[Music by C. Ezra Lange]

David Burda:

Welcome to the 4sight Health Roundup podcast, 4sight Health's podcast series for healthcare revolutionaries. Outcomes matter, customers count, and value rules. Hello again, everyone. This is Dave Burda, news editor at 4sight Health. It is Thursday, June 11th. Only three more days until the big, ultimate fighting championship cage match on the south lawn of the White House. Talk about Beyond Thunderdome. I wonder if they'll have that bare chested, oiled up, muscular sax player wearing animal skins playing the National Anthem on Sunday. That would be pretty cool. I bet Cheeto Jesus would really, really like that, especially on his 80th birthday. My only question is who in the presidential line of succession has to sit this one out? Maybe Chuck Grassley. I'm not sure his heart could take it. Plus, it doesn't start until after 7:00 PM and that's a little late for old Chuck. You know, effective succession planning is part of good governance, especially at the nation's hospitals and health systems. And there's your transition. We're gonna talk about healthcare governance on today's show with Dave Johnson, founder and CEO of 4sight Health and Julie Murchinson, partner at Transformation Capital. Hi, Dave. Hi, Julie. How you two doing this morning? Dave?

David W. Johnson:

We're adjusting to the post-move life so we've got a, we're in a new apartment in downtown Chicago and still unpacking. , It took me 10 minutes last night to find a can opener for the beer I wanted to have with my pizza. <Laugh> , so we're doing okay adjusting.

Burda:

See, you gotta go with
the brand of beer where you don't need an opener, right?

Johnson:

Yeah. Yeah. Like you, Dave. I need to become a regular American.

Burda:

Yeah. Scale down, Dave. , Julie, how are you?

Julie Murchinson:

I'm well. I'm on my last week of travel for the summer, so I'm excited to be at home for a little while. Yeah. That's for sure.

Burda:

Yeah, road weary. Okay. Before we talk about healthcare governance, let's talk about Sunday's age match. Dave, have you ever watched a UFC fight and regardless of the answer, are you gonna watch on Sunday?

Johnson:

I have never watched a UFC fight, and I probably won't be watching Sunday since I manage, I bet we'll be unpacking boxes.

Burda:

Julie, are you throwing a cage match watch party this weekend?

Murchinson:

Oh, I will be blissfully ignoring all activity in that direction. <Laugh> <laugh>

Burda:

I've never seen a UFC fight and I don't plan on starting Sunday. I think season two of Patience starts on PBS at that time. It's about an autistic woman who solves previously unsolvable crimes in York, England. So,

if you haven't seen it, highly recommend it and, maybe she should come to Washington, right?

Murchinson:

Yeah.

Burda:

She'll be putting in a lot of hours. All right, enough of this nonsense. Let's talk about healthcare governance. The idea for this show came from a new report from the Governance Institute. The Institute has been around for a while. They used to cover their surveys on hospital governance practices as a reporter back in the day. NRC Health, which was called National Research Corporation back in the day, bought the Institute in 2006. What the Governance Institutes have been doing the past 20 years? I'm not really sure. Maybe the answer to that is not much because the report they released said health system governance pretty much stinks. Let me throw out a few numbers from the report and share what it said about them. There are 3,897 not- for-profit and state or government-owned hospitals in the US. Those hospitals have about 1,500 fiduciary boards, about 3,000 subsidiary boards, and more than 3,000 advisory boards. About 70% of all those boards have no continuing education requirements for board members. Less than 10% of average board meeting time is spent on director education and less than 1% of hospital patient revenue is invested in board development. And all that adds up to a few problems. Health systems are expanding faster than their board structures. That means fewer people are overseeing larger operations. That's hard to believe with all those boards. Anyways, the capabilities and skillsets of health system boards are not keeping pace with industry changes and complexities. Health system governance isn't adapting as fast as it should to industry changes and the quality of board decision making is degrading as a result. Dave, does this reflect what you're seeing in the field? , What are the consequences of that? And

other than hiring the Governance Institute to fix things, what would you do if you ran a health system to improve your governance? <Laugh>

Johnson:

Well, I probably would hire the Governance Institute. There is new dynamic leadership at NRC with my friend Trent Green as their CEO and his former boss and also my friend David Barick alongside him at the helm. I'm very curious to see where they take the company, which has been pretty sleepy, Dave, as you, as you point out. As the report indicates, there's a lot of wood to chop, in not- for-profit governance. These sleepy go- along nonprofit boards at hospitals and health systems aren't prepared at all for the coming healthcare revolution. By the way, did you see what I did there?

Burda:

I did. <Laugh>

Johnson:

Plug for the book. <affirmation> Dave, I'm gonna amplify some of the themes in the report that you didn't touch on quite as much. You hammered on a smaller number of boards overseeing a larger number of health systems andwhat that potentially portends for the system. But other things they got into is that board development is front loaded and then largely abandoned, you know, so you get all kinds of attention during your initiation process and then good luck. 70% of boards have no continuing education requirement at all. Do you believe that? Less than one 100th of 1% of patient hospital patient revenue is invested in board development. You know, governance, I think, is a little bit more important than 100th of 1% of revenues. AI is advancing faster than the boards responsible for governing it. That's a societal-wide problem, but since healthcare has lagged other industries in adopting to new technologies, probably even more important here. And we all know that

you get these multi-board structures, often as a result of mergers that create signal failure across the health system as a whole. They take a long time to manage and it's a lot of activity, not necessarily a lot of outcome. And here's one that used to really bug me when I was a banker, and it's only gotten worse, is that boards emphasize financial performance at the expense of integrated decision making. I, it used to drive me nuts how boards managed to rating agency medians. Since when does a rating agency determine what your vision should be for the future and how you should invest to meet it? So we're at a moment in the industry where we need architectural redesign, exponential improvement, not incremental improvement and boards have to be there to lead the charge. I'm just gonna highlight something I've written extensively about, which are the structural flaws in the composition and operations of not- for-profit boards. And that's not even taking into account the self-dealing that occurs when local board members who have business with the hospital sit on the board. They have no interest in being tough or overly engaged. They just wanna, <laugh> you know, keep their gravy chain running. So, here at Structural Flaws, I'll tick them off quickly. They tend to be very large, too large, and, they're not compensated. There often are too many boards in operation. They require a lot of care and feeding. Their orientation is primarily philanthropic. So, companies pick board members to maximize philanthropy. They often lack needed expertise. They cede strategy to management. I mean, in my experience, and Julie, I bet you feel the same way, boards need to own strategy. They need to work in partnership with management to implement it. But in nonprofit boards, usually strategies seeded to management. Education and training as illustrated by the NRC report is haphazard and often inadequate. And maybe the one that is most pernicious, that doesn't get talked about a lot is there's a structural flaw in the nature of nonprofit organization. So management operates on short-term contracts, boards don't receive equity and there's a mismatch, I think, between the need to hit short-term performance goals, which management's gonna emphasize and the

organizational long-term needs to reposition, remain competitive, make the right types of investments. So there's a lot to do, and organizations can do it. They need to do it. I worry that far too many of the healthcare organizations in the country aren't doing it and therefore are really underprepared for the tsunami of disruption and reinvention that's coming,

Burda:

Yeah. It's who are the good fundraisers, right? Mm-Hmm. And who's not gonna cause any problems? Thanks, Dave. Julie, any questions for Dave?

Murchinson:

Oh, Dave, these are tough situations, right? How do you think nonprofit board members should be compensated and incentivized?

Johnson:

Well, they should be compensated. I mean, you don't have to pay them, like, board members of publicly traded companies. But, for me, that compensation does a few things. One, it allows organizations to attract people with necessary expertise. You know, let's say consumerism <laugh>, you know, something these organizations are terrible at, you can go out or HR or, or, or, so the compensation helps doing that. What it also allows a board chair to do is hold members accountable for being prepared. You know, in my experience with nonprofit boards, which is significant, the level of preparation among board members is: some people are always prepared, some people are never prepared, and most people are somewhere in the middle and that just gets a whole lot harder to justify if you're a board member and you're getting some compensation for it.

Burda:

Yeah, be prepared. Read the board packet before the board meeting, not at the board meeting. <Laugh> Right? <Laugh> We've all seen that happen. Thanks, Dave. Julie, do you see any of these governance problems in the healthcare technology sector of the industry and, if so, how does that play out in the market? And if you ran a health tech company, what would you do to have the best board around?

Murchinson:

I think health tech companies have different governance issues that honestly seem sort of tame compared to the nonprofit health systems only because of the typical size of the businesses where some of these issues exist and the potential impact really. But I don't know, I think some people would say that the issues are worse. So first, this is probably tooting my own horn, but, you know, in most venture-backed health tech companies, the boards are made up of, you know, generalist investors where healthcare is just one of the many things they invest in. So they don't know anything about FDA, software as a medical device framework, or how health plans make formulary decisions or, you know, what clinical validation means to a hospital CMO. So, you know, companies in this space can get in trouble pretty quickly if they don't have the right kind of healthcare expertise somewhere on the board. I think this report highlights something amazing about AI governance that every company, regardless of the industry you're in, should be worried about, but specifically healthcare because, you know, the investors who invest in these companies three to five years ago have zero vocabulary for evaluating model drift, algorithmic bias and the kinds of things that can go wrong in AI. And I would say specifically in a clinical context, right? So this may be less of an issue for companies that, you know, don't have as much of a clinical solution, but I think it's a real liability for everybody, frankly. And then the typical issue really is founder-dominated boards, which the report talks about in terms of concentrated governance risk, where a single bad decision travels fast and we've definitely seen that play out, especially in earlier stage companies. So

there's certainly issues, you know, in all sorts of boards. If I were putting a board together, I have to say the first thing I would do is really think about, putting an operator on the board. Someone who's actually sold into or run, you know, a health system, health plan, whatever their end customer is and maybe a regulatory expert would kind of depend upon the company, but I think an operator sees things differently than maybe a full investor board, and that's not always a great combination frankly on some of these boards. I know operators who get frustrated by this, the operators don't tend to have the same kind of financial alignment the investors do. So it's not always the best mix, but it can be obviously a different voice. This whole thing, Dave, about board education, I mean, it's shocking, honestly. So educating your board continuously and finding ways to really build that in, I think, is really critical. And, you know, I guess lastly, well, if I thought about the AI and clinical comments I made, we might be at the point where companies need to make, AI or clinical governance more of a structural committee than perhaps it's been in the past. So I'm not quite sure what the right structure is to really address that, but it feels like we're getting to the point where it needs some, some really specific focus across many organizations. And lastly, I would just say that what happens on, I think, a lot of boards, but, you know, small company boards certainly can be this way is that defining that line between what the board, you know, purview is and what management, you know, manages is really critical and a lot of boards micromanage, a lot of boards are two hands off. But I've seen companies in health tech, you know, build really durable businesses and they tend to build strong governance structures early, GoodRx, Progeny, Veeva. I mean, there's, there's a bunch of companies in this space and I don't think it's a coincidence. I think governance can be a competitive advantage more so than just overhead.

Burda:

Putting an operator and somebody with regulatory experience on there. They're both pains in the asses, but I think you need both those perspectives. Thanks, Julie. Dave, any questions for Julie?

Johnson:

Julie, fantastic response and I particularly liked your discussion of, you know, operators having a different, , mindset than investors and how important that can be. And it raises in my mind just broadly the question of, of diversity and, and what are the right ways that board should think about having diversity, , and I'll let you define that however you want, but, , making sure that, , enough perspective is being brought into, , the corporate dialogue so that the company, , doesn't go down a rabbit hole, isn't too myopic, , and is prepared for what's coming.

Murchinson:

It's such a great question given where we've come from, you know, with the DEI focus and a lot of diversity that unfortunately really ended up focusing on optics, even though I think the philosophy was really intended to focus on diversity because of its ability to broaden, , perspective and judgment and, you know, strengthen discussions and, , how boards kind of prosecute plans and strategies. So I do think board diversity matters, but it's really the, , the experience base that different board members bring, the way they think, their expertise and, I think that kind of diversity is critical and we don't see enough of it in m- many boards, frankly. The on person in health systems I would really credit for being a leader in this area is Warner Thomas at his time in Ochsner, and certainly he's doing the same thing at Sutter. He believes strongly that if the organization is really focused on what is best for the patient and to a certain extent, perhaps the consumer, he wants someone on that board who has that type of experience. So he thinks about what the strategy of the system is and then how to, you know, , put a board together or pull those types of, , experienced people into the board to really broaden the

discussion and frankly help educate the rest of the board on an ongoing basis about how to think about that strategy in a really different way than the way we've paid live service to a lot of these strategies. So, , he's, you know, he's one to study.

Burda:

Diversity is a strength, right? Everybody should know that. Thanks, Julie. All I can say is I know people who have joined health system boards after they retired like it was some sort of entitlement for connections made or years served and that's not the type of governance we need in healthcare right now. Now let's talk about other big healthcare news that happened this week. Julie, what else happened that we should know about?

Murchinson:

Well, this is kind of last week's news, but, I suspect you guys probably saw that Roy Schoenberg from Amwell has joined Amazon Health as Neil Lindsay's right hand, which is gonna be really fun to watch.

Burda:

A lot of changes happening there. Thanks, Julie. Dave, what's your big healthcare news of the week?

Johnson:

The HFMA had their annual conference outside DC this week and I was there and on stage for it, a fantastic event. But they invited Casey Mulligan, who is the new four abilities are at HHS to come and address this audience, largely a revenue cycle audience. And he was there to talk about the new rule for state directed payments and it's tough. You know, it's going to basically cut out the, what he called the Argentine Tango, which is the ability of states to you know, get free money from the government through various schemes to increase Medicaid funding and

he had charts and so on. But for the HFMA to invite him on stage and then for him to engage in a dialogue with health system leaders was pretty powerful and I really do think, and it's not entirely fair, but hospitals are taking the brunt of the criticism for the affordability crisis in healthcare right now and, I think the sector is starting to realize that they need to pay attention to it. Hence, we need better governance, right? <Laugh>

Burda:

Well, that's an example of good governance, having the guts to invite somebody with a different perspective to your meeting, right? <affirmation> So, it's a live example of what we were all just talking about. That's great. Thanks, David. Thank you, Julie. That is all the time we have for today. If you'd like to learn more about the topics we discussed on today's show, please visit our website at 4sighthealth.com. You also can subscribe to the Roundup on Spotify, Apple Podcasts, YouTube, or wherever you listen to your favorite podcasts. Don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I'm Dave Burda for 4sight Health.