AMENDED AGENDA
Special Meeting of the Executive Compensation Committee of the
El Camino Hospital Board
Thursday, February 26, 2015, 4:30 p.m.
El Camino Hospital, Medical Staff Conference Room, First Floor
2500 Grant Road, Mountain View, California
Jeffery Davis will be participating via teleconference from the following address:
Blvd Diamanté s/n Col. Los Cangrejos, Cabo San Lucas B.C.S., C.P. 23473
Bob Miller will be participating via teleconference from the following address:
Sunnyside Lodge, 1850 Lake Blvd., Tahoe City, CA 96145

MISSION: The purpose of the Executive Compensation Committee ("Compensation Committee") is to assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in its responsibilities related to the Hospital’s executive compensation philosophy and policies. The Compensation Committee shall advise the Board to meet all applicable legal and regulatory requirements as it relates to executive compensation.

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<tr>
<th>AGENDA ITEM</th>
<th>PRESENTED BY</th>
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<tbody>
<tr>
<td>1. CALL TO ORDER</td>
<td>Nandini Tandon, Chair</td>
<td>4:30 p.m.</td>
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<tr>
<td>2. ROLL CALL</td>
<td>Julie Johnston, Director, Comp &amp; Benefits</td>
<td>4:31 – 4:32</td>
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<tr>
<td>3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES</td>
<td>Nandini Tandon, Chair</td>
<td>4:32– 4:33</td>
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<td>4. PUBLIC COMMUNICATION</td>
<td>Nandini Tandon, Chair</td>
<td>4:33 – 4:34</td>
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<td>5. CONSENT CALENDAR ITEMS</td>
<td>Nandini Tandon, Chair</td>
<td>public comment</td>
</tr>
<tr>
<td>Approval:</td>
<td></td>
<td>Motion Required</td>
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<td>Information:</td>
<td></td>
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<tr>
<td>b. FY15 Executive Compensation Committee Goals – Status Update</td>
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<td>c. FY15 Executive Compensation Committee Pacing Plan Revised</td>
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<td>d. Best Practices Articles</td>
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<tr>
<td>i. Aligning Incentives and Mission</td>
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<tr>
<td>e. Andrew Lewis Bio</td>
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<tr>
<td>ATTACHMENT 5</td>
<td></td>
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<tr>
<td>6. ADJOURN TO CLOSED SESSION</td>
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<td>4:37</td>
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<tr>
<td>7. POTENTIAL CONFLICT OF INTEREST DISCLOSURES</td>
<td></td>
<td>4:37 – 4:38</td>
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A copy of the agenda for the Special Meeting of the Committee will be posted and distributed at least twenty-four (24) 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.
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<tr>
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<tr>
<td>8. CONSENT CALENDAR</td>
<td>Nandini Tandon, Chair</td>
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<td>Approval:</td>
<td>Motion Required 4:38 – 4:40</td>
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<tr>
<td>- Minutes of the Executive Compensation Committee Meeting, Closed Session (November 20, 2014) Gov’t Code Section 54957.2.</td>
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<tr>
<td>Information Only, Not for Approval:</td>
<td>Kathryn Fisk, Chief HR Officer</td>
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<tr>
<td>- Report involving Gov’t Code Sections 54957 and 54957.6 for report and discussion on personnel matters:</td>
<td>Information</td>
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<tr>
<td>- Report on Sullivan Cotter Services</td>
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<tr>
<td>9.</td>
<td>Andrew Lewis and Mike Stewart, Sullivan Cotter and Associates</td>
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<tr>
<td>Report involving Gov’t Code Sections 54957 and 54957.6 for report and discussion on personnel matters and Health and Safety Code Section 32106(b) for a report involving health care facility trade secrets:</td>
<td>Discussion 4:40 – 5:10</td>
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<td>- Compensation Program Design</td>
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<td>10.</td>
<td>Mick Zdeblick, Chief Operations Officer Rich Katzman, Chief Strategy Officer</td>
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<tr>
<td>Report involving Gov’t Code Sections 54957 and 54957.6 for report and discussion on personnel matters and Health and Safety Code Section 32106(b) for a report involving health care facility trade secrets:</td>
<td>Discussion 5:10 – 5:19</td>
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<td>- X-Box Tool for Strategic Planning</td>
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<td>11.</td>
<td>Kathryn Fisk, Chief HR Officer</td>
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<tr>
<td>Discussion involving Gov’t Code Sections 54957 and 54957.6 for report and discussion on personnel matters and Health and Safety Code Section 32106(b) for a report involving health care facility trade secrets:</td>
<td>Discussion 5:19 – 5:29</td>
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<tr>
<td>- Executive Performance</td>
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<td>12.</td>
<td>Andrew Lewis and Mike Stewart, Sullivan Cotter and Associates</td>
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<tr>
<td>Discussion involving Gov’t Code Sections 54957 and 54957.6 for report and discussion on personnel matters and Health and Safety Code Section 32106(b) for a report involving health care facility trade secrets:</td>
<td>Possible Motion for Recommendation 5:29 – 5:56</td>
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<tr>
<td>- Aligning Compensation Program Design with Mission, Goals, and Strategies</td>
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<td>13.</td>
<td>Nandini Tandon, Chair Kathryn Fisk, Chief HR Officer</td>
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<tr>
<td>Report involving Gov’t Code Sections 54957 and 54957.6 for report and discussion on personnel matters and Health and Safety Code Section 32106(b) for a report involving health care facility trade secrets:</td>
<td>Possible Motion for Recommendation 5:56 – 6:26</td>
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<td>- Goals and Roles for Joint Meeting with Board</td>
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<td>AGENDA ITEM</td>
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<td>14. RECONVENE OPEN SESSION</td>
<td>Nandini Tandon, Chair</td>
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<td>To report any required disclosures regarding permissible actions taken during Closed Session.</td>
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<td>15. CLOSING COMMENTS</td>
<td>Nandini Tandon, Chair</td>
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<td>16. ADJOURNMENT</td>
<td>Nandini Tandon, Chair</td>
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Upcoming Executive Compensation Committee Meetings in FY 2015:
- March 11, 2015, 5:30 p.m. – Joint Meeting of the Board and the Executive Compensation Committee
- March 25, 2015 – Semi-Annual Board and Committee Session
- April 22, 2015
- May 28, 2015
1. **Call to Order.** The meeting of the Executive Compensation Committee (the “Committee”) was called to order by Vice Chair David Reeder, at 4:30 p.m.

2. **Roll Call.**
   - **Members Present:** Chair Nandini Tandon (by phone), Vice Chair David Reeder, Jeffrey Davis, Jing Liao (4:57 p.m.), Bob Miller, Julia Miller, and Prasad Setty
   - **Members Absent:** Teri Eyre

3. **Potential Conflict of Interest Disclosures.** Vice Chair Reeder asked if any Committee member had a conflict of interest on any of the items on the agenda. There were none.

4. **Public Communication.** There were none.

5. **Consent Calendar.** Vice Chair Reeder asked if anyone wished to remove any items from the consent calendar. There were no requests.

**MINUTES OF SEPTEMBER 25, 2014 MEETING**

**Action:** Motion to approve the Minutes of September 25, 2014.

**Movant:** B. Miller

**Second:** J. Miller

**Ayes:** Tandon (by phone), Davis, B. Miller, J. Miller, Reeder, Setty

**Noes:** None

**Abstentions:** None

**Absent:** Eyre, Liao

**Recused:** None

**Motion Passed**

**FY15 EXECUTIVE COMPENSATION COMMITTEE GOALS**

For information only. No action was taken.

**UPDATED FY 51 EXECUTIVE COMPENSATION COMMITTEE PACING PLAN**

For information only. No action was taken.
BEST PRACTICES ARTICLES
For information only. No action was taken.

6. **Discussion Item: Strategic Planning, Goal-Setting and Tracking** Rich Katzman, Chief Strategy Officer, presented an overview of the strategic plan, goal-setting, and tracking. Discussion followed. It was noted by Member Bob Miller that improvements could be made so that performance incentive plan goals and threshold/target/maximum measurements could be approved together. He then suggested identifying the most critical goals to address in FY16, and that consideration be given to two year goals. Many Committee members expressed concern about having too many performance incentive plan goals. Vice Chair Reeder shared the Board’s efforts on the development of three main goals, known as Big Dot goals.

7. **Adjourn to Closed Session at 5:13 pm.**

**Move:** To adjourn to Closed Session at 5:13 p.m. pursuant to the Gov’t Code Section 54957.2 for approval of the closed session minutes, Gov’t Code Sections 54957 and 54957.6 and Govt Health and Safety Code Section 32106(b) for discussion on opportunities for improving the goal setting process and oversight of the Executive Performance Incentive Plan, discussion on Draft letters of Rebuttable Presumption of Reasonableness, receiving an update on Executive Leadership Development and Succession Planning, and discussion on Performance of Executive Compensation Consultant and FY 16 Consulting Services.

**Movant:** Davis
**Second:** Miller
**Ayes:** Tandon (by phone), Davis, Liao, B. Miller, J. Miller, Reeder, Setty
**Noes:** None
**Abstentions:** None
**Absent:** Eyre
**Recused:** None
**Motion Passed**

8. **Agenda Item 14 – Reconvene Open Session at 6:50 p.m.** No action was taken.

9. **Agenda Item 15 – Closing Comments.** Vice Chair Reeder asked for any closing comments from the Committee. Chair Nandini Tandon thanked all Committee members for a productive discussion.
10. **Agenda Item 16 – Meeting Adjournment.**
   
   **Motion:** To adjourn the Executive meeting at 6:51 p.m.
   
   **Movant:** Setty
   
   **Second:** Reeder
   
   **Ayes:** Tandon (by phone) Davis, Liao, B. Miller, J. Miller, Reeder, Setty
   
   **Noes:** None
   
   **Abstentions:** None
   
   **Absent:** Davis
   
   **Recused:** None
   
   **Motion passed**

Attest as to the approval of the foregoing minutes by the Executive Compensation Committee and by the Board of Directors of El Camino Hospital:

__________________________
Nandini Tandon, Chair
Executive Compensation Committee

__________________________
Dennis Chiu, JD, Secretary
Board of Directors
Attachment 5b - FY15 ECC Goals Update for 022615 ECC.doc
Executive Compensation Committee
Goals for FY 2015
Update 2/26/15

Purpose
The purpose of the Executive Compensation Committee ("Compensation Committee") is to assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in its responsibilities related to the Hospital’s executive compensation philosophy and policies. The Compensation Committee shall advise the Board to meet all applicable legal and regulatory requirements as it relates to executive compensation.

Staff: Kathryn Fisk, Chief Human Resources Officer and Julie Johnston, Director HR Compensation and Benefits

The Chief HR Officer and Director HR Compensation and Benefits 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. The CEO, and other staff members as appropriate, may serve as a non-voting liaison to the Committee and may attend meetings at the discretion of the Committee Chair. These individuals shall be recused when the Committee is reviewing his/her compensation. The CEO is an ex-officio of this Committee.

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<thead>
<tr>
<th>Goals</th>
<th>Timeline by Fiscal Year</th>
<th>Metrics</th>
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<tr>
<td>(Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)</td>
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<td>Themes:</td>
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<tr>
<td>Advise the Board and Management on effective goal setting process and oversight of the Executive Performance Incentive Plan.</td>
<td>Q1 (finalize metrics FY 15) - completed</td>
<td>Alignment with mission, vision, strategy</td>
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<td>Q3 (recommend opportunities for improvements for FY 16)</td>
<td>Simplicity</td>
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<td>Q4 (approval of FY 16 goals and measures)</td>
<td>Transparency</td>
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<td>Cascade and delegation</td>
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<td>Collaboration</td>
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<td>Goals</td>
<td>Timeline by Fiscal Year</td>
<td>Metrics</td>
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| **2. Oversee the implementation of the policy changes approved by the Board ensuring strategic alignment and proper oversight of compensation-related decisions.** | Q1 – implementation – completed, Board approved Benefit policy changes 8/14  
Q3 - accept letter – completed 1/15  
Q4 – accept report | • Oversee implementation of policy changes  
• Recommend acceptance of the letter of rebuttable presumption of reasonableness.  
• Evaluate impact of the changes and practices that better reward performance and results. |
| **3. Evaluate the effectiveness of the executive performance review process and the annual/biannual cycle that includes self-assessment, stakeholder feedback, talent profiling, and executive leadership development.** | Q4 – accept reports | Elements may include:  
• Executive performance appraisal process  
• Tools for ongoing/periodic self-assessment and stakeholder feedback  
• Development of the executive team as a whole and as individuals  
• Supporting the executive team developing leaders within ECH  
• Review the Hospital’s Leadership policy |

**Submitted by:**  
Nandini Tandon, PhD, Chair, Executive Compensation Committee  
Kathryn Fisk and Julie Johnston, Executive Sponsors, Executive Compensation Committee
## EXECUTIVE COMPENSATION COMMITTEE
### DRAFT for 2/26/15 Meeting
### PACING PLAN FOR FY 2015

### FY2015: Q1

<table>
<thead>
<tr>
<th>JULY</th>
<th>AUGUST</th>
<th>SEPTEMBER</th>
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<tr>
<td><strong>No Board Meeting</strong></td>
<td><strong>13 – Board to take action on:</strong> 1. CEO FY 15 individual goals 2. Executive FY 15 individual goals (CR, RK, IH) 3. Executive Benefit Plan Policy 4. Executive Personnel Action</td>
<td><strong>10 - Board to Discuss</strong> 1. CEO’s FY 14 Performance 2. FY 14 Organizational Goal results</td>
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<tr>
<td><strong>Key:</strong>  Blue = Board Ebony = Executive Compensation Committee</td>
<td><strong>Board to review and discuss:</strong> 1. SCA summary of feedback on CEO 2. CEO’s performance during FY 14 3. Progress Report on ECC</td>
<td><strong>25 – Committee Meeting</strong> Committee to take action on: 1. FY 14 organizational score 2. FY 14 individual scores for CEO &amp; ex team 3. FY 14 performance incentive payout amounts (execs and CEO) 4. Minutes of May 15, 2014 meeting Committee to Discuss: 1. Metrics for achieving Committee’s FY 15 goals 2. FY 15 ECC Pacing Plan 3. Process of how Committee wants to improve its performance 4. Metrics for effective goal setting and oversight of the Executive Performance Incentive Plan Committee to receive: 1. FY 15 ECC approved goals 2. ECC updated charter 3. Report regarding implementation of policy changes approved by the Board 4. Best Practice article</td>
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<tr>
<td>OCTOBER</td>
<td>NOVEMBER</td>
<td>DECEMBER</td>
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| 8 - Board to take action on the following items:  
  1. Accept Moss Adam’s financial audit  
  2. Approve FY 14 organizational score  
  3. Approve FY 14 executive individual scores  
  4. Approve FY 14 executive payout amounts (discuss in closed, vote in open)  
  5. Determine CEO’s discretionary score and FY 14 individual score  
  6. Approve FY 14 CEO payout amount (discuss in closed, vote in open)  
  7. Approve FY 15 metrics for Organizational goals  
  8. Accept Exec Comp minutes from May 2014 meeting | 12 – Board Meeting  
No actions  
20 - Committee Meeting  
Committee to take action on:  
  1. Letter of rebuttable presumption  
  2. Minutes from September 25, 2014 meeting  
  3. Executive Compensation consulting services for FY 16  
Committee to discuss:  
  1. Revised FY 15 Pacing Plan  
  2. Opportunities for improving goal setting process  
  3. Report on ECH Strategic Plan and planning process including Board perspective  
Committee to receive:  
  1. Update on executive development/succession planning  
  2. Update on ECC’s progress toward goals  
  3. Best Practice Articles | No Board Meeting |
<table>
<thead>
<tr>
<th>JANUARY</th>
<th>FEBRUARY</th>
<th>MARCH</th>
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<tr>
<td>14 – Board to take action on the following items:</td>
<td>11 – Board Meeting</td>
<td>11 – Board Meeting</td>
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<tr>
<td>1. Accept letter of rebuttable presumption</td>
<td>No actions</td>
<td>1. Accept Exec Comp minutes from November 2014 meeting</td>
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<tr>
<td>2. Accept Exec Comp minutes from September 2014 meeting</td>
<td>26 – Committee Meeting</td>
<td>11 – Joint Board &amp; Committee Meeting</td>
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<td>Committee to take action on:</td>
<td>Committee may discuss:</td>
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<td></td>
<td>1. Minutes from November 20, 2014 meeting</td>
<td>1. Best Practice: Establishing Incentive Plan Goals</td>
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<td>Committee to review and discuss:</td>
<td>2. Proposed direction for executive compensation plan design</td>
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<td>2. X-box</td>
<td>4. Recommendations for Improving the Committee’s and Board’s effectiv</td>
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<td></td>
<td>3. Aligning Comp Plan design with mission, goals, strategies</td>
<td>is in overseeing executive compensation</td>
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<td>4. Goals for March Joint Session</td>
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<td>Committee may:</td>
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<td></td>
<td>1. Determine proposed direction for executive compensation plan</td>
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<td>design</td>
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<td>2. Develop recommendations for Improving the Committee’s and Board’s</td>
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<td>effectivenss in overseeing executive compensation</td>
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<td>APRIL</td>
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<td>JUNE</td>
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| 8  – Board may discuss or take action on the following items:  
  1. Receive update on Executive Succession Planning and Leadership Development  
  2. Recommendations for Improving the Committee’s and Board’s effectiveness in overseeing executive compensation  |
| 13 - Board will discuss or take action on the following items:  
  1. Minutes February 26, 2014 meeting  
  2. Committee Update  |
| Board may discuss or take action on the following items:  
  1. Possible changes to Executive Compensation Philosophy/Total Comp realignment  
  2. Possible addition of LTIP and LTIP goals  |

**22– Committee Meeting**  
Committee to take action on:  
1. Minutes February 26, 2014 meeting  
2. Possible changes to Executive Compensation Philosophy/Total Comp realignment  
Committee to review and discuss:  
3. Consultant’s report on market analysis  
4. Proposed FY 2016 organizational and individual performance incentive goals  
5. Hospital’s leadership policy  
6. Executive Performance Appraisal process  
7. Executive Performance Incentive Plan Design  
8. Discuss committee goals for FY 16, meeting calendar, and review Charter  
9. Other process improvement or policy changes discussed at Joint session  
10. Committee Charter |

**28 – Committee Meeting**  
Committee will/may take action on:  
1. Salary ranges for FY16  
2. CEO’s recommendations on FY 16 base salaries  
3. CEO’s recommendations on executives’ individual goals  
4. CEO’s FY 16 base salary recommendation  
5. CEO’s FY 16 individual goals recommendation  
6. Executive compensation and benefit policies  
7. FY 16 committee goals recommendation, meetings, and pacing plan  
8. Interview and recommend new community members (if needed)  
9. Approval of April 22 minutes  
Committee will review and discuss:  
1. Committee Self Review Discussion  
2. Progress against FY 15 committee goals  
Committee to receive:  
- Update on progress of executive leadership and succession planning  |

11 - Board will/may to take action on the following items:  
1. FY 16 CEO base salary  
2. FY 16 executive base salaries  
3. FY 16 organizational goals  
4. FY 16 CEO individual goals  
5. FY 16 Committee goals  
6. Executive Compensation and Benefit policies  
7. Accept Committee’s report evaluating strategic alignment and oversight of comp decisions  
8. If needed, approve appointment of new members  
9. Approval of April 22, 2015 minutes
## FY2016: Q1

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<th>JULY</th>
<th>AUGUST</th>
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| **No Board Meeting** | 11 – Board to take action on: TBD  
Board to review and discuss:  
1. Consultant summary of feedback on CEO  
2. CEO’s performance during FY 15  
3. Progress Report on ECC | 10 - Board to Discuss  
1. CEO’s FY 14 Performance  
**TBD – Committee Meeting**  
Committee to take action on:  
1. FY 15 organizational score  
2. FY 15 individual scores for CEO & ex team  
3. FY 15 performance incentive payout amounts (execs and CEO)  
4. Minutes of May 28, 2015 meeting  
Committee to Discuss and possible action on:  
1. Metrics for achieving Committee’s FY 16 goals  
2. FY 16 ECC Pacing Plan  
Committee to receive:  
1. FY 16 ECC approved goals  
2. ECC updated charter  
3. Best Practice article |

**Key:** Blue = Board  
Ebony = Executive Compensation Committee
Cost Savings vs. Quality Care

Debate continues about whether, after years of attention to cost-cutting in all aspects of healthcare, a pivot to heavy concentration on quality is needed. Are the two demands at odds?

There is little abatement in aggressive cost cutbacks. As the AHA Environmental Scan notes: "Providers will be under tremendous pressure due to lowered reimbursement rates and increased patient volumes from health insurance exchanges and expanding Medicaid rolls. Some health systems are approaching the challenge by trying to reduce costs by 20-30% overall." The fundamental alteration of the healthcare business model will continue to drive such reductions.

Yet care quality is equally demanded, and healthcare leaders recognize they must focus rigorously on both cost and quality, with the only way to bridge the two being devotion to value. This term is being defined as "delivering the best possible outcomes at a given level of cost. We call this competing on outcomes." Such competition moves away from simply seeking the lowest cost or market pricing power.

Increasing Volume, Variety and Complexity of Affiliations

Organizations pursue the value equation within a changing and often unclear healthcare environment. The uncertainty is borne out by a recent B. E. Smith executive survey that revealed a split between the 44% Confident or Very Confident in outlook for the year and the 47% who hold an Uncertain or Very Uncertain outlook.

Healthcare leaders are responding with stepped-up pursuit of a wide range of alignments that include horizontal scale increases via hospital mergers and acquisitions (M&A) and vertical integration of physician practices, ambulatory centers, post-acute providers and others. Some are undertaking even more transformative moves that may be harbingers of the future: embracing risk-shifting by becoming payers as well as providers. Price-waterhouseCoopers estimates that 50% of health systems have applied or intend to apply for an insurance license.
All of this realignment can create ever more complex organizations, which leaders must work to simplify. Noted management consultant Adrian Slywotzky has called healthcare delivery “hassle map heaven,” warning the industry to adapt and be truly customer-centric.

Migration of Care Outside the Hospital is Accelerating
A parallel movement to value and realignment is a shift to caregiving outside the four walls of the hospital into various ambulatory entities such as urgent care centers and stand-alone EDs, as well as greater reliance on post-acute settings such as home care and long-term acute care providers. More surgeries are now performed outpatient than inpatient, and hospital ownership of free-standing ambulatory care centers has grown 27%. Brian Silverstein, M.D., of research firm Sg2, observes that the hospital profit base 10 years ago was 64% inpatient and 35% outpatient. “Today, that’s flipped,” he says.

Driven by the emerging population health movement, telemedicine is also booming. Video consultations are projected to grow from 5.7 million in 2014 to 130 million by 2018. Geisinger has found that telemonitoring of patients “improved the efficiency of care managers and delivered a 3.3 times return on Geisinger’s investment.”

This migration does not represent simply tinkering with the care delivery model. It is a response to far more disruptive forces. Non-traditional healthcare clinics are growing due to accessibility and convenience. Urgent care centers have become a $13 billion market and the rise of retail clinics in drugstores and other locations has been dramatic, doubling between 2012 and 2015. The recent rebranding of CVS to CVS Health sends a clear directional message from this self-described “new entrant.”

Healthcare Consumerism has Arrived
Most of the trends described are fueled by - and require - far more active consumer participation in the process than has traditionally been the case. While the rise of consumer power has been predicted for many years, it now appears to be here in force. Newly insured individuals and the spread of high-deductible plans are driving more customer awareness of healthcare delivery options, further fueled by greater market price transparency.

Additionally, aging “baby boomers” are healthier, better educated and more accountable for their well-being. This important population will insist on being involved in their own care and their patient rights.

Altarum confirms the trend: “Similar to prior years, this survey finds strong evidence that consumers want a seat at the table in decisions about their health. Nine out of 10 consumers prefer to be in control of medical decisions, while 64% take steps to learn about their health condition instead of relying solely on the doctor for information.”

Population Health Driving Communities of Service
Beyond the move to outpatient care, alignments and partnerships are extending to very non-traditional delivery settings such as soup kitchens, Red Cross facilities and non-governmental organizations. These innovative approaches are being driven by the substantial interest in population health. They are motivated by the recognition that stronger preventative medicine and wellness programs are needed and will succeed if they meet individuals at their locations and states of readiness.

This emergent trend is creating true “communities of service” designed to keep patients out of the hospital and leverage post-acute care management. It is a model that optimizes what an observer described as the essence of population health: “customized coordinated care.”

Changing Environment Creating New Leadership Competencies and Compensation
Leadership is being heavily impacted by the altering landscape, creating new success requirements. A particularly notable trend is that CEO turnover is on the rise, reaching its highest level in 2013: 20%. Retirement, hospital M&A and the pressures of change are all contributing factors.

B. E. Smith’s research suggests the consequences of CEO turnover can be far-reaching in many organizations. When asked which executives are likely to leave after a CEO departure and which initiatives are most affected, respondents indicated:

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7 Modern Healthcare, June 23, 2014. See also a study by Kaufman Hall finding that “inpatient utilization rates per 1,000 declined across all age groups, averaging a 5 percent across-the-board drop.” R. York, K. Kaufman, M. Grube, “Where have all the inpatients gone?” Health Blog, January 6th, 2014.
9 Parks Associates forecast quoted in mHealthNews, August 26, 2014.
11 AHA Environmental Scan cites growth in percentage of workers with HDPs from 4% in 2006 to 20% in 2013.
12 Altarum Institute, 2014 Survey of Consumer Health Care Opinions
Executive compensation is adapting to the new leadership realities as well, albeit somewhat slowly. B. E. Smith continuously monitors the compensation landscape. Over the past year, pay raises in the executive suite ranged between 2% to 3%, with CEO increases slightly higher. Consensus forecasts average 2% for 2015.

There is clear movement to alignment of compensation with the performance-based care model. Despite progress, though, 43% of surveyed executives say their organization has yet to match incentives to key values such as cost containment, patient engagement and clinical outcomes. Such changes will accelerate in 2015 and beyond. Experimentation with compensation typical in other industries is also occurring. Examples include stay bonuses to promote project completion or complete merger transitions and flexible, metrics-based bonuses to motivate individual goals.

Organizations Focusing on Succession Planning and Emerging Leaders

Given the C-level turnover and the urgency to promote the skills necessary to thrive, healthcare organizations are increasingly training their sights on two interrelated initiatives: succession planning and development of emerging leaders. The former is overdue, as 64% of executives still report no succession program in place. With at least 40% of CEO hires resulting from internal promotion, the need for a more formal succession approach is desirable. Some hospitals are turning to outside advisors to help build customized programs.

Leadership development is about more than identifying the next-in-line. Strategic organizations are devoting attention to younger and emerging leaders, realizing the need to build a strong bench in the face of an aging workforce and a younger generation that may need new incentives to seek leadership roles.

Recommended education and emerging-talent development efforts include:

- **Executive coaching and one-on-one real-time mentoring**
- **Leadership development programs tailored to an organization’s specific needs**
- **Regular competency assessment**
Physician Leadership a Clear Priority
Two data points are compelling when it comes to the role of physicians in the leadership equation. First, physicians continue at a rapid pace to become employees rather than independent practitioners. Forecasts suggest over 75% of physicians could be employed in hospitals and systems by 2020. Second, physicians are underrepresented in senior leadership, representing just 14% of C-suite hires in a recent study.

This situation is changing rapidly as organizations seek closer integration of the clinical and administrative. Doctors are being recruited for new positions such as Vice President of Clinical Transformation or Informatics as well lending their voice as part of management dyads or triads with other leaders. Roles span the operational, strategic and even cultural. As the AHA Environmental Scan observes, the physician leader must drive a culture of accountability, commitment to care excellence and continuous performance improvement. Determining the right skill sets, identifying physicians with the best cultural fit and providing strong training are all becoming paramount.

Workforce Engagement Remains a Key Ingredient in Achieving Quality
The shift to value-based care is increasing the emphasis on patient satisfaction and employee engagement at every level of the organization. Yet achieving such engagement continues to be very challenging. A recent B. E. Smith survey found executives completely divided: Given the attention to this topic over the years, one would expect greater progress toward positive engagement, suggesting further prioritization needed. B. E. Smith frequently advises organizations on enhancing workforce engagement. Recommendations include:

- Foster a truly collaborative culture that sees individuals as partners who can bring ideas to the table.
- Promote the right competitive environment that motivates rather than stifles change.
- Gain leadership exposure to people outside healthcare for fresh perspectives.
- Be attentive and work hard to overcome cultural and social norms that inhibit engagement. For example, women comprise 80% of the healthcare workforce but only 18% of leadership.

The trends discussed here span a range of factors impacting institutional structures, competitive forces, patient demands, population health and workforce development and engagement. Clearly 2015 presents many challenges, but healthcare leaders should recognize that successfully navigating the changes presents exceptional opportunities to make significant progress towards transforming not only their organizations, but the industry as a whole.
The healthcare industry is recognizing the need to convert data into knowledge and knowledge into intelligence, but has a way to go.

**Big Data and the Analytics Imperative**

The healthcare industry is recognizing the need to convert data into knowledge and knowledge into intelligence, but has a way to go.
B
ecause the healthcare industry is embarking on reform-prompted structural and financial overhauls, classic and comfortable production-based executive incentives are under scrutiny. Modifying executive compensation parameters is not easy, partly because moving in new strategic directions implies adopting new performance metrics. Compensation committees with a strong desire for stability may find that if they resist change, their strategic direction and their compensation packages will become misaligned at the top levels of the organization.

Joseph Pepe, MD, president and CEO of CMC Healthcare System in Manchester, New Hampshire—which includes the 330-licensed-bed Catholic Medical Center, the New England Heart Institute, as well as a number of subsidiaries—is helping the CMC board take a new direction when updating executive compensation. “The compensation committee is looking at this now, trying to find out what’s fair,” he says. “They are used to focusing on what like institutions are doing. I’m trying to get them a little bit out of their comfort zones, suggesting that we look beyond overall revenue, although I think that is a consideration.

“Instead,” Pepe says, “we should look at what we want to achieve for the future. For example, if the future depends on the capabilities of improved operational efficiency, clinical integration, quality outcomes, and care management, then why not develop metrics around these so that there’s incentive pay based on where we need to go in the future?”

Focus on mission and strategy

One-third (33%) of respondents to the HealthLeaders Media Executive Compensation Survey say their organization’s executive compensation structure needs major enhancements to attract, retain, and engage leaders. Joel Seligman, president and CEO of Northern Westchester Hospital, a 200-staffed-bed community
Here are selected comments from leaders addressing matters related to executive compensation.

"Qualitative goals include implementation of the payer strategy and payer partnerships, infrastructure built for population health management and high-risk management care delivery systems, new physician compensation and incentive systems, and development of new and innovative business structures."

—President of a medium health system

"We are looking at relating compensation to reducing costs and length of stay, while improving outcomes and employee retention."

—Vice president of finance for a small hospital

"Incentives overall tie to a fee-for-service world. Locally, margin targets are set, which incorporate the impact of population health and readmissions. In effect, there is no direct linkage, but rather there is an indirect linkage to both population health management and the trend away from acute care admissions."

—Chief financial officer of a large health system

"The CEO receives incentives regardless of financial or quality outcomes. We still have a good old boy setup."

—Chief nursing officer of a medium hospital

"There have been no changes. Compensation is still based on traditional metrics."

—Chief medical officer of a large health system

"Compensation packages are evolving to include performance achievement across the care continuum, and to be more team-focused."

—Vice president of operations for a large health system

What Healthcare Leaders Are Saying

IN CONSIDERATION OF THE SHIFT FROM FEE-FOR-SERVICE TO VALUE-BASED PURCHASING, HAS YOUR ORGANIZATION MODIFIED ITS GROUP OR TEAM INCENTIVES FOR EXECUTIVE COMPENSATION PACKAGES, OR IS IT EXPECTED TO DO SO?

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<thead>
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<th>Option</th>
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<tr>
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<td>33%</td>
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<tr>
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<td>43%</td>
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<tr>
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TO ATTRACT, RETAIN, AND ENGAGE LEADERS, WHAT IS THE OUTLOOK FOR EXECUTIVE COMPENSATION STRUCTURE AT YOUR ORGANIZATION?

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<th>Option</th>
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<tr>
<td>Needs major enhancement</td>
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<tr>
<td>Needs minor enhancement</td>
<td>49%</td>
</tr>
<tr>
<td>Needs no enhancement</td>
<td>18%</td>
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Individual, team goals

Incentives are split fairly evenly between individual (45%) and team goals (55%). Advisors expect more emphasis in the future on team goals, but do not expect a severe decrease in individual goals.

“There are two forces involved,” Seligman explains. “One is a push toward individual accountability—holding individuals responsible and rewarding or punishing them accordingly. The second force is about teams, and it is more powerful. I would expect that incentives will shift gradually toward being more team-based. This is about building a culture of teamwork and trust between people and process.”

While 15% of respondents rely exclusively on individual goals, and 23% rely solely on team goals, the majority (62%) has some mix of team and individual goals. Still, it is prudent to monitor the mix closely. "If you get too myopic about an individual goal without being able to look at a team at the total impact that it’s having on an organization,” says Wiltermood, “you could potentially get into some trouble.”

The objectives that are on top of the chart of individual incentive payments are the same as the items that are on the top of the team incentive chart—a mixture of financial objectives, clinical objectives, and staff engagement/satisfaction targets. “Individual goals and team goals aren’t very different anyway,” Seligman notes.

While staff engagement or satisfaction is relatively common as an executive incentive (47% have it as an individual goal, and 51% have staff engagement as a team goal), physician engagement is near the bottom of each chart, with 26%. Considering its importance, especially with care redesign efforts and the need for the industry to focus on improved outcomes and provider efficiency, one wonders why physician engagement isn’t part of variable compensation more frequently. Seligman observes that physician engagement is difficult to measure.

“I think we gravitate toward things that are easier to measure and are readily available—we all know what operating results mean,” he says.

Pepe adds that there isn’t an agreed-upon definition for physician engagement, either. “It’s very difficult to define how to measure physician engagement. Once we as an industry figure out how to define physician engagement, then we’ll monitor it.”

Change is needed

Healthcare reform causes organizations to review their strategic direction. Organizations must develop a new understanding of their financial foundation, and at the same time examine how to change their core deliverable: patient care.

More than one-fifth (21%) say their organization has made changes to its executive compensation strategies to address the financial realities of healthcare now. (But that includes 4% who say that the changes made were in the wrong direction! Just 17% describe the implemented changes as being in the right direction.) In addition to the 21% who have acted, Pepe notes the 50% who recognize that change is needed but have yet to devise a plan (35%) or implement it (15%).
“Combined, I see that 71% have changed executive compensation strategies or recognize a change has to occur,” Pepe says. “This tells me that it’s clear that the industry is taking this seriously, and the majority feel that financial reform is not just a fad or a fantasy.” He expresses concern for the 20% who say they have not changed executive compensation packages to address the financial realities of healthcare because they believe no change is needed. “Traditionally there are laggards,” he says, “and I worry that in this market those laggards may look more like a Borders bookstore in the future than like Amazon.”

Pepe sympathizes with the 35% who recognize change is needed but have no plan, particularly because of the difficulty of making projections in uncertain times. “In our market, a lot of organizations are going through a transition process where they’re trying to come up with a new strategic plan that’s much different than the old strategic plan. The previous plan may have been a six-year strategic plan. Now if you go any more than three years, then you might as well be looking into a crystal ball.”

Performance metrics in play

Probably because an organization’s overall mission and strategy have a degree of stability, the components of executive compensation packages are not subject to sudden shifts. But over the past three years, higher percentages are saying that performance metrics are evolving. In our 2012 survey, 19% identified performance metrics as the aspect of their compensation package that has evolved the most in the previous two years. Answering the same question in this year’s survey, 27% say performance metrics have evolved the most.

Says Pepe, “Performance metrics are changing in two ways. One, they’re becoming less task-like and more quantitative. And they’re changing from volume to value metrics. What we’re trying to do at CMC is go toward the value metrics of physician alignment, with metrics such as mortality rates, readmission rates, integration, and so on. However, we still live in a volume world, and because of that, operating margin is still one of our metrics. But more and more we’re putting value metrics in our compensation packages.”

Although Pepe suggests that organizations are including value metrics more frequently, some are found close to the bottom of the list of clinical performance parameters that organizations expect to emphasize for executive incentives over the next three years. Patient satisfaction targets are mentioned most frequently, by 76%. Says Wiltermood, “Certainly everybody’s focus is on HCAHPS and readmissions. Those are things that have immediate financial consequences to us if we don’t manage them correctly.”

Other metrics covering activities that are probably very important to healthcare reform appear lower on the list. For instance, only 25% say that they will be emphasizing access-to-care targets over the next three years, and only 22% will be emphasizing care network expansion. Says Seligman, “This is not just new to us from a financial perspective. It’s completely new to us. Most hospitals haven’t had ambulatory care networks and prevention programs. Now these are new parts of our structure and our scope. So I don’t think the metrics have caught up with the incentive plans yet. We don’t really agree on what good metrics are. One of the problems with executive compensation strategies is finding metrics that have some global relevance to them.”

Using access to care as an example, Seligman reminds us, as Pepe did, that if incentive parameters don’t match strategic objectives, progress toward the objectives may be impeded. “If there’s stuff we don’t measure,” he says, “we don’t improve. People may say that access to care is an important goal, but it’s kind of sad how hard it is to measure and how it looks like few people measure it well.” But the absence of metrics today should not impede the industry from making progress.

“Let’s look at how poorly or how well we’re measuring what is supposed to be a very important part of our mission. And then let’s work on it,” says Seligman. “I’m a believer in looking for ways to track the important things as
a way to ultimately improve them. So if we believe in our charitable mission of providing access for people, then I would challenge everyone to tell me how they do that.”

**Incentives: Financial and beyond**

Regardless of one’s approach, we should remember that the point is, indeed, to unite the executive team and by extension the whole organization in support of the mission. And as organizations revisit their mission statements and strategies in light of the requirements of healthcare reform, they are (or should be) revisiting their compensation packages, as well.

As Pepe notes, “In this time of change going from volume to value, you need staff engagement in order to make such a change. If you don’t have engagement, then change becomes quite difficult.” Some “classic” approaches to compensation may have to be abandoned or deemphasized. Pepe continues, “I think that the time has come where we actually reward people for metrics and stop rewarding them because they exist.”

Although Seligman recognizes that rewards based on financial performance are fundamental, he recognizes the need to look beyond. “At Northern Westchester Hospital, the incentive based on the financial performance of the hospital has represented about 25% of the calculation of everyone’s bonuses. That’s a meaningful number, and it’s not changing. But it’s not 40% or 50% or 60%, it’s 25%. Across the industry I think you’ll find the criteria for financial performance may be less prominent, or you’ll see incentives morphing from what had been our economic bottom line, our P&L, to financial metrics that are moving toward the idea of population health management.”

At Enloe, the simplicity of the balanced scorecard and an emphasis on team performance provide both engagement and focus in troubling economic times. Wiltermood says, “When times are tough financially, you have to try to maintain high employee morale at the same time you’re trying to find ways to balance the budget and cut costs. We try very hard to make sure that as we strive for improvement in one area, it doesn’t cost us in another area. Our compensation structure forces us to hold all those things up in front of us at all times, and I think that it’s been pretty effective for us.”

Executive compensation programs can be complex, especially as organizations add facets intending to allow their compensation programs to reflect industry trends, and as operating experience allows organizations to add precision to their metrics. The advantages of such evolution are that attention can be targeted more accurately and executives can place more confidence in what will likely be more precise goals.

A possible disadvantage is that complexity can dilute our attention. Our survey shows that 9% of the value of executive compensation packages is in the form of incentives, which causes one advisor to wonder, considering that the 9% would likely be divided among a handful of performance metrics, whether we are providing sufficient reward to affect behavior. In other words, we should ask ourselves whether the variety that often is the natural by-product of program enhancement actually distracts us instead of providing us more focus. Indeed, that is part of the balancing that comes with implementing executive compensation programs.

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**Intelligence Report: Aligning Incentives and Mission**

**How are incentives split between individual and team goals?**

- **Average based on individual goals:** 45%
- **Average based on team goals:** 55%

**Which aspect of executive compensation has evolved most at your organization over the past two years?**

<table>
<thead>
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<tbody>
<tr>
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<tr>
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<td>Separation package</td>
<td>3%</td>
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<tr>
<td>Other</td>
<td>10%</td>
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There are reasons B. E. Smith has been highly ranked for eight consecutive years. Like the 5000+ professionals we’ve placed in our 35-year history. That’s experience you can trust to guide your healthcare organization through turbulent times.
Attachment 5e - Andrew Lewis bio.docx
Andrew Lewis

West Region Manager

Andrew Lewis is a Principal at Sullivan, Cotter and Associates, Inc. and manages the firm’s business in the western United States. Prior to joining SullivanCotter, Andy was a Partner at Mercer specializing in health care and other tax-exempt organization executive and broad-based compensation. He is a specialist in helping health care institutions restructure their cash compensation programs to be more efficient and reflective of emerging market trends.

Andy brings more than 17 years of consulting experience to SullivanCotter. In addition to his projects with traditional health care organizations, he has worked extensively for tax-exempt research institutions, including Federally Funded Research and Development Centers (FFRDCs) and national labs, as well as think tanks, membership associations and foundations.

Some recent client examples include the following:

- Assisting the compensation committee of a large academic medical center on the design of a new employment contract for the CEO, development of change-in-control and severance agreements and the design of a long-term incentive plan.

- Conducting an audit of the pay programs and policies of a renowned academic medical center in order to facilitate an ongoing clinical integration program across their various subsidiaries.

- Designing a new annual incentive plan for a regional health care system to better align goal difficulty with that of industry peers.
- Advising the board of a large tax-exempt research institution on a new long-term incentive plan design.
- Helping a community hospital to restructure their executive reporting relationships.
- Developing a new job family based salary program for the employees of a large Midwest health care system.
- Working with numerous compensation committees of health care institutions to ensure compliance with IRS intermediate sanctions legislation.

Andy has a Bachelor of Arts in economics from the State University of New York at Geneseo and a Master of Industrial and Labor Relations degree from Cornell University.