______ 3. ______ 4. ______	Other/new skills/ attributes needed: 1. ______ 2. ______ 3. ______ 4. ______	# of current directors with strategic skills: 1. ______ 2. ______ 3. ______ 4. ______	# of current directors with other/new skills: 1. ______ 2. ______ 3. ______ 4. ______	Talent gaps: 1. ______ 2. ______ 3. ______ 4. ______

Talent Pool	# of directors needed for immediate gaps: 1. ______ 2. ______ 3. ______ 4. ______	Names/skills in current candidate pool (if applicable): 1. Name: ______ Skills: 1. ______ 2. ______ 3. ______ 2. Name: ______ Skills: 1. ______ 2. ______ 3. ______ 3. Name: ______ Skills: 1. ______ 2. ______ 3. ______	Decisions to make: How many people do we need to add to the candidate pool? What skills are missing in the pool? Where/how to find candidates?	**Plan Implementation**: Actions/deadlines: 1. ______ 2. ______ 3. ______ 4. ______ 5. ______ 6. ______

*To receive a copy of this matrix in spreadsheet format, please download it at www.governanceinstitute.com, or contact The Governance Institute at info@governanceinstitute.com or (877) 712-8778.

Once the Recruiting Is Done: Engaging and Retaining Board Members

Board Satisfaction

One cannot effectively address board satisfaction without talking—communicating—with the board. Some boards are working with consultants to construct specially designed "board satisfaction surveys" (including individual director interviews) to help board leaders and the CEO get a better sense of the board's strengths and weaknesses, including director satisfaction.

Most boards that go through this exercise not only learn a lot about their boards and governance responsibilities, but also find it helpful for the governing board to then build a multi-year board education and development plan. Further, this is an important tool to help preempt dissatisfied directors and implement changes that can make meetings more valuable and engaging.

Board Satisfaction Questions to Consider

Does your board set aside dedicated time to take stock of how it is doing? Is this time well spent/sufficient or how can the board improve its efforts in this regard?

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How does your board invest in its talent (i.e., what does it do to ensure board members feel their time serving on the board is personally valuable and time well spent)? One way to accomplish this is through a one-day annual "governance retreat" to provide board members the opportunity to take a satisfaction deep dive and brainstorm on how the board is doing and how it can improve.

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Do the CEO and board leaders listen to, and learn from, the directors (e.g., ways to improve meetings)? (We recommend meeting with directors on at least an annual basis.)

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Does your board benchmark and monitor its performance and satisfaction?

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Does your board talk about its meetings, including how they can be improved? (A popular and effective solution is to conduct a five-minute meeting evaluation at the end of each meeting. The most important aspect of this is to act upon what is learned from the evaluations!)

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When was the last time your board reviewed its meeting structure and agenda to make certain that meetings are valuable and engaging?

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Board Education

Few would argue about the benefits of board education—especially during these changing times. However, high-performing governing boards are continually learning, asking questions, and obtaining information not merely on their own organization, but also on industry trends and developments.

Board Education Questions to Consider

Does your board take time for annual board education retreats?

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Does learning continue during board meetings? (This is a telltale sign of effective meetings, when board members are not merely asked to review organizational performance, but when they are learning about cutting-edge industry trends and using that information to help frame strategy and policy.)

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Does your board have a robust education program that provides a strong orientation program and individual director education plans and goals? (Note: every board member is different and has different training, education, and skills. It is very helpful for the CEO and board leaders to ask individual directors what would help them—what individual learning methods and topics would strengthen their role as a board member.)

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Are your board meetings engaging? Have you asked your board members? A recent survey of one board disclosed that the governing board was highly engaged; unfortunately, the survey did not tell the whole story. When interviewed, individual directors confirmed that the board was highly engaged, but board meetings were not. Board members wanted more discussion, more meeting engagement, and more education, learning, and discussion to occur at board meetings.

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Healthcare is in the midst of enormous, foundational change. And not unlike the healthcare industry itself, hospital and health system governance is also in the midst of fundamental change—boards are increasingly becoming an essential factor for organizational success. Thus, healthcare leaders are beginning a new journey to recruit directors with the skills necessary to move hospitals and health systems forward into an accountable, value-based healthcare system.

Boards must now view director recruitment as a significant part of the organization's strategy—continuous governance improvement through a proactive, rigorous process of pooling board talent that is ongoing and directly integrated with the strategic plan and future vision.

Organizations that put and place their talent in the front-end (on the governing board) are not only less likely to be surprised, but better able to partner with the CEO and management to help navigate the myriad challenges and changes happening in our healthcare delivery system.

Appendix A.
Sample Board Skills Matrix

(for customization)

Name of Organization: ___________________________

Board's Strategic Imperatives *(edit as needed)*	Current Need	Future Need	Current/ Ongoing Need	Skills Currently Provided by: *(skills not exclusive to directors listed)*	Examples of Individuals Who Bring This Skill
Advocacy					Legislator; lawyer; public or elected official; marketing, media, or philanthropy expert
Construction/Real Estate					Architect; engineer; realty executive; developer
Governance Effectiveness					Lawyer; chief executive or consultant
Investment					Investment analyst/broker; banker
Finance/Accounting/Compliance					Finance or accounting officer; controller; banker; lawyer
Marketing/Communications					Market research or media executive
Healthcare Quality and Safety					Physician, nurse, or other healthcare professional; industry expert
Social Services/ Community Outreach					Social service or public health professional; clergy; civic volunteer leader; media executive
Revenue Streams					Health insurance payer/ HMO executive; foundation executive
Strategy/Planning					Chief executive; planning/ policy expert
Technology					Executive-level specialist from academia, business, healthcare
Workforce Development					Educator; HR professional; consultant; major employer

Appendix B. Sample Competency-Based Selection Guidelines for Boards of Directors

(customize as appropriate for your board)

Core Competencies *Required of ALL board members*	Essential Competencies *Should be present in the board AS A WHOLE and, therefore, be strong attributes of one or more but not necessarily all members*	Desirable Competencies *These characteristics would be an asset to the board at the present time, given the strategic priorities*
A demonstrated commitment to the organization's mission, vision, values, and ethical responsibilities and to the communities and consumers we serve	Knowledge of, or ties to, the communities and consumers served by the organization (refers to broad knowledge of communities and consumers)	Particular knowledge of community benefit issues and health needs in the communities served throughout the region (e.g., needs of poorer communities and vulnerable populations)
A demonstrated willingness to devote the time necessary to board work, including board education	High-level executive experience in a business or educational organization	Managed care background or experience
A demonstrated capability to exercise leadership, teamwork/consensus-building, systems thinking, and sound judgment on difficult and complex matters that come before a governing body	Financial background and expertise	Legal background or experience
Personal integrity and objectivity, including no conflicts of interest that would prevent a board member from discharging his or her responsibilities	Experience and expertise in a healthcare field	Human resources, employee benefits, or executive compensation experience or background
	Physicians for the knowledge and perspective they bring	High level of community and regional visibility
	Diversity of experience, backgrounds, gender, and ethnic origin; representative of economically disadvantaged citizens	Quality assessment/improvement background or experience
	Knowledgeable about healthcare marketplace in our region and related issues potentially affecting our organization	
	Knowledgeable about post-acute care issues	
	Large non-public business experience (100+ employees)	
	Small business experience (less than 100 employees)	

Governance Committee
Updated January 11, 2021

FY21 GC Pacing Plan – Q1		
July 2020	**August 4, 2020**	September 2020
No scheduled meeting *At each meeting:* **Regular Consent Calendar Items:** Minutes, Committee Recruitment Update, Article of Interest **Other Regular Items:** - Board Recruitment Update - Report on Board Actions - FY21 Pacing Plan - Roundtable Launch Board and Committee Self-Assessments	- Consider Hospital Board Member Competencies for FY21/22 - Planning for October Joint Education Session - Planning for February Board Retreat - Review Annual Board and Committee Self-Assessment (BSA) Results and Develop Action Plan for the Board	*No scheduled meeting*
FY21 GC Pacing Plan – Q2		
October 6, 2020	November 2020	December 2020
- Final Planning for October Joint Education Session - FY21/22 Board Education Plan - Review Policy and Procedure for Advisory Committee Member Nomination and Selection - February Board Retreat Planning - Governance Committee Self-Assessment Results **Wed. 10/28/2020** **Board & Committee Joint Education Session**	*No Scheduled Meeting*	*No scheduled meeting*

Governance Committee
Updated January 11, 2021

FY21 GC Pacing Plan – Q3		
January 2021	**February 2, 2021**	**March 23, 2021**
No scheduled meeting	- Planning April Education Session - Assess Progress on FY21 Board Action Plan - ~~Review Board Officer Nomination and Selection Procedures~~ - FY21 Board Member Competencies - Board Education (1 and 2) - Delegation of Authority to Approve ECH Community Benefit Grant Funding to the Finance Committee (Revise CB Policy)	- Set FY22 Governance Committee Dates - Develop FY22 Governance Committee Goals - Final Planning April Education Session - Review Process for Election and Re-Election of NDBM's to the ECH Board - Assess Governance Structure Resiliency During COVID-19 Pandemic Response and Recovery - Board Education (3, 4 and 5) - Review Advisory Committee Structure - Review and Recommend Annual Board Self-Assessment Tool - Possible Bylaws Revision - Review Board Officer Nomination and Selection Procedures
FY20 GC Pacing Plan – Q4		
April 2021	May 2021	**June 1, 2021**
No scheduled meeting **Wed. 4/28/2021** **Board & Committee Educational Gathering**	*No scheduled meeting* ***Launch Board Self-Assessment***	- Review and Recommend all FY22 Committee Goals to Board - Assess Progress on FY21 Board Action Plan - Review Proposed FY22 Advisory Committee and Committee Chair Assignments - Review Committees' progress against FY21 Goals - Confirm Self-Assessment Sent to District (from GC charter) - Finalize FY22 Master Calendar (for Board approval in June) - Assess ECH Board Structure - Board Education (6, 7 and 8) - Assessing Board Diversity

Governance Committee
Updated January 11, 2021

El Camino Hospital
Board Education Topics for Consideration during FY21

At its October 13, 2020 meeting, the Governance Committee approved the following topics and requested that they be paced for discussion throughout the year. The Committee will review each topic and make recommendations as to how to best educate the Board in these areas.

	Meeting Date	Education Topic	Presenter
1.	February 2021	Building an Outpatient Strategy	
2.	February 2021	Understanding System-ness and Promoting System Alignment	
3.	March 2021	Building a Reliable Culture of Safety	
4.	March 2021	Board Oversight of Quality in the Telehealth Era	
5.	February 2021	Technology and Cyber Security	
6.	June 2021	Assessing and Renewing Board Governance	
7.	June 2021	Diversity	
8.	June 2021	Best Practices in Board Succession Planning	

FY21 El Camino Hospital Board Action Plan
Approved November 11, 2020

	What	Who		By When	Current Status
	Strategic Oversight				
1.	Define the role and establish process for Board oversight and engagement of the upcoming strategic planning process.	Board Chair, CEO		12/9/20 Board	Discussed at 12/9/20 Board
	Clarify Governance Processes and Structures				
2.	Review pacing plan and past agendas to identify items that could be placed on the consent agenda or delegated to create more time for strategic discussion.	Chair, CEO, Dir. Gov. Services		12/30/20	Ongoing
3.	Continue to provide executive summaries and framing questions for each agenda item to focus attention and stimulate discussion.	CEO, Executives, Dir. Gov. Services		12/30/20	Ongoing
4.	Conduct a review of the current committee structure to determine if it is still in alignment with current governance responsibilities.	Governance Committee		2/2/21 GC 2/10/21 Board	Delayed
5.	Work with committee leadership and executive sponsors to develop a more effective mechanism for communication between the board and committees.	Chairs, Vice Chairs, Executives, Dir. Gov. Services		1/15/21	Delayed
	Increase the Board's Diversity				
6.	Request the Governance Committee develop a set of recommendations to increase the representation of diversity on our governing bodies as reflected from the communities we serve.	Governance Committee		3/23/20 GC 4/7/21 Board	**May Be Delayed**

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Governance Committee
From: Cindy Murphy, Director of Governance Services
Date: January 28, 2021
Subject: Report on Board Actions

Purpose: To keep the Committee informed with regards to actions taken by the El Camino Hospital and El Camino Healthcare District Boards.

Summary:

1. Situation: It is important to keep the Committees informed about Board activity to provide context for Committee work. The list below is not meant to be exhaustive, but includes agenda items the Board voted on that are most likely to be of interest to or pertinent to the work of El Camino Hospital's Board Advisory Committees.

2. Authority: This is being brought to the Committees at the request of the Board and the Committees.

3. Background: Since the last time we provided this report to the Governance Committee, the Hospital Board has met three times and the District Board has met three times. In addition, since the Board has delegated certain authority to the Executive Compensation Committee, the Compliance and Audit Committee and the Finance Committee, those approvals are also noted in this report.

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
ECH Board	October 14, 2020	- Resolution Recognizing the El Camino Health Foundation for Establishing COVID-19 Relief Fund - FY21 Period 2 Financials - FY20 Financial Audit and Cash Balance and 403(b) Plan Audits - Quality Committee Report, including Credentials and Privileges Report - FY20 Organizational Performance Score - FY21 Readmissions Organizational Performance Goal Metrics - Neuro-Interventional Call Panel - Medical Director, Cardiac Rehabilitation
	November 11, 2020	- *Resolution 2020-10*: Recognizing Brian Richards' Service to the Organization - Medical Staff Report - Quality Council Minutes - Medical Staff Credentials and Privileges Report - Election of Carlo Bohorquez, CFO and Deb Muro, CIO to the Pathways Home Health and Hospice Board of Directors - Pathways FY21 Budget - FY21 Board Action Plan

Report on Board Actions
February 2, 2021

Board/Committee	Meeting Date	Actions (Approvals unless otherwise noted)
		- Revised Policy and Procedures for Nomination and Appointment of Community Members to the Board's Advisory Committees - FY21 Board Retreat Agenda - Annual Safety Report for the Environment of Care - FY21 CEO Base Salary - FY20 CEO Incentive Compensation Payout
	December 9, 2020	- FY21 Period 3 and 4 Financials - FY20 CEO Incentive Compensation Payment - Quality Committee Report Including Credentials and Privileges Report
ECHD Board	October 20, 2020	- FY20 Year End Consolidated Financials - FY20 Year End Community Benefit Report - ECHD Conflict of Interest Code - FY20 Year End ECHD Stand Alone Financials - FY20 Financial Audit - FY21 Period 2 Financials - Appointment of District Director George Ting as Chair of the ECH Board Member Election Ad Hoc Committee and as Liaison to the Community Benefit Advisory Council - Revisions to the ECHD Community Benefit Grants Policy (moves up timeline for notification to the public regarding grant funding cycle)
	December 4, 2020	- Accepted the November 3, 2020 Election Results (John Zoglin, Julia E. Miller, and Carol A. Somersille, MD elected) - Elected Carol A. Somersille, MD to the El Camino Hospital Board of Directors - Appointed Julia E. Miller as Vice Chair of the ECHD Board
	December 29, 2020	- Endorsed John Zoglin as Candidate for Alternate Independent Special District Member of Santa Clara County LAFCo - Approved $100,000 in funding for Community COVID-19 Vaccination Program
Executive Compensation Committee	N/A	
Compliance and Audit Committee	N/A	
Finance Committee	N/A	

List of Attachments: None.

Suggested Committee Discussion Questions: None.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Governance Committee
From: Dan Woods, CEO
Date: February 2, 2021
Subject: Board Education Planning: Understanding Systemness and Promoting System Alignment

Purpose: To discuss how we will incorporate a discussion about understanding systemness and promoting system alignment as part of the February Board Retreat.

Summary:

1. Situation: At its October 13, 2020 meeting, the Committee reviewed a proposed Board education plan and asked staff to incorporate eight items into Governance Committee agendas for the coming year to address the Committee's understanding and how to support the Board and other stakeholders on these topics.

2. Authority: One of the Governance Committee's chartered responsibilities is to plan for Board Education.

3. Background: The February Board Retreat will be focused on our current strategic planning effort. Our partners from McKinsey will lead the retreat and a discussion about systemness and system alignment will be a part of the session.

4. Assessment: N/A

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments:

1. McKinsey and Co. Article
2. Proposed Board Education Plan

Suggested Committee Discussion Questions: What advice does the Committee have for management regarding how best to incorporate this topic into the discussion at the Retreat?

McKinsey & Company

Healthcare Systems and Services Practice

The hospital is dead, long live the hospital!

Innovations that will shape the next generation of hospitals.

By Dr. Penny Dash, Caroline Henricson, Dr. Pooja Kumar, and Natasha Stern

May 2019

Executive summary

The world is changing, and so are hospitals. In response to significant external forces, innovations in both how healthcare is delivered and how hospitals are structured are emerging. Through these innovations, hospitals can better position themselves to survive—and even excel—in tougher conditions.

Nine major forces are involved:

— Changes in patient populations and their needs

— Higher patient expectations

— Recognition that many types of care can be better provided in community settings

— Data suggesting that high-quality care requires high-volume centres, and the emergence of standalone single-specialty centres

— Advances in clinical knowledge and technology

— Impact of digital technologies on how healthcare is delivered

— Difficulties in attracting and retaining an appropriately skilled workforce

— Financial and funding challenges

— Requirements to measure quality

Whilst their relative importance differs from country to country, these forces are at play across the globe. To investigate how hospitals are responding, we have identified global best practices through interviews with healthcare experts in conjunction with extensive desktop research.

Our results show that contemporary healthcare providers around the world are facing several urgent imperatives: to strengthen clinical quality; increase the delivery of personalised, patient-centred care; improve the patient experience; and enhance their efficiency and productivity. As a consequence, providers are introducing innovations in care delivery—often to achieve multiple aims. These innovations include adopting lean and standardised processes to improve quality and optimise productivity, increasing the use of automation and nonmedical staff members to change how they their clinical workforce is deployed, employing new technologies to deliver better-quality care at lower cost, involving patients more closely in care delivery, and harnessing patient-generated data to personalise treatments. In our experience, the providers that are achieving the best results have put as much attention on change management as on the changes themselves. By addressing the mind-sets and cultures of both the clinical and nonclinical staff, these providers have increased their organizations' agility and realised lasting success.

(continued)

Executive summary (continued)

Many providers are also making a variety of strategic, structural changes to their hospitals, sometimes in response to incentives or payment reforms. Leading health-care delivery systems are pursuing three types of strategy as they strive to balance quality, access, and cost.

— Many large "regional hub" hospitals are seeking to increase volumes in specialised services to deliver high-quality care affordably.

— Smaller hospitals (sometimes called local or community hospitals) are forming networks to invest in infrastructure, share back-office costs, and attract and retain staff who want to undertake a range of clinical work. In some countries, such networks are also being formed by larger hospitals, again with the goal of sharing gains from economies of scale and volumes.

— Vertical integration is increasing amongst regional hubs, smaller local hospitals, community-based care and, in some cases, payer organisations. This last trend is making it easier for delivery systems to coordinate the full range of care and provide care closer to patients' homes.

Which of these strategies is best for a given healthcare provider depends on both the provider's starting point and local market conditions: for example, regulations, cultural beliefs, funding sources, competitive conditions.

Some countries may not yet be feeling the full force of the external factors reshaping their hospitals. We believe, however, that this is a case of "not yet" rather than "not ever." All hospitals today need to make choices about how to alter the way they deliver care. If they are to improve efficiency, meet the expectations and requirements of patients (and often payers), and attract and retain the best staff, providers need to continue to innovate.

The hospital is dead, long live the hospital!

Innovations that will shape the next generation of hospitals

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- Recognition is increasing that care is better provided in a community setting
- High-quality care requires concentration into specialised, high-volume centres of excellence
- Clinical advances are delivering better quality and outcomes
- Digital technologies have begun to affect how healthcare is delivered and have the potential for disruptive change
- Availability and expectations of the healthcare workforce are changing
- Payers find it increasingly difficult to finance healthcare in line with increasing costs—which puts pressure on hospitals to deliver high-quality care more affordably.
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The world is changing for hospitals

Hospital care is changing rapidly and radically. Standalone hospitals, once the flagships of healthcare in many communities, are no longer the answer to some of today's most urgent healthcare needs. Neither are they islands that can ignore trends sweeping across our world. Hospitals must adapt and rethink their offerings to fit future needs.

Nine major external forces are affecting the work of hospitals. Whilst their relative importance differs country to country, these forces are at play across the globe.

Patient populations are getting older, and their needs are becoming more complex. The proportion of patients with more than one long-term condition is increasing. In the United Kingdom, for example, the proportion of these high-need patients increased from 32 percent in 2002 to 43 percent in 2012.[1] The cost of caring for these patients is up to eight times higher than the cost of caring for healthy adults.[2] More people are surviving heart attacks[3] and strokes[4] than ever before; however, they often require significant post-discharge care—40 percent of stroke survivors, for example, need support to perform daily activities after leaving hospital.[5] Similar trends in patient populations and cost burdens can be seen throughout Europe, as well as the rest of the developed and developing world.[6,7]

Patients have far higher expectations than before. Patients—along with their families and caregivers—expect to receive more information about their conditions and care, access to the newest treatments, and better amenities.[8] They also want greater involvement in healthcare de-

1 Department of Health Long Term Conditions Team. *Long Term Conditions Compendium of Information: Third edition.* UK Department of Health. 2012.
2 George J, Martin F. Briefing paper (4): Living with long term conditions. British Medical Association. 2016.
3 Schmidt M et al. 25 year trends in first time hospitalisation for acute myocardial infarction, subsequent short and long term mortality, and the prognostic impact of sex and comorbidity: a Danish nationwide cohort study. *BMJ.* 2012;344:e356.
4 Edwards JD et al. Trends in long-term mortality and morbidity in patients with no early complications after stroke and transient ischaemic attack. *Journal of Stroke and Cerebrovascular Disease.* 2017;26(7):1641–5.
5 Stevens E et al. The Burden of Stroke in Europe. Stroke Alliance for Europe, 2017.
6 Busse R et al. Tackling chronic disease in Europe: Strategies, interventions and challenges. European Observatory on Health Systems and Policies. 2010.
7 Multimorbidity: A Priority for Global Health Research. The Academy of Medical Sciences. April 2018.
8 Time to think differently: Public expectations and experience of services. The Kings Fund. 2012.

cisions and have higher standards. Many patients are increasingly acting as consumers,[9] a result of easier access to information and technology, the growth of "retail" models of healthcare that prioritise patient comfort and satisfaction (for example, dialysis centres that offer free Wi-Fi and television during the four-hour sessions[10]) and, in many countries, higher cost-sharing levels.

Recognition is increasing that care is better provided in a community setting. Patients benefit when their care is managed outside of the hospital whenever possible. Better primary preventive care for patients with chronic conditions reduces both the complication rate and need for hospital care.[11] Early post-surgical discharges can be made without increased complications and may improve patient satisfaction.[12] Conversely, longer hospitalisations can lead to significant loss of muscle strength in elderly patients—one study found that older people can lose up to 5 percent of muscle strength for each day of treatment in a hospital bed.[13] In addition, clinical advances are making it possible to perform a growing number of procedures in outpatient settings. At present, only a tiny percentage of total knee-joint replacements in the United States are being performed on an outpatient basis; orthopaedic surgeons there predict that 28 percent of those operations will move to outpatient settings within ten years.[14] Meanwhile, online healthcare platforms such as WeDoctor and Ping An Good Doctor in China and Practo in India are emerging, with a goal of keeping more patients out of hospitals. The trend towards increasing outpatient care is also reflected in the growth of free-standing retail clinics or urgent care centres in Australia, the United Kingdom, and the United States (although the development of this mode of provision has been slower in Australia than in the other countries[15]).

High-quality care requires concentration into specialised, high-volume centres of excellence. There is considerable evidence that the volume of activity is positively correlated with the outcomes delivered. This relationship has been proved in many areas of planned care—including joint replacement surgery,[16] cataract surgery,[17] paediatric surgery,[18] and cancer surgery[19]—as well as acute care (for example, for major trauma,[20] strokes,[21] and heart attacks[22]). One response to this evidence is the emergence (especially in Asia) of specialist providers that deliver standalone,

9 Pearl R. Are you a patient or a healthcare consumer? *Forbes*. October 15, 2015.
10 NephroPlus. Hemodialysis. Nephroplus.com.
11 Jonkman NH et al. Do self-management interventions in COPD patients work and which patients benefit most? An individual patient data meta-analysis. *International Journal of Chronic Obstructive Pulmonary Disease*. 2016;11:2063–74.
12 Gonçalves-Bradley DC et al. Early discharge hospital at home. *Cochrane Database of Systematic Reviews*. 2017;6:CD000356.
13 Department of Health Comptroller and Auditor General. Discharging older patients from hospital. National Audit Office. May 2016.
14 Unpublished McKinsey survey of practising US clinicians.
15 Harris P et al. The Australian public's preferences for emergency care alternatives and the influence of the presenting context: A discrete choice experiment. *BMJ Open*. 2015;5:e006820.
16 Ravi B et al. Relation between surgeon volume and risk of complications after total hip arthroplasty: Propensity score matched cohort study. *BMJ*. 2014;348:g3284.
17 Bell CM et al. Surgeon volumes and selected patient outcomes in cataract surgery: A population-based analysis. *Ophthalmology*. 2007;114(3):405–10.
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19 Huo YR et al. Systematic review and a meta-analysis of hospital and surgeon volume/outcome relationships in colorectal cancer surgery. *Journal of Gastrointestinal Oncology*. 2017;8(3):534–46.
20 Zacher MT et al. Association between volume of severely injured patients and mortality in German trauma hospitals. *British Journal of Surgery*. 2015;102(10):1213–9.
21 Saposnik G et al. Hospital volume and stroke outcome: does it matter? *Neurology*. 2007;69(11):1142–51.
22 Fanaroff AC et al. Outcomes of PCI in relation to procedural characteristics and operator volumes in the United States. *Journal of the American College of Cardiology*. 2017;69(24):2913–24.

Sidebar 1

Digital technologies are affecting healthcare delivery in five principal ways

- Automating manual tasks to improve consistency and free up time for staff to provide patient care
- Enabling patients and caregivers to play a bigger role through greater access and interactivity
- Allowing real-time management of assets and flows, which can improve department throughput
- Implementing applications for real-time decision support, which can reduce variability in the type and timeliness of care received
- Enhancing connectivity between patients and clinicians even when they are not co-located (e.g., through remote monitoring)

high-volume care in such specialties as ophthalmology, cardiology, and nephrology. These providers effectively disintermediate general hospitals as a place for the provision of some types of specialist care.

Clinical advances are delivering better quality and outcomes. Advances in clinical knowledge have led to some truly astonishing achievements. For example, UK deaths from cardiovascular disease fell by 68 percent between 1980 and 2013, even though the prevalence of the disease hovered consistently around 3.5 percent.[23] Similar reductions have been observed in other developed countries.[24] The lower mortality is attributable to both better treatments (for instance, new surgical interventions, statins, thrombolysis, and stenting) and better understanding of the condition's causes, which eventually led to significant declines in smoking rates. Decreases in mortality from breast cancer are also striking—in the United States, for example, mortality declined by 34 percent from 1975 to 2010[25]—largely as a result new therapies (such as cyclophosphamide/methotrexate/5-fluorouracil [CMF] and tamoxifen) in the 1970s and adjuvant therapy in the 1990s, not better screening. For many patients, antiretroviral therapy has converted HIV/AIDS from being a deadly disease to a chronic condition.[26] The development of sofosbuvir and other new direct-acting antiviral medications has transformed the lives and prognoses of thousands of hepatitis C patients.[27] However some of the clinical advances are very expensive, and thus payers in some countries have raised questions about which ones to fund.

Digital technologies have begun to affect how healthcare is delivered and have the potential for disruptive change. Digital technologies are driving multiple disruptions in care delivery, including a shift to self-service, remote access, and greater transparency. The types and volume of data available are exploding, which has important implications for clinical decision making. The sidebar, "Digital technologies are affecting healthcare delivery in five principal ways" discusses this in more detail.

Availability and expectations of the healthcare workforce are changing. The global workforce shortage of 7.2 million healthcare workers in 2013 is projected to grow to 12.9 million by 2035.[28] Shortages increase the strain on the workforce, leading to employee overwork and burnout.[29] Attracting students

[23] Bhatnagar P et al. Trends in the epidemiology of cardiovascular disease in the UK. *Heart*. 2016;102:1945–52.
[24] Global Burden of Cardiovascular Diseases Collaboration. The Burden of Cardiovascular Diseases Among US States, 1990-2016. *JAMA Cardiology*. 2018;3(5):375–89.
[25] Naroda SA, Iqbal J, Miller AB. Why have breast cancer mortality rates declined? *Journal of Cancer Policy*. 2015;5:8–17.
[26] Quinn TC. HIV epidemiology and the effects of antiviral therapy on long-term consequences. *AIDS*. 2008;22(Suppl 3):S7–12.
[27] Varadarajan T. The business of saving lives. *WSJ Opinion*. October 20, 2017.
[28] Global health workforce shortage to reach 12.9 million in coming decades. World Health Organization. November 11, 2013.
[29] Dixon L. The state of the health care worker shortage. Talent Economy. November 17, 2017.

to nursing programmes, for instance, becomes more challenging, which is why some hospitals offer large signing bonuses, college tuition, and free housing to employees and their children.[30]

Payers find it increasingly difficult to finance healthcare in line with increasing costs—which puts pressure on hospitals to deliver high-quality care more affordably. The rise of healthcare spending is expected to continue to exceed gross domestic product (GDP) growth in wealthy countries and in an increasing number of emerging economies. US healthcare spending has been projected to exceed 24 percent of GDP by 2040,[31] whilst spending on healthcare and long-term care in the European Union and Norway is projected to reach 13 percent of GDP by 2060.[32] Payers, employers, and governments are struggling to find funds to keep up with the high annual growth of healthcare costs, and thus they are putting more pressure on healthcare providers to deliver high-quality care affordably. Capital requirements and availability are also an issue, caused by ageing infrastructure and the need to invest in new technologies.

There are more requirements to measure and publish quality metrics and to receive financial bonuses for high-quality care. In the past, patients had limited information about the quality of their hospitals and doctors. Today, hospitals in Canada,[33] Scandinavia,[34] and the United Kingdom[35] are legally required to publish quality measurements. Mortality, readmittance, and infection rates are amongst the required metrics, and some healthcare providers are voluntarily releasing additional information. As more data becomes available, patients have a greater opportunity to assess hospitals—and even doctors—before deciding where and to whom to go. Moreover, in many cases, financial bonuses are being awarded for the provision of high-quality care. In Sweden, for example, performance-related payments are linked to quality targets and compliance with clinical guidance.[36] In England, National Health Service (NHS) providers have an incentive to support improvements in quality through Commissioning for Quality and Innovation (CQUIN) payments: they are given additional funds for delivering specified improvements, as set out in the NHS standard contract.[37] Increasingly, hospitals must have distinctive offerings for payers and patients to attract and retain their business.

All of the forces described above are putting pressure on hospitals to improve their operations—including their productivity. In response, innovations in how care is delivered are being developed and implemented. Hospitals are adopting many of these innovations to better position themselves to survive—and, in many cases, to excel. The following sections describe key innovations in healthcare provision and hospital structure. We expect the trend towards innovation to continue in all markets and all parts of the world (although the speed at which it takes hold may vary). Which of these strategies is best for a given hospital depends on both its starting point and local market conditions.

Note: *An addendum to this article, entitled "The nine forces changing the world for hospitals" provides more details about these forces. To obtain a copy of the addendum, readers can contact the authors of this paper.*

[30] Kavilanz P. Hospitals offer big bonuses, free housing and tuition to recruit nurses. *CNN Money*. March 8, 2018.
[31] Teitelbaum J et al. The financial sustainability of health systems: A case for change. A joint report from McKinsey and World Economic Forum. 2012.
[32] Appleby J. Spending on health and social care over the next 50 years: Why think long term? The King's Fund. 2013.
[33] Sutherland J, Repin N. Hospital quality policy brief. Vancouver: UBC Centre for Health Services and Policy Research. 2014.
[34] KPMG. Through the looking glass: A practical path to improving healthcare through transparency—Scandinavia. KPMG International. March 2017.
[35] NHS England. Clinical Services Quality Measures (CSQMs). NHS.uk. Accessed September 21, 2018.
[36] Glenngård AH. The Swedish health care system. The Commonwealth Fund. Accessed May 3, 2018.
[37] NHS England. Commissioning for quality and innovation (CQUIN) guidance for 2017–2019. NHS publications gateway reference 07725. March 2018.

Innovations in clinical care delivery

In hospitals around the world, innovations in care delivery are being introduced. These innovations often have multiple goals: to strengthen clinical quality; increase the delivery of personalised, patient-centred care; enhance the patient experience; and improve their efficiency and productivity. Each of these goals is an urgent imperative for hospitals today.

Adopting lean processes

Amongst hospitals, enormous variation exists in how services are delivered, resulting in significant differences in both the quality of care and unit cost of care delivery. This variation exists within hospitals, across hospitals within a region or a country, and across countries. Unwarranted variation in English NHS acute hospitals, for example, is estimated to cost an excess £5 billion a year (out of a total budget of £55.6 billion[38]). Similar costs have been seen in other countries.[39]

Lean, standardised processes—learned from best-practice peers and aided by artificial intelligence (AI) and digital control centres—are being adopted by hospitals to ensure consistently high-quality care and improve productivity. For example, the Beth Israel Deaconess Medical Center in Boston has worked with data scientists from Amazon and Google to analyse seven petabytes of data and develop operational tools to help the health system use its resources more efficiently when delivering clinical care. For instance, AI is being used in operating theatres to more accurately predict how much time to schedule for a particular patient-surgeon combination, which has increased efficiency by 30 percent.[40]

The Vall d'Hebron University Hospital in Barcelona provides another example of how dedication to lean processes is shaping the clinical environment. In the hospital's new operating room, a process engineer, who is not medically trained, spends all day thinking about how to rationalise processes and improve outcomes. To support efficient patient and staff flows, display screens allow staff to regularly monitor operating room logistics.

Workforce reform

In response to the increasing cost of care provision and the worsening shortage of healthcare professionals, hospitals around the world have started to reallocate tasks to different types of staff to free up time for those highly trained to perform activities for which specific education and qualifications are critical.

Aravind Eye Hospitals, a cataract surgery specialist in India, has expanded the use of technicians in the operating room to assist surgeons with specific tasks, which enables the surgeons to be more efficient and treat many more patients. Today, technicians make up about 60 percent of Aravind's workforce. In addition, Aravind has expanded the role of its nurses, which it calls mid-level ophthalmic personnel, to perform all hospital tasks other than operations and diagnoses.[41]

Similarly, many countries have increased the responsibilities of nurses. In England, nurses with special training in specific areas are

[38] Lord Carter of Coles. Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. Department of Health. February 2016.
[39] Kelly AS et al. Prospective identification of patients at risk for unwarranted variation in treatment. *Journal of Palliative Medicine*. 2018;21(1):44–54.
[40] Interview with John Halamka, Chief Information Officer, Beth Israel Deaconess Healthcare, 23 February 2018.
[41] Pandey S et al. Why Indian nonprofits are experts at scaling up. Stanford Social Innovation Review. Spring 2017.

authorised to prescribe certain medications and manage diseases in their specialty.[42] In parts of the United States, anaesthesia care is provided by certified registered nurse anaesthetists (CRNAs). In 2017, US CRNAs administered anaesthetics approximately 43 million times.[43]

Two recent McKinsey reports, *The Productivity Imperative for Healthcare Delivery in the United States* and *The Future of Work*, have highlighted the potential for technology to address some of the workforce shortages in healthcare.[44,45] For example, automation may be able to reduce wait times and increase productivity, enabling doctors and nurses to focus more effectively on improving patient outcomes. Machines could also take on routine activities such as registration, checkout, and some dispensing of prescription drugs.

Technological improvements in inpatient care

Automation, technology-enabled scheduling of patient and staff time, and decision assistance—including computer vision (the use of computers to analyse and interpret digital images)—are three ways in which technology is already shaping the delivery of care in many hospitals.

In recent years, a few hospitals with an especially high degree of service automation have opened. For example, the Humber River Hospital (HRH) in Toronto launched its brand-new, high-tech facility to patients in October 2015. CEO Barbara Collins had previously found that "only 38 percent of staff time was spent with patients; the rest was spent on charting, walking around, and supply collection." With a new hospital twice the size of three old facilities but with the same operating budget, HRH set out to automate as many manual tasks as possible, both to enable staff to spend more time with patients and to give them the systems and technology needed to create an environment for highly reliable care. Today, HRH has automated approximately 80 percent of its

back-of-the-hospital services, such as pharmacy, laundry, and food delivery.[46] In addition, it is using technology to improve frontline clinical care. (See the sidebar "Humber River Hospital (Toronto) is using technology to improve frontline care".)

Scheduling resources in an efficient and cost-effective way is challenging, and at many hospitals, these tasks are often left to individuals with limited training or experience. To solve this problem, a team from Massachusetts Institute of Technology (MIT) in Cambridge, Massachusetts, developed an AI robot for automating hospital scheduling of doctors and nurses. The tool anticipates room assignments and suggests which nurses to assign to patients for different procedures. When the team tested the tool in a tertiary care centre's labour-and-delivery ward, 90 percent of the recommendations were accepted. Furthermore, the solution received positive feedback for creating a more even workload, given that it could consider all the scheduling constraints and complexities that are often difficult for humans to grasp quickly.[47]

Real-time decision support, including computer vision, offers many advantages to hospitals. It not only proactively identifies and alerts staff to patients whose clinical status is deteriorating, but also reduces errors and saves staffing costs through more accurate and efficient processes. Complex algorithms are increasingly able to match—and even outperform—the diag-

[42] NHS at 70: The changing role of nurses. HCL Workforce Solutions. May 4, 2018.
[43] Certified registered nurse anesthetists fact sheet. American Association of Nurse Anesthetists. Updated September 17, 2018.
[44] Sahni N et al. *The Productivity Imperative for Healthcare Delivery in the United States*. McKinsey report. February 2019.
[45] Manyika J, Sneader K. Automation and the future of work: Ten things to solve for. McKinsey Global Institute. June 2018.
[46] Kutscher B. Inside North America's first all-digital hospital. Modern Healthcare. April 30, 2016.
[47] Gombolay M et al. Robotic assistance in coordination of patient care. Proceedings of Robotics: Science and Systems. June 2016.

Sidebar 2

Humber River Hospital (Toronto) is using technology to improve frontline care

- Staff are equipped with personal digital assistants so they can connect directly with patients who have hit their call buttons, thereby reducing hallway traffic
- Blood pressure, temperature, and other vital signs are automatically transferred to the patient's electronic health record
- Lab testing is fully automated. Once a sample for testing is sent to the laboratory, human hands never touch it again, which reduces the risk of human error and contamination. Test results are delivered within approximately one hour, and staff are informed of abnormal results on their portable devices
- A closed-loop, fully automated medication administration system matches each bar-coded medication to the bar code on a patient's armband; the system not only documents medication administration for the nurses, but also has virtually eliminated medication errors
- Automated guided vehicles reduce staff's need to transport supplies, food, linens, and non-narcotic medications
- Radio-frequency identification (RFID) in staff name badges allows for silent tracking in the event that a staff member presses a button signalling a need for assistance during a stressful situation with a patient or family
- RFIDs are also incorporated into stretchers and wheelchairs, allowing tracking of the location of the nearest available equipment
- A central command centre enables visualisation of the full hospital, including bed status and incoming emergency room patients. Visualisation and artificial intelligence make rapid decision making and efficient patient flows possible, since patient care coordinators can prioritise patients and solve logistical challenges on the spot

nostic accuracy of clinicians. Image-based diagnostics using AI-enabled computer vision can create opportunities to achieve improved performance and greater accessibility. A tool that outperforms the best-trained specialists can provide diagnoses from any location in the world using the imaging equipment already available. In fact, several tools can be used with mobile-phone cameras. Examples include:

- Mobile platforms developed by a Stanford University team can detect skin cancers using mobile-phone images with the same accuracy as dermatologists.[48] These platforms provide a route for quick, accessible screening for melanoma worldwide.
- ET Medical Brain, Alibaba's cloud-based solution, combines data hosting and image diagnostics at hospitals in China. Recent successes include a tool to detect thyroid cancer from ultrasound images that has an 85 percent accuracy rate, an improvement on human accuracy levels of 60–70 percent.[49]
- CellScope's application allows a smartphone or tablet to be used as a high-power microscope to identify parasite levels in blood samples from people with onchocerciasis, thus opening an opportunity for advanced diagnostics in remote environments. This technology has been used to guide treatment strategies with a specificity of 99.7 percent.[50] CellScope, a private US company, has patents in the United States and China and has done field studies in Cameroon, Hawaii, India, the Ivory Coast, Thailand, and Vietnam.[51]

[48] Esteva A et al. Dermatologist-level classification of skin cancer with deep neural networks. *Nature*. 2017;542:115–8.
[49] Xiao E. Alibaba cloud doubles down on healthcare for its AI business. Tech in Asia. Mar 29, 2017.
[50] Kamgno J et al. A test-and-not-treat strategy for onchocerciasis in Loa loa–endemic areas. *New England Journal of Medicine*. 2017;377:2044–52.
[51] CellScope. Patent Information. Cellscope.com/legal.

Many decision-support and computer-vision technologies are new and still not in widespread use—in some instances, because of a lack of research or evidence; in other cases, because of difficulties adapting them to local systems. Some contracts have been paused or terminated as a result. For example, Rhön-Klinikum, one of the largest German providers, terminated collaboration with its previous vendor after working together for one and a half years. The reason, said Rhön-Klinikum, was “the gap between aspirations and reality,”[52] in part because medical guidelines differ in different countries. Rhön-Klinikum now cooperates with an Austrian big-data service provider, Mindbreeze.

Moving care outside the hospital by using new technologies

As technology improves and allows remote care to achieve patient experience and clinical quality that is at least on par with traditional face-to-face care, a range of clinical services will likely shift to remote modalities through telemedicine and online consultations. Hospitals, by either building their own platforms or harnessing existing technologies, can reduce their costs whilst still providing service to patients. In the future, remote-access technologies and the ability to send a large amount of data very quickly are expected to continue changing healthcare delivery in several ways. For example:

Connecting patients to specialists directly. Visits that do not require physical examination (such as medication adjustments based on symptoms or readily available lab data) or for which critical data can be gathered remotely (for example, blood pressure measurements that automatically upload to an electronic health record) are amenable to telemedicine. Intermountain Healthcare, based in Salt Lake City, Utah, uses an improved staffing model to support remote patient consultation, which reduces the need for patients to take time off work and enables specialist input at an early stage in a patient’s evaluation.[53]

Similarly, India’s Aravind Eye Hospitals uses telemedicine to serve rural patients in locales where physicians are unwilling to travel or work. With the help of the International Agency for the Prevention of Blindness, Aravind set up five IT-enabled vision centres from which telemedicine consultation could be provided. More than 90 percent of patients received appropriate care at these vision centres. Each centre is linked directly to Aravind’s base hospitals in Tamil Nadu, Chennai. This system has allowed Aravind to continue to provide high-quality care without charging needy patients—a group that is more than 60 percent of the hospitals’ beneficiary population.[54]

Connecting specialised doctors in one area with primary care physicians (PCPs) in another area, to share knowledge and provide training. For example, Partners Healthcare in Boston, Massachusetts, introduced an e-consult initiative through which PCPs can request a specialist opinion. A PCP sends the service a question (linked to the patient’s record); the service then routes it to the appropriate specialist, who reviews the record and provides written guidance within 48 hours. In a study of 27 primary care practices, referrals were avoided in 65 percent of the cases, and in two-thirds of these cases, there was no further referral in the following six months.[55] A similar programme connecting PCPs to nephrologists in Canada found a 45 percent reduction in referrals.[56]

Even though new technologies promise cost savings and increased patient satisfaction in the near term, adoption has been slow, for several reasons: cost, lack of payment models for remote consultations, privacy and security concerns, difficulty accurately triaging patients according to visit types, and resistance to change in healthcare practices to accommodate new modalities.[57]

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52 Frankfurter Allgemeine Zeitung. March 6, 2018.
53 Molpus J. Intermountain Health CEO is bullish on telemedicine. HealthLeaders. June 13, 2017.
54 Shainesh G, Kulkarni S. Aravind Eye Care’s vision centers—reaching out to the rural poor. Indian Institute of Management Bangalore. October 1, 2016.
55 Ferris T. e-Consults in ambulatory specialty care. Hospitals in Pursuit of Excellence case study. 2014.
56 Keely E et al. Nephrology eConsults for Primary Care Providers: Original Investigation. *Canadian Journal of Kidney Health and Disease*. 2018;5:2054358117753619.
57 Kruse, CS et al. Evaluating barriers to adopting telemedicine worldwide: A systematic review. *Journal of Telemedicine and Telecare*. 2018;24(1):4–12.

Patient involvement in care delivery

Contemporary patients are value-conscious, demand high quality, and increasingly compare healthcare providers to leaders in customer experience such as Amazon and Apple. To manage these new expectations, hospitals are offering digital solutions to increase patients' involvement in, and visibility into, their care.

Emerging initiatives are giving patients increased control of care scheduling and medical records. In Sweden, a nationwide healthcare service, "1177 Vårdguiden", allows patients to schedule and cancel appointments online, view their medical records, keep track of and renew prescriptions, and get support and treatments online.[58]

Hospitals are also beginning to offer care options that provide more personalised input from patients and their treatment teams. For example, a Johns Hopkins team in Baltimore has introduced the Corrie Health app to aid recuperation after a heart attack—from discharge to recovery. The app allows patients to track medications and physical activity, as well as stay in tune with indicators for recovery, such as heart rate, blood pressure, and mood. The data is shared with care teams to aid a successful recuperation.[59]

Harnessing patient-generated data

Expanded data sets that include genetic, lifestyle, and physiological data can improve the precision of healthcare diagnoses and treatment. Increasing investments are being made to collect data across these dimensions on population-sized samples, pinpoint key risk factors for disease development, and identify biomarkers for effective treatment.[60] Personalising treatment offers the possibility of reducing overall healthcare-provision expenditures by 5–9 percent and

increasing average life expectancy by two to 15 months.[61]

Today, most treatment decisions are based on standardised guidelines, using evidence from clinical trials. However, as the cost of DNA sequencing has plummeted, some hospitals have started using genetic analysis to personalise care. In specific cases, treatment can be tailored to the genetics of the patient or the disease. For example, Dana-Farber Cancer Institute, based in Boston, uses genomic sequencing in 40 percent of leukaemia and lung cancer patients to select specific targeted therapies. Recent results demonstrate that genetics can also be used to identify patients at risk of steroid-induced growth stunting.[62]

Precision medicines can also be informed by real-time data capture. An example is mPower, an iPhone app developed by the University of Rochester Medical Center in Rochester, New York. mPower creates a clearer picture of Parkinson's disease progression by measuring the user's dexterity, balance, gait, and memory. Researchers have already gained greater insight into the factors that make symptoms better or worse, such as sleep, exercise, and mood.[63]

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58 Så fungerar vården i Stockholm. 1177 Vårdguiden. 1177.se.
59 Marvel FA et al. Digital health innovation: A toolkit to navigate from concept to clinical testing. *Journal of Medical Internet Research*. 2018;20(1):e2.
60 Large, population "biobank" datasets have been collected by the UK Biobank, deCODE genetics, CARTaGENE biobank, Qatar Biobank, Estonian Genome project, and the Nord-Trøndelag Health Study, among others.
61 Henke N et al. The age of analytics: Competing in a data-driven world. McKinsey Global Institute. December 2016.
62 Hawcutt DB et al. Susceptibility to corticosteroid-induced adrenal suppression: A genome-wide association study. *Lancet Respiratory Medicine*. 2018;6:442–50.
63 mPower. Living with Parkinson's Disease. Parkinsonmpower.org.

Innovations in organisational structures

Increasingly, healthcare providers are making strategic structural changes to achieve and maintain access to high-quality, cost-efficient care. In some cases, payment reforms are providing incentives or other support for the effort.

Three broad types of structural changes are helping to maintain the balance of quality, access, and cost:

Larger "regional hub" hospitals are seeking to increase volumes in specialised services. These hospitals aim to deliver high-quality care affordably. Mergers, affiliations, or structural system reconfiguration (to hub-and-spoke models, for example) to redirect tertiary or quaternary patients to regional hubs support these moves.

Smaller, local, or community hospitals with the potential to thrive independently are forming networks or groups. The networks help the hospitals achieve three aims: increase their ability to invest in infrastructure, share back-office costs, and attract and retain staff who want to undertake a range of clinical work. Forming networks or groups also creates an opportunity to share best practices across hospitals and adopt the best ways of working. These hospitals generally focus on providing services for more common conditions to ensure they can achieve suitable caseloads for maintaining quality.

Regional specialised hubs, local community hospitals, and other types of community-based care are vertically integrating. These entities aim to improve their ability to coordinate the full range of care and provide care closer to patients' homes, in response to patient needs and expectations. They may also take on population health management.

Larger regional hub hospitals

Around the world, many hospitals are consolidating services to increase volumes in specialised services. The result is larger regional hubs.

In England, clinical networks have been created for major trauma, acute stroke care, and acute cardiac care, the result of which is a smaller number of higher-volume, nationally accredited centres whose quality and volumes are monitored via national clinical audits.[64] This approach has resulted in a network of 27 major trauma centres and 75 cardiac intervention centres, as well as networked care delivery for acute stroke. Patients in need of these services are now routed directly to a specialist centre, bypassing small, less specialised hospitals. The development of major trauma centres has increased the odds of postinjury survival by almost 20 percent in the past five years, saving the lives of more than 1,600 victims.[65] In London, the number of hyper-acute stroke centres has been reduced from 31 to eight, with resulting improvements—from 2008 to 2012, there was a 7-percent reduction in length of stay and a relative reduction in mortality of 15–17 percent.[66]

In Denmark, the government and the country's five health regions invested €550 million in new "super hospitals," with the aim of improving the quality of the entire hospital system and structure. The structural modernisation arose from both the need for increased specialisation to provide higher-quality care and the shift to out-of-hospital treatment for low-need patients.[67]

In the Netherlands, four hospitals in Friesland combined their clinical services into one location in 2017; in 2018, seven hospitals in North Holland and nine in South Holland formed a single service for prostate

[64] Examples of these audits include: The Trauma Audit & Research Network (Performance comparison: Trauma care. Tarn.ac.uk); Healthcare Quality Improvement Partnership (Rising to the challenge: The fourth SSNAP annual report 2017. HQIP. November 29, 2017); and Myocardial Ischaemia National Audit Project (Weston C et al. Heart attack in England, Wales and Northern Ireland: Annual Public Report April 2015–March 2016. NICOR. June 27, 2017).
[65] NHS. More than 1,600 extra trauma victims alive today says major new study. England.nhs.uk. August 20, 2018.
[66] Morris S et al. Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: Difference-in-differences analysis. *BMJ*. 2014;349:g4757.
[67] Styrket akutberedskab—planlægningsgrundlag for det regionale sundhedsvæsen. Sundhedsstyrelsen. June 26, 2007.

cancer treatment. The changes were designed to improve quality of care by making sure that surgery was performed by the highest-qualified specialists. The changes have been encouraged by Dutch payers, who are seeking to finance the top institutes in each specialty.[68]

Networks built around specialty hubs improve specialist utilisation whilst delivering higher-quality care. In some specialties, this effort has been supported by technological innovations. For example:

— In the United States, Avera Health reported that it achieved cost savings of $62 million, reduced critical-care bed-days by 11,000, and avoided 260 deaths in one year by using an electronic intensive care unit (eICU) system to provide remote specialist care to rural hospitals in South Dakota.[69]

— Emory Healthcare in Atlanta, in collaboration with Macquarie University in Sydney, has taken this concept further by staffing eICUs during out-of-hours periods with intensive care specialists located in Australia.[70]

Resistance to structural change is common in many countries, however. Sometimes, as in the Netherlands, providers are autonomous, and there is no regulatory authority to decide which procedures can (or must) be performed in each hospital. This is not the case in many other countries, though. Another problem is that hospitals and clinical staff are often reluctant to give up part of their offerings because of concerns about loss of revenues and the diversity of work. However, the trend towards consolidation—a result of increasing recognition of the benefits of centralisation—is gaining public support and political approval.

Smaller hospitals forming networks or groups

At the same time, smaller or more remote hospitals are increasingly forming community-based networks to increase the likelihood of their survival. In the United States, 80 rural hospitals closed from 2010 to 2017, and an additional 700 are believed to be at risk of closure.[71] Many of the at-risk hospitals are small, with fewer than 25 beds, but provide the only hospital services for more than 35 miles.

One community-based network, Intermountain Healthcare, based in Salt Lake City, Utah, has grown from 15 hospitals in 1975 to a network of 22 hospitals and more than 185 clinics today.[72] Other examples of networks or groups include Tenet and HCA in the United States and Asklepios and Rhön Klinikum in Germany.

For small hospitals, a network can make it possible to reduce individual costs by co-investing in IT-enabled infrastructure and by sharing management and back-office functions. Forming a network can also provide additional advantages to small hospitals that are geographically close to each other. For example, it can give the hospitals access to larger volumes of patients to support high-quality care. In

[68] de Kruif F. Operaties gebundeld in Maasstad. NRC. June 15, 2018; van Aartsen C. Negen ziekenhuizen vormen prostaatkankernetwerk. Zorgvisie. June 7, 2018; and van der Meij R. Binnen twee jaar een borstkankercentrum in Friesland. Leeuwarder Courant. Updated July 20, 2017.
[69] Royal Philips. Avera Health achieves significant cost savings and improved patient outcomes in rural areas with Philips eICU program. Cision PR Newswire. February 26, 2018.
[70] Al Idrus A. Philips partners on Australia's first remote ICU monitoring program. FierceBiotech. September 23, 2016.
[71] Zach E. Death by a thousand cuts: Rural health care in decline. Center for Health Journalism. May 12, 2017.
[72] National media highlight Intermountain's strategic direction. Intermountain Healthcare newsroom.

addition, networks can strengthen the hospitals' value proposition for staff, who can undertake a greater range of clinical work in their local communities. Staff members can also share innovations and best-in-class management practices with the other facilities in the network.

Vertical integration

A third ongoing structural change is vertical integration, which makes it possible for hospitals to offer a greater range of services, from primary and community care to acute and post-acute care. Some hospitals push vertical integration even further, taking on functions not traditionally associated with inpatient care, such as population health management (often, by offering health insurance). For example, Intermountain Health and a number of other US hospital networks now offer health insurance plans to local residents.[73]

In other cases, hospital networks are taking on population health management by becoming accountable care organisations (ACOs). In this model of healthcare provision, a provider, or group of providers, takes responsibility for the provision of healthcare to a defined population. Typically, the ACOs are paid a fixed amount to provide care and are expected to reduce per-patient costs while achieving predefined quality of care metrics.

For example, the Northumbria ACO in England, which includes a hospital, primary care providers, and the local council, serves a population of more than 320,000. The organisation has developed programmes for specialist emergency care, urgent care, and primary care services (accessible seven days a week) and is redesigning community and social care services. This approach has created new opportunities for Northumberland to integrate care and increase technology use along the patient pathway.[74]

Similarly, Clalit, an Israeli ACO, insures more than 50 percent of the country's population, operates primary and specialist clinics, and owns hospitals that account for about one-third of Israel's hospital beds.

McKinsey analysis suggests that vertical integration has several benefits. Some of them pertain to the quality of care, which is enhanced by the ability to share full patient data and to ensure seamless continuity of care. (For example, patients can be "handed over" to community clinics prior to hospital discharge.) Other benefits derive from the ability to attract personnel by offering multidisciplinary training and career paths that involve both hospital and community settings. In addition, financial benefits are realised by optimising care by matching each patient's actual needs with the larger capacity available across the healthcare system.

From a regional or national perspective, the downside of all three types of innovative structures is that it can give strong market power to an organisation that offers a substantial proportion of all hospital capacity and care delivery in a particular area. Many countries have put in place regulations to prevent such market power from leading to higher prices or lower quality of care.[75]

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[73] National media highlight Intermountain's strategic direction. Intermountain Healthcare newsroom.
[74] Northumbria Healthcare NHS Foundation Trust. Key facts about us. Northumbria.nhs.uk.
[75] Szostak DC. Vertical integration in health care: The regulatory landscape. *DePaul Journal of Health Care Law.* 2015;17(2):65–120.

Moving forward

In this article, we have outlined the many ways in which hospitals are changing and will continue to change. Major forces that are affecting hospitals now include rapidly changing healthcare needs due to demographic and epidemiological factors, the advent of technology-enabled healthcare systems that can deliver care in radically different ways, and the changing expectations of both the healthcare workforce and, crucially, healthcare consumers.

New entrants and disrupters will be a powerful force in all geographies and, in some cases, may reshape the whole healthcare ecosystem. Technology—be it robotics for surgery, remote monitoring, data collection and sharing systems, artificial intelligence, or precision medicine—will fundamentally change the way in which patients and clinicians interact with each other and participate in the healthcare system.

We are certain that how healthcare is provided will change: some types of care provision will shift to be closer to home or will become self-care; others will be consolidated. In most parts of the world, the increased focus on both clinical quality and patient experience will continue—or accelerate. In some countries or markets, hospitals might use their current organisational advantages to position themselves as the core of whole healthcare delivery systems. In other areas, primary and community care providers may finally deliver on their long-term promise to move a lion's share of patient care out of hospitals.

We are also certain that accepting the need for change will not be sufficient on its own to enable providers to succeed in the future. Rather, the best results will be achieved by those providers that put as much attention into change management as they do on the changes themselves. No change effort will achieve its goals unless it includes a strong focus on altering the mind-sets and cultures of both the clinical and nonclinical staff. In our experience, providers that approach change management in this way have increased their organizations' agility and realised lasting success.

Influenced by regulation, funding, competition, population dynamics, and other external factors, the emerging picture will differ amongst countries. In all cases, to be truly sustainable and successful, hospitals will need to consider what they can do to improve the quality and efficiency of service delivery, how they can adopt technology to support those changes, and which strategic choices they should make to the services they provide, the patients they serve, and the partners they work with.

Whilst hospitals have already undergone significant changes since they were first established more than a thousand years ago, our sense is that changes in the next 10 years will be far more significant than those hospitals experienced in the past 20 to 30 years. Change may not necessarily be apparent in all countries now, but we believe that this is a case of "not yet" rather than "not ever".

We cannot predict the rate at which different healthcare systems will change or exactly what the hospitals of 2030 will be like. However, they are highly likely to be very different from what we think of as an average hospital today.

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El Camino Hospital
Board Education Topics for Consideration during FY21

At its October 13, 2020 meeting, the Governance Committee approved the following topics and requested that they be paced for discussion throughout the year. The Committee will review each topic and make recommendations as to how to be educate the Board in these areas

	Board Meeting Date	**Education Topic**	**Presenter**
1.		Building an Outpatient Strategy	
2.	February Retreat	Understanding System-ness and Promoting System Alignment	
3.		Building a Reliable Culture of Safety	
4.		Board Oversight of Quality in the Telehealth Era	
5.		Technology and Cyber Security	
6.		Assessing and Renewing Board Governance	
7.		Diversity	
8.		Best Practices in Board Succession Planning	

Prepared by

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Governance Committee
From: Gary Kalbach, Member, El Camino Hospital Board; and Vice Chair, Governance Committee
Date: February 2, 2021
Subject: Draft Resolution 2021-02 Delegating Authority to the El Camino Hospital Board Finance Committee and Revising the El Camino Hospital Community Benefit Grants Policy and the Finance Committee Charter.

Recommendation(s): To recommend that the El Camino Hospital Board approve Draft *Resolution 2021-02*: Delegating Authority to the El Camino Hospital Board Finance Committee and Revising the El Camino Hospital ("ECH") Community Benefit Grants Policy ("Policy") and the Finance Committee Charter ("Charter").

Summary:

1. Situation: At the ECH Board's June 2020 meeting, following discussion and approval of the FY21 ECH Community Benefit Plan (the "Plan"), Board Chair Chen requested that staff or the Governance Committee provide a recommendation to the Board to amend the Community Benefit process and how the Board considers the plan on a yearly basis.

2. Authority: On February 12, 2020, the Board approved a "Procedure for Delegating Specific Authority to the Board's Advisory Committees (the "Procedure") that requires Governance Committee review of any proposed delegation of authority to a Board Advisory Committee.

3. Background: The FY21 Plan provides grants to 47 outside organizations, $100,000 in sponsorship funding and $200,000 in placeholder funds totaling $3,696,000 million. Under the current Policy, the Hospital's Community Benefit staff receives grant applications, reviews them thoroughly and brings their recommendations to the Community Benefit Advisory Council ("CBAC") for consideration. The CBAC is comprised of professionals in the community from various settings who have knowledge of the community's unmet health needs. The community benefit staff then brings the CBAC's recommendations to the Board for review and approval. As noted above, Chair Chen requested a proposal to amend the process for review and approval of the Plan.

   The proposed revisions to the Policy (1) replace the CBAC review with review by "The CEO's Committee" and (2) provides for Finance Committee approval of the Plan NTE $5 million annually. The proposed revision to the Charter provides for Finance Committee approval of the Plan NTE $5 million annually. The Board will be aware of the total Plan amount as part of the annual budget approval process and will be informed of significant mid-year changes to the Plan as noted in the Policy. The Board would retain authority to approve the Plan if it exceeds $5 million.

4. Assessment: $3.7 million is a small percentage of ECH's net revenue and does not warrant the expenditure of significant Board time reviewing each grant proposal as the Board has done in the past. Review by the CBAC is an unnecessary step.

5. Other Reviews: Legal counsel has reviewed and approved the proposed delegation of authority.

6. Outcomes: N/A

List of Attachments:

1. Procedure for Delegating Specific Authority to the Board's Advisory Committees
2. Draft Revised Finance Committee Charter
3. Draft Revised ECH Community Benefit Grants Policy
4. Draft Resolution 2021-02

Suggested Committee Discussion Questions:

1. Does this proposal provide for appropriate governance-level review of the annual ECH Community Benefit Grant Plan Proposals?

Procedure for Delegating Specific Authority to Board Advisory Committees

COVERAGE:

El Camino Hospital Board of Directors, El Camino Hospital Board Advisory Committees, All El Camino Hospital Staff

PURPOSE:

The Board Advisory Committees are made up of members of the Board and other individuals. As such, the Board Advisory Committees may advise the Board but cannot take action on behalf of El Camino Hospital without a specific delegation of authority by the Board.

The purpose of this procedure is to ensure efficient and thorough Board-approved procedures for delegating specific authority to the members of the Board Advisory Committees to take action on behalf of El Camino Hospital for the management of certain activities and affairs of El Camino Hospital.

DEFINITIONS:

Board: El Camino Hospital Board of Directors

Board Advisory Committees: The Compliance and Audit Committee, the Executive Compensation Committee, the Finance Committee, the Governance Committee, the Investment Committee, and the Quality, Patient Care and Patient Experience Committee

REFERENCES:

N/A

PROCEDURE:

A. Proposals for delegation of authority to a Board Advisory Committee shall originate from a Board member or one of the Board Advisory Committees and must be submitted in writing to the Governance Committee for evaluation.

B. Proposed delegations of authority submitted to the Governance Committee by a Board member or Board Advisory Committee for consideration, or submitted to the Board by the Governance Committee for approval, shall contain the following elements:

1. The proposal shall recommend the specific language and scope of the proposed delegation of authority.

2. The proposal shall specifically describe the Board's retained authority.

3. The proposal shall state that persons exercising authority under the delegation are recognized as "agents" of El Camino Hospital for purposes of such person's right to indemnification by El Camino Hospital.

4. The proposal shall state that any proposed action outside the scope of the Board's approved delegation of authority shall require further Board approval.

C. The Governance Committee shall obtain advice of legal counsel to confirm whether the specific delegation of authority is consistent with California Law.

D. The Governance Committee shall consider whether the proposed delegation of authority is consistent with the mission and activities described by the applicable Board Advisory Committee's Charter and whether to recommend the proposed delegation of authority to the Board for approval.

E. If the Governance Committee recommends that the Board approve a proposed delegation of authority to a Board Advisory Committee, the Board shall consider approval of the proposed delegation of authority.

F. Resolutions of the Board approving a delegation of authority to a Board Advisory Committee shall be in writing and shall contain the following elements:

1. The resolution shall specifically define the delegation of authority and the scope of the delegation of authority.

2. The resolution shall specifically describe the Board's retained authority.

3. The resolution shall state that persons exercising authority under the delegation are recognized as "agents" of El Camino Hospital for purposes of such person's right to indemnification by El Camino Hospital.

4. The resolution shall state that any proposed action outside the scope of the Board's approved delegation of authority shall require further Board approval.

<u>Approvals</u>:

Governance Committee: 2/4/2020
Hospital Board of Directors: 2/12/2020

El Camino Health

El Camino Hospital Board of Directors
Finance Committee Charter
Draft Revised February 2, 2021

Purpose

The purpose of the Finance Committee (the "Committee") is to assist the El Camino Hospital (ECH) Board of Directors to ("Board") provide oversight, information sharing and financial reviews related to operating and capital budgeting, financial planning, financial reporting, capital structure, banking relationships and certain contractual agreements for El Camino Hospital and its affiliated entities where ECH is the sole corporate member ("the Organization"). In carrying out its review, advisory and oversight responsibilities, the Committee shall remain flexible in order to best define financial strategies that react to changing conditions.

Authority

All governing authority for the Organization resides with the Board and, except as specifically provided in Sections E and F of "Specific Duties," the Committee serves as an advisory body only. The Committee will report to the Board at the next scheduled meeting any recommendation made or action taken within the Committee's authority. The Committee has the authority to select, engage, and supervise any consultant it deems necessary to advise the Committee on issues related to its responsibilities. In addition, the Committee, by resolution, may adopt a temporary advisory committee (ad hoc) of less than a quorum of the members of the Committee. The resolution shall state the total number of members, the number of board members to be appointed, and the specific task or assignment to be considered by the advisory committee.

Voting members of the Committee shall include the directors assigned to the Committee and external (non-director) members appointed to the Committee.

Membership

- The Committee shall be comprised of two (2) or more Hospital Board members. The Chair of the Committee shall be appointed by the Board Chair, subject to approval by the Board. All members of the Committee shall be eligible to serve as Chair of the Committee.

- The Finance Committee may also include 2-4 Community members[1] with expertise which is relevant to the Committee's areas of responsibility, such as banking, financial management, planning and real estate development, etc.

- All Committee members, with the exception of new Community members, shall be appointed by the Board Chair, subject to approval by the Board. New Community members shall be appointed by the Committee, subject to approval of the Board. All Committee appointments shall be for a term of one year, expiring on June 30th, renewable annually.

- It shall be within the discretion of the Chair of the Committee to appoint a Vice-Chair from among the members of the Committee. If the Chair of the Committee is not a Hospital Board member, the Vice-Chair must be a Hospital Board member.

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[1] Community Members are defined as Members of the Committee who are not El Camino Hospital Board Directors.

Staff Support and Participation

The CFO shall serve as the primary staff support to the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional members of the executive team may participate in the Committee meetings as deemed necessary.

General Responsibilities

The Committee's primary role is to provide oversight and to advise the management team and the Board on matters brought to this Committee. With input from the Committee, the management team shall develop dashboard metrics that will be used to measure and track financial performance for the Committee's review. It is the management team's responsibility to develop and provide the Committee with reports, plans, assessments, and other pertinent materials to inform, educate, and update the Committee, thereby allowing Committee members to engage in meaningful, data-driven discussions. Upon careful review and discussion and with input from management, the Committee shall then make recommendations to the Board. The Committee is responsible for ensuring that performance metrics which are not being met to the Board's expectations are reported to the Board.

Specific Duties

The specific duties of the Committee are:

A. Budgeting

- Review the annual operating and capital budgets for alignment with the mission and vision of the Organization and make recommendations to the Board.

- Review any financial requests in excess of the CEO's signing authority and make recommendations to the Board.

- Review the Organization's long-range forecasts and financial plans and make recommendations to management regarding steps advisable to improve the Organization's financial strength.

B. Financial Reporting

- Review each accounting period's financial statements and ensure the Board is advised of any necessary corrective actions.

- Obtain a clear understanding of the Organization's financial reporting process by reviewing the hospital's dashboard items and periodic financial reports and advise management on how to improve its financial reporting in order to improve accountability and ease of reading and understanding.

C. Financial Planning and Forecasting

- Semi-annually receive an update on management's assessment of expected results as well as potential risks related to the payor contracts.

- Evaluate the financial implications of emerging payment processes and provide advice to management regarding associated risk management concerns.

- Evaluate financial planning and forecasting to help ensure it remains in alignment with the mission and strategic direction of the Organization.

D. Treasury, Pension Plans, and Contracting Concerns

- Review and make recommendations to the Board regarding all new debt issuances and derivative instruments in excess of $1 million.

- Monitor compliance with debt covenants and evaluate the Organization's capital structure.

- Review and make recommendations to the Board regarding changes in banking relationships, including, without limitation, depository accounts, investment accounts and major credit facilities. The term "major credit facilities" does not include management-approved trade credit facilities offered in the ordinary course of business by vendors to the hospital. The Committee may recommend delegation of approval authority for specified changes to the CFO, but must maintain reporting and oversight of any such changes

- Review and make recommendations to the Board regarding proposed plan design or benefit design changes in excess of management authority limits to employee retirement plans, excluding changes to investments within those plans.

- Review and make recommendations to the Board regarding contractual agreements with persons considered to be "insiders" under IRS regulations, and those which are in excess of the CEO's signing authority

E. Capital and Program Analysis

- Review and make recommendations to the Board with respect to the business plans of all capital items or proposed business ventures in excess of the CEO's signing authority, and all variances to budget in excess of the CEO's signing authority on projects in process.

- Review retrospective analyses of all strategic business ventures and all strategic capital expenditures in excess of $2.5 million, as presented by management or as per the review schedule set forth by the Committee, to assess the reasonableness of business plans that were developed at the time of original approval and to promote learning as a result of any identified issues or concerns.

- Review and recommend approval for the acquisition or disposition of capital which is in excess of $5 million.

- Approve unbudgeted capital expenditures exceeding the CEO's signature authority but not in excess of $5 million.

- Approve the annual ECH Community Benefit Plan including grants to outside organizations, sponsorships and placeholder funds, combined which shall not exceed $5 million annually.

F. Physician Financial Arrangements

- Review and recommend for Board approval Physician Financial Arrangements in excess of 75% of fair market value in accordance with the Corporate Compliance: Physician Financial Arrangements Policy.

- Approve Physician Financial Arrangements in excess of 250,000 annually or if upon renewal or amendment, the annual increase is greater than 10% in accordance with the Corporate Compliance: Physician Financial Arrangements Policy.

- Approve the Annual Summary Report of Physician Financial Arrangements.

G. Financial Policies

- Review and recommend approval of any Board-level financial policies, excluding any financial policies for which responsibility has been specifically assigned to another Board Committee.

H. Ongoing Education

- Endorse and encourage Committee education and dialogue relative to emerging healthcare issues that will impact the viability and strategic direction of the Organization,

I. Management Partnership

- Work in partnership with the CFO and other hospital executives to assist in the development of financial policies which will help ensure the Organization's success.

- Provide ongoing counsel to the CFO regarding areas of opportunity for either personal or organizational improvement.

Committee Effectiveness

The Committee is responsible for establishing its annual goals, objectives and work plan in alignment with the Board and Hospital's strategic goals. The Committee strives for continuous improvement with regard to its processes, procedures, materials, and meetings, and other functions to enhance its contribution to the full Board.

Meetings and Minutes

The Committee shall meet at least once per quarter. The Committee Chair shall determine the frequency of meetings based on the Committee's annual goals and work plan and the operational requirements of the organization. Minutes shall be kept by the assigned staff and shall be delivered to all members of the Committee when the agenda for the subsequent meeting is delivered. The approved minutes shall be forwarded to the Board for information.

Meetings and actions of all committees of the Board shall be governed by, and held and taken in accordance with, the provisions of Article VI of the Bylaws, concerning meetings and actions of directors. Special meetings of committees may also be called by resolution of the Board or the Committee Chair. Notice of special meetings of committees shall also be given to any and all alternate members, who shall have the right to attend all meetings of the Committee. Notice of any special meetings of the Committee requires a 24-hour notice.

Current Status: *Active* **PolicyStat ID:** *6942910*

Origination:	*04/2014*
Effective:	*01/2018*
Last Approved:	01/2018
Last Revised:	01/2018
Next Review:	12/2020
Owner:	*Barbara Avery: Directo Community Benefit*
Area:	*Finance*
Document Types:	*Policy*

Draft Revised Community Benefits Grants Policy 2/2/2021

COVERAGE:

El Camino Hospital Community Benefit Grantees

PURPOSE:

El Camino Hospital (the "Hospital") recognizes that the health of the community is improved by the efforts of many different organizations, and the Hospital has a history of supporting those organizations by making grants to them. The grant making process includes soliciting applications, evaluating the proposed use of the funds, and including the advice of a committee comprised of members of the executive team appointed by the CEO (CEO's Committee) ~~a Community Benefit Advisory Council~~. The Hospital annually approves a plan that~~which~~ includes a provisional list of organizations and the amount of the expected grants to each sponsorships, and placeholder funds which shall be approved by the Hospital Board Finance Committee and included in the annual budget. The total amount approved by the Finance Committee shall not exceed $5 million,

PROCEDURE:

A. To ensure that the Hospital can be responsive to the changing health needs in the Hospital during a fiscal year, the senior Community Benefit staff (VP of Corporate and Community Health Services and Director of Community Benefit) will follow the guidelines below:

   1. The total annual Community Benefit expenditures, as authorized by the Hospital Board Finance Committee ~~of Directors~~ approval of the Hospital's annual Community Benefit Plan, cannot exceed the approved aggregate amount.

2. Approved individual grant amounts, as stated in the annual Plan, may be increased after need is demonstrated. Grant metrics must be revised to reflect the additional resources. Increases to these previously awarded grants in excess of $50,000 up to $150,000 require the approval by the CEO. Increases to these previously awarded grants in excess of $150,000 must be presented to the CEO's Committee Community Benefit Advisory Council ("CBAC"), receive their recommendation for support and be approved by the Hospital Board Finance Committee and reported to the Hospital Board of Directors.
3. New grants may be added during the fiscal year if need is demonstrated. Proposals with detailed budgets and metrics must be presented to the CEO's Committee CBAC and receive their recommendation for support. New grants in excess of $50,000 require the approval of the Hospital Board Finance Committee.
4. There are times when an individual grant award is not needed to the extent it was in the original plan. In these cases, the funds not needed may be used to fund the grant increases detailed in paragraphs 2 and 3 above.
5. The Finance CommitteeCBAC and the Board will receive a report identifying all grant funding changes at the end of the fiscal year.
6. Three year grant funding may be awarded to selected grantees. The total amount of funding for multi-year grants may not exceed 30% of the total aggregate amount of annual Community Benefit Plan approved by the Finance CommitteeBoard. Grantees will be required to submit mid-term and annual reports and must demonstrate success meeting outcome metrics and budgetary goals.

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

Attachments

No Attachments

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Note Acknowledgments have not yet been assigned. Clicking the button below will assign them.

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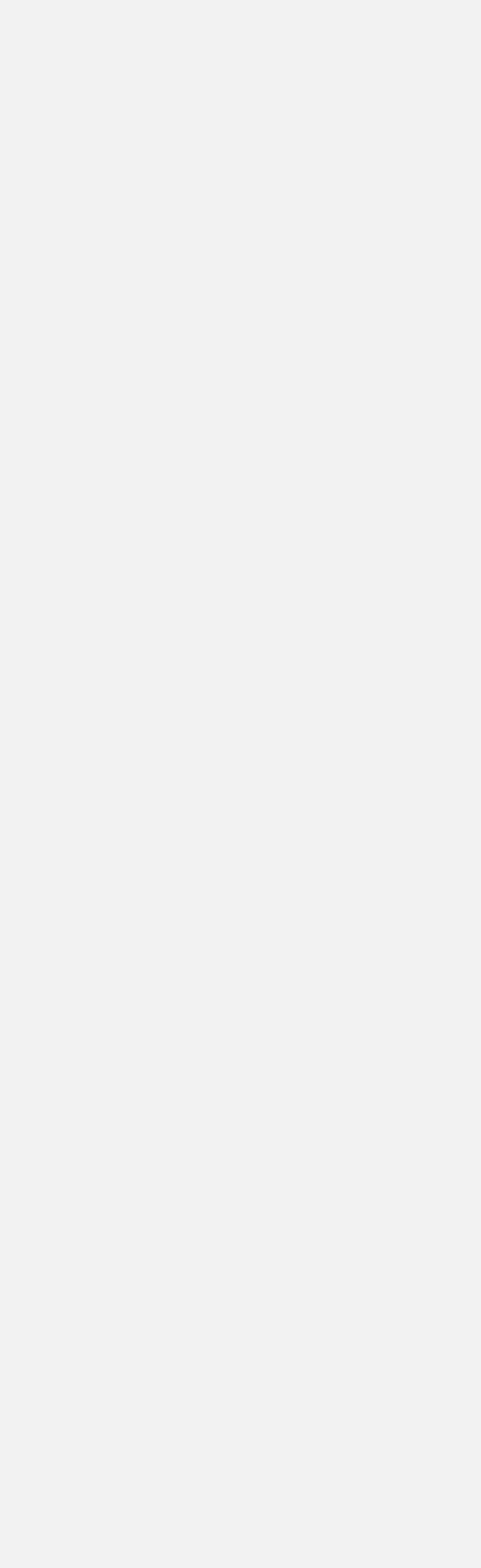

EL CAMINO HOSPITAL
DRAFT RESOLUTION 2021-02
DELEGATING AUTHORITY TO THE FINANCE COMMITTEE TO APPROVE THE ANNUAL EL CAMINO HOSPITAL COMMUNITY BENEFIT PLAN NOT TO EXCEED $5 MILLION ANNUALLY

WHEREAS, the Board of Directors has determined it is necessary to carefully consider and approve the annual El Camino Hospital Community Benefit Grant Plan (“Plan”) proposal:

WHEREAS, on the recommendation of the Governance Committee, the Board has determined such work can be undertaken by the Board’s Finance Committee; now, therefore, be it:

RESOLVED, that the Board’s Finance Committee shall have authority to annually approve the Plan, including grants to outside organizations, sponsorship and placeholder funds not to exceed a total of $5 million annually; be it further

RESOLVED, the Board shall retain authority to approve the Plan if it exceeds $5 million annually; be it further

RESOLVED, that persons exercising authority under the delegation are recognized as “agents” of El Camino Hospital for purposes of such person’s right to indemnification by El Camino Hospital; be it further

RESOLVED, any proposed action outside the scope of the Board’s approved delegation of authority shall require further Board approval.

DULY PASSED AND ADOPTED at a regular meeting held on February 10, 2021, by the following votes:

AYES:

NOES:

ABSENT:

ABSTAIN:

____

Julia E. Miller, Secretary/Treasurer
ECH Board of Directors

DRAFT

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Governance Committee
From: Dan Woods, CEO
Date: February 2, 2021
Subject: Proposed FY21 Hospital Board Member Competencies

Recommendation(s): To recommend that the El Camino Hospital Board recommend approval of the Proposed FY21 Hospital Board Competency Matrix to the El Camino Healthcare District Board of Directors.

Summary:

1. Situation: In FY20, the Governance Committee recommended and the Board adopted the attached competency matrix (see attached). Using the competency matrix, all Board members evaluated themselves and all other Board members resulting in identification of gaps in overall Board competencies. The gap analysis was then used to inform Board member retention and recruitment efforts.

2. Authority: One of the Governance Committee's chartered responsibilities is to define the necessary skill sets, diversity, and other attributes required for Board members to support Hospital strategy, goals, community needs and current market conditions and make recommendations to the Board regarding Board composition.

3. Background: The Board has, over time, modified the highest priority competencies in response to changing Hospital strategy, goals, community needs and market conditions. Competency 3 (leadership of high performing organizations in other industries including Board experience) replaced healthcare industry experience and experience in clinical integration/continuum of care in FY19. The current terms of Directors Chen (2nd) and Kalbach (1st) expire on June 30, 2021. At its January 26, 2021 meeting, the District Board re-elected Director Chen to a third three-year term and appointed an Ad Hoc Committee to review the re-election of Director Kalbach.

4. Assessment: There is a need to confirm the Board competencies for FY21.

5. Other Reviews: None

6. Outcomes: Recommendation for FY21 Board Competency Matrix. The El Camino Healthcare District Board has the ultimate authority to determine necessary competencies for El Camino Hospital Board Directors.

List of Attachments:

1. Draft Revised FY21 Board Competency Matrix

Suggested Board Discussion Questions:

1. Is the Competency Matrix adequate for FY21? If not, what should be added or deleted?
2. What are the top priority Board competencies for FY21?

DRAFT FY21 Competency Matrix
Rating Tool & Rating Scale

Level of Knowledge/Experience 1 = None (no background/experience) 2 = Minimal 3 = Moderate/Broad 4 = Competent 5 = Expert	**Lanhee Chen**	**Peter C. Fung, MD**	**Gary Kalbach**	**Julie Kliger**	**Julia Miller**	**Jack Po, MD**	**Robert Rebitzer**	**Carol Somersille, MD**	**George Ting, MD**	**John Zoglin**
1. Understanding of complex market partnerships										
2. Long-range strategic planning										
3. Experience Leading High Performing Organizations, incl. Board Experience										
4. Finance/entrepreneurship										
5. Health care policy										
6. Oversight of diverse business portfolios										
7. Complex partnerships with clinicians										
8. Experience in more than one area of the continuum of care										
9. Patient care quality and safety metrics										
1. **Analytical Thinker**: separates the important from trivial										
2. **Collaborative**: feels collaboration is essential for success										
3. **Community-Oriented**: always keeps stakeholders in mind										

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Governance Committee
From: Cindy Murphy, Director of Governance Services
Date: February 2, 2020
Subject: April 2021 Joint Board and Committee Education Session

Recommendation(s):

To recommend that the Board approve the revised agenda for the Joint Board and Committee Education Session.

Summary:

1. Situation: The Board continues to request ongoing education to support its work. As well, ongoing Board education is considered a best practice, vital to effective Board functioning.

2. Authority: It is within the Committee's chartered responsibilities to recommend educational activities, Hospital Board and Committee member education, training, and development.

3. Background: The organization is undertaking a strategic planning process that we hope will culminate in approval of an updated strategic plan by April 2021. Understanding the organization's strategy is critical to the effectiveness of the Committees.

Proposal:

A. Update on the Current Strategic Plan Implementation by Dan Woods
B. Presentation Regarding Strategic Planning Process and Results.

4. Assessment: N/A

5. Other Reviews: None.

6. Outcomes: N/A

List of Attachments: None.

Suggested Committee Discussion Questions:

1. Does the Committee agree with the proposed agenda?
2. Does the Committee have any additional suggestions?

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Governance Committee
From: Cindy Murphy, Director of Governance Services
Date: February 2, 2021
Subject: Roundtable Discussion

Purpose:

To review the effectiveness of the Committee's meeting.

Summary:

1. Situation: How effective was this meeting?

2. Authority: N/A

3. Background: We included an excerpt from the Governance Institute's "Elements of Governance" Series titled "Board Committees" in the Committee's February 6, 2018 packet. Committee Chair Fung asked that we include the questions posed in the "Committee Meeting Effectiveness Assessment Options" section for the Committee to discuss at the conclusion of the meeting.

4. Assessment: N/A

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments: None.

Suggested Committee Discussion Questions:

1. Brief discussion topics: what worked well/should be repeated? What should be changed/added/deleted?
2. Were the meeting packet and agenda helpful?
3. Did key issues receive sufficient attention?
4. Did we spend the right amount of time on each issue?
5. Was there a significant amount of discussion (vs. presentation)?
6. Were discussions kept at the governance level?
7. Did all members participate fully?
8. Did we hold ourselves accountable to the rules of engagement?