BoardBrief

Prepared for Colorado Hospital Association Trustees

Critical Conversations

Leadership Discussions the Board Should Have Now

Hospital leaders must navigate through a complex health care environment that continues to come under increasing examination and debate. The effects of health care reform, changing payment incentives, declining reimbursement, the increasing call for transparency, and scrutiny of health care costs and quality mean that boards today, more than ever, must focus their attention on the most critical issues confronting their organizations.

Critical Conversation # 1: Quality and Patient Safety - It's Job One, So How Well Do You Do It?

The expectation of informed, engaged and active participation in quality oversight and leadership should be the foundation for every board meeting agenda. Attaching a measure to the amount of board meeting time spent on quality is one way to stimulate boards to carry out their quality accountability and raise their level of quality and patient safety knowledge, engagement and effectiveness. Being conscious of the amount of governance time spent on quality will raise its prominence on the list of board priorities. Quality should be at the forefront in board discussions and decisions on just about any subject on the agenda.

How engaged is your board? The "Boards on Board" governance "how-to" guide from the Institute for Healthcare Improvement (IHI) suggests that boards typically fall into one of four categories when it comes to carrying out their quality accountabilities, including board engagement in improving quality and safety, effectiveness, and understanding of quality principles. Put your board to the IHI's quality and safety engagement test by asking which category your board fits, and why:

1. Actively engaged and capable; already leading a high-performance organization and wondering how they can do their board work even better;
2. Actively engaged; often showing that commitment through a high-profile event, but needing a much stronger foundation for continual work on improvement;
3. Not fully engaged, but having strong, latent capabilities and talent on the board; looking to light a fire with the full board, but not sure how to proceed; and
4. Neither engaged nor capable; feeling quality is just fine; viewing quality of care as not the board's proper business, but rather that of the medical and executive leadership.

"Quality fraud." Infusing your agenda with a focus on quality begs another perspective on the board's responsibility for quality and patient safety: the one of compliance, and avoidance of "quality fraud." "Quality fraud" is a term not often heard, but it is one that every board should pay close attention to.

Both the Office of Inspector General (OIG) and the Department of Justice (DOJ) have ramped up their attention to quality and patient safety. Quality is increasingly being linked to reimbursement, and these government agencies want to ensure that patients are receiving the quality of care they are paying for.

Payment for poor quality is viewed by the DOJ as a false claim, and failure to accurately report quality data may be considered potential fraud. Further, both the OIG and the DOJ place the responsibility for quality of care squarely on the shoulders of the board, which means that board engagement and oversight to ensure high quality is paramount.

The OIG and DOJ recommend that boards of trustees consider the following questions, which should be a part of the critical conversations your board has about quality and patient safety:[2]

1. What are the goals of the organization's quality improvement program? What metrics and benchmarks are used to measure progress toward each of these performance goals? How is each goal specifically linked to management accountability?
2. How does the organization measure and improve the quality of patient care? Who are the key management and clinical leaders responsible for these quality and safety programs?
3. How are the organization's quality assessment and improvement processes integrated into overall corporate policies and operations? Are clinical quality standards supported by operational policies? How does management implement and enforce these policies? What internal controls exist to monitor and report on quality metrics?
4. Does the board have a formal orientation and continuing education process that helps members understand external quality and patient safety requirements? Does board membership include expertise in patient safety and quality improvement issues?
5. What information is essential to the board's ability to understand and evaluate the organization's quality assessment and performance improvement programs? Once these performance metrics and benchmarks are established, how frequently does the board receive reports about quality improvement efforts?
6. How are the organization's quality assessment and improvement processes coordinated with its corporate compliance program? How are quality of care and patient safety issues addressed in the organization's risk assessment and corrective action plans?
7. What processes are in place to promote the reporting of quality concerns and medical errors, and to protect those who ask questions and report problems? What guidelines exist for reporting quality and patient safety concerns to the board?
8. Are human and other resources adequate to support patient safety and clinical quality? How are proposed changes in resource allocation evaluated from the perspective of clinical quality and patient care? Are systems in place to provide adequate resources to account for differences in patient acuity and care needs?
9. Do the organization's competency assessment and training, credentialing, and peer review processes adequately recognize the necessary focus on clinical quality and patient safety issues?
10. How are "adverse patient events" and other medical errors identified, analyzed, reported, and incorporated into the organization's performance improvement activities? How do management and the board address quality deficiencies without unnecessarily increasing the organization's liability exposure?

Critical Conversation #2: Executive Compensation: Can You Defend It?

Wall Street financial executives aren't the only ones finding their compensation the subject of news headlines. Increasingly, the glare of publicity is turning on hospital executives as well.

The IRS' Form 990 is designed to provide greater transparency into executive compensation. Boards should take action to make sure they carry out a sound and defensible compensation process, including:[3]

- Establishing a comprehensive, written process for evaluating executive compensation;
- Ensuring that no conflict of interest exists for trustees evaluating and approving executive compensation;
- Comparing the executive's compensation and benefits to that of other similarly situated executives using independent data, surveys and compensation consultants;
- Evaluating and accounting for executive performance against pre-established goals; and
- Documenting the board's processes, considerations and decisions.

To ensure that executive compensation reviews are rock-solid, hospital boards of trustees should engage in a critical conversation that answers these questions:

- Is the CEO's full compensation and benefits package documented in a written employment contract?
- Does the board have and adhere to a conflict of interest policy? Is that policy applied to compensation and benefit reviews and decisions?
- Does the board have a compensation committee? If so, is there a policy specifying criteria for committee selection? Do those criteria include freedom from conflicts of interest?

- Does the hospital have a written policy establishing criteria for hiring a compensation consultant, and requiring the consultant to be free of conflicts of interest?
- Have compensation evaluations included comparison with compensation and benefits offered by similar organizations?
- Could nonqualified deferred compensation and/or retirement plans offered by the organization be considered "excessive?"
- Have executive benefits been recently reviewed? Are CEO travel and other benefits governed by a written policy and monitored by the board?
- Is the CEO's compensation tied to achievement of documented performance measures?

Critical Conversation #3: Community Benefit - How Do You Measure Up?

The lack of a quantifiable measure for community benefit has become a source of debate. At the center of the debate is whether the community benefit provided by hospitals is commensurate with the tax-exempt benefits they receive. According to Steven T. Miller, Commissioner for Tax Exempt and Government Entities of the IRS, the goal of Form 990 revisions, and specifically the creation of Schedule H, was to create transparency for hospital practices that in turn provide for a more-informed review and decision-making process regarding the community benefit standard.[1]

As allegations of excessive compensation and inequitable levels of charity care and community benefit draw scrutiny and attention, trustees need to engage in a critical conversation that seeks answers to these questions: [2,3]

- Does the hospital's mission clearly affirm the hospital's commitment to serving the community's health care needs?
- Has a community needs assessment been recently conducted? Can the organization's strategic initiatives be clearly tied to the highest priority needs identified in the assessment?
- Does the hospital have a written financial assistance and charity care policy? Is eligibility clearly defined? How do patients learn about its availability?
- Have the policy and eligibility been reviewed in response to increasing community needs resulting from economic pressures?
- Has the hospital clearly and comprehensively defined the amount and types of community benefit it provides?
- Is the hospital separating bad debt, Medicare and Medicaid shortfalls from charity care and community benefit activities?
- Does the hospital have a written bad debt policy? Has the board recently reviewed it, and is the board aware of how it's applied in the current recession?
- Will the hospital's level of community benefit stand up to public scrutiny?
- How comprehensive is the hospital's community benefit report? Does it capture all facets of the benefits provided by the hospital? Does it effectively tell the hospital's full community benefit story to the community?

Critical Conversation #4: The Board's Role in Difficult Economic Times

The financial effects of the economic recession and now health care transformation on hospitals are well-evident, and trustees must demonstrate strong leadership to navigate through the economic challenges of declining patient volumes, a changing reimbursement system, payment cuts, growth in expenses that outpace sluggish revenue growth, and more. [1,2]

Engaged participation in board meetings and a detailed understanding of financial issues has never been more important for trustees. Board conversations should include:

- *Constant oversight of the hospital's financial performance*. Trustees must think openly and broadly, and work together with senior leaders and medical staff leaders to find new solutions for pressing financial issues.
- *Regular review of progress on strategic plan initiatives.* The board should evaluate if strategic initiatives are being impacted by financial restraints, and if they should be adjusted or reprioritized to account for changing circumstances. Trustees should take into consideration the implications of making adjustments, and the risks of not taking action.
- *Discussion of subsidized and uncompensated care needs in the community.* The board must understand how health care needs are trending, if the organization has the resources to continue to meet changing needs, and what plans are in place to support those resources if the trend continues for the foreseeable future.

- *Continued evaluation of charitable giving levels.* Has the board developed and implemented a detailed and strategic fundraising plan? Are strategies being tracked and plans adjusted accordingly? Are new and innovative opportunities being developed? Are donor relationships being nurtured? Is hospital news shared, and are there opportunities for donors to interact with senior leaders and the board?

Critical Conversation #5: Hospital and Medical Staff - Partners in Care

The delivery of care is shifting from traditional structures to models that incorporate integrated approaches, continuums of care, quality outcome measures, and shared financial risk. The ability to deliver high quality care and improve health outcomes while managing costs will significantly determine hospitals' and health systems' ability to succeed in a value-based health care environment.[3] To succeed in today's changing health care environment, hospitals and their medical staffs must be closely aligned and work collaboratively to provide complete care for patients, as well as to manage and improve the health of a population.

New structures of care and payment systems are designed to incentivize coordination of care and quality outcomes versus fee-for-service payments which have typically been viewed as payments for volume of care.[1] Early examples of value-based care delivery models in which hospitals and medical staff must succeed as collaborative partners include CMS demonstration programs which were designed to evaluate hospital/physician collaboration coupled with global payment and permitted gainsharing, or sharing of cost savings between hospitals and physicians (examples include Medical Hospital Gainsharing, Physician Hospital Collaboration Demonstration, Acute Care Episode Demonstration).[2]

New payment systems, many of which have been implemented under the Patient Protection and Affordable Care Act (ACA), include shared savings and risk, bundled and capitated payments, and penalties for low quality of care scores and high readmissions. The se payment systems, coupled with the shift in delivery of care settings from acute hospitals settings to outpatient and ambulatory settings, are also driving forces behind the need for hospitals and physicians to ensure strong collaborative partnerships.

Despite these forces, the *2014 Industry Survey: Forging Healthcare's New Financial Foundation* conducted by Health Leaders Media suggests a lack of readiness to assume risk and establish agreements based on results with care partners. Monitoring care along the continuum was found in the survey to be one of the greatest challenges to clinical quality improvement, a challenge which will require strong medical staff partnerships to overcome.[4]

More than half the hospitals and health systems responding to the survey also indicated that addressing physician-hospital alignment is among their top three priorities for achieving financial goals. However, only a third of physicians included this alignment among their top three priorities. HealthLeaders analyst, Michael Zeis, noted this may indicate difficulties for hospitals and health systems as they move forward in today's transforming health care environment.[4]

While collaboration has always been important, today hospital leadership must be a positive, collaborative, results-producing effort between the administration, the medical staff and the board of trustees. The medical staff must participate meaningfully in hospital governance, and actively contribute to strategic directions and decisions. Board members must act as catalysts for physician participation, and ensure that decisions benefit both at-large community interests as well as the interests of the physician community. Board members must assure that discussions and analysis are mission-driven, and meet conflict of interest standards. Finally, trustees must consistently monitor strategic direction, and hold both managers and physicians accountable for achieving targeted outcomes.

Nurturing a trust-based board/medical staff relationship helps ensure the hospital's ability to respond most effectively to future issues, challenges and changing payment and care delivery structures. Consider the following suggestions for building trust between hospital leadership and the medical staff:

1. *Develop a formal hospital/physician relationship.* Hospitals can increase market share by systematically seeking physicians' input and aggressively addressing their concerns.
2. *Pursue the joint development of ancillary services.* Health care organizations and physician groups should seek opportunities to form mutually beneficial partnerships to expand or reinvigorate these services.
3. *Involve physicians in leadership.* When physicians and hospitals work in the spirit of partnership facing strategic issues, that spirit goes a long way toward ensuring mutual success.

4. *Offer physicians choice.* Individual relationships should be pursued that meet the interests and comfort levels of both specialists and primary care physicians, rather than a "one-size-fits-all approach."
5. *Stick to the basics.* Establish a foundation of trust, a demonstrated economic benefit for all parties, and a shared commitment to meeting community health needs.

A critical conversation about hospital/medical staff relations alignment may include:

- What leadership roles do physicians hold in our organization?
- What roles could or should the organization consider physicians for?
- What skills, experience or attitudes are important in physician leadership positions?
- Are physicians properly prepared to take on leadership positions?
- How can the hospital help physicians prepare for leadership opportunities? Should or can the hospital develop a physician leadership development program?[9]
- What opportunities for hospital/physician collaboration may be pursued?
- If gainsharing programs, integrated hospital/physician contracts, or similar hospital/physician opportunities presented themselves, is the organization ready to take advantage of them?
- What is the medical staff's perspective on these questions? Has the board heard and listened to first-hand accounts of physician views?

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