



GOVERNING BOARD MANUAL



Without a doubt, the unsung heroes of our rural hospitals are the more than five hundred citizens who serve as members of the governing boards. They are rarely in the limelight, and that is the way it should be. They spend countless hours every month preparing for, then attending and participating in, their respective board meetings. They are grocers, teachers, car dealers, bankers, carpenters, moms, and retirees; and they are thrust into a very complex, highly-charged environment where the stakes could not be higher and asked to take ultimate responsibility for the overall care provided by the hospital.

In our small, rural Illinois towns, the hospital is usually the largest or nearly the largest employer and an important ingredient to the vitality of the community. The hospital requires local community representatives to govern its operations. To do so, we ask common folks to serve on governing bodies and provide oversight for melting pots of people and emotions. We ask them to serve as overseers of a huge composite of healthcare services rendered to their fellow citizens. We don't pay them a cent, yet they are asked to make decisions on life and death policies and approve multi-million dollar budgets and expenses.

Now, just who in their right minds would agree to serve on a hospital board? Where do these folks come from? More often than not, board members agree to serve without having any idea of what the job entails. After about three months, they wonder why they ever agreed. After about a year, they become fascinated by their hospital and begin to know their contributions are vital. They quickly realize how much our hospitals depend on their leadership and commitment.

Governing board members are special people and are to be held in the highest of regard. We sincerely hope the articles in this Manual will help them better understand the tasks before them and reassure them that their problems are far from unique.

Ada Bair, President
Board of Directors, ICAHN

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You Wanted to Be a Board Member? A Board Member's Perspective

by Tom Vaughn, Member, Board of Directors, Franklin Hospital, Benton, Illinois

In the early 1990s, a good friend and county board member came to me and said that there was an opening on the county's hospital board. "You need to take this appointment," he said. "The hospital runs itself. You just go to a board meeting once a month."

I was thinking about the former friend a few years later as I sat in the commons area of the nursing home attached to the facility and made the motion to close the county's only remaining hospital. The large area health care corporation had given up trying to make it a viable entity and was leaving. It was about as low as I've ever felt.

Eight years later, the hospital is still functioning, coming from the ashes of that moment and providing quality healthcare, good jobs and, in many instances, saving lives. The rise from that lowest moment to our present condition is a happy story in itself. Suffice it to say that it is gratifying these several years later to still be thanked for the job we did in avoiding the unthinkable.

Our first and best decision as a board was to hire a tireless and imaginative CEO. Following that choice and under his guidance, we took the hospital to critical access status. I then suggested we rename the facility "Lazarus Hospital." I later agreed that was too irreverent, but it clearly indicated what we, as a board under duress and with our entire supportive community, had done.

I report these things, not to dissuade anyone from ever wanting to become a hospital board member for one of these vital community healthcare resources, but to encourage and support those who wish to do the unenviable job of stepping up to be a "doer" instead of a "watcher." You will become that rarest of commodities in today's social climate: a true public servant. You are that classic person who is not afraid of what happens next.

The role of the board member is to be the eyes and ears of the community served, not to "run a hospital." You ensure that the hospital is operated effectively. It is the classic job of overseers, who view the operation as a whole from a high altitude and not attempt to operate the hospital the board visits only monthly.

The board member generally serves with a diverse group of individuals who each bring his or her own knowledge and experience into play. This diversity is the board's strength. Regardless of political bias or basic philosophies, the most important aspect of this collection is that board members form a viable, effective group, united by their common goal: the welfare of their hospital. I consider the most important aspect of the mission to be personal selflessness on the part of the members to the point that the individuals become close allies. You take personal possession of everything in this environment. It's "your hospital," "your CEO" (until you give him away), and "your board."

I wouldn't serve on a board where there were personal agendas or any degree of rancor. I would not resign; I would just do little else until the job of changing that environment was done. Board members automatically have a commonality of purpose. You all have the same mission, and it is the hospital's mission statement. In almost every situation and meeting, you will be the only folks in the room that do not make money through the healthcare entity you govern.

So what is the job? It's first, foremost, and always to learn. It starts out this way and it continues. One of the best pieces of advice I've ever received is, "Shut up and pay attention." This accelerates understanding, but does it mean new board members should keep their mouths shut in their early experience? No! Questions you will ask will speed your learning. The fearlessness to ask these questions, even if they may seem silly in later reflection, is one of the qualities you have that made someone ask you to serve in the first place. Board service, just like growing old, is not for "sissies."

THE BOARD MEMBER'S ROLE

There are opportunities to gain knowledge everywhere. Sources range from orientation tours and conversations with your CEO, to board retreat conferences, to tremendous reference materials available online on virtually any aspect of healthcare. Increasing your knowledge of the realities of your hospital's operation and the world of healthcare in general will make you a better board member every year.

It is important, however, not to be overwhelmed by the information available to you. There are publications and in-service opportunities on an endless list of board concerns and responsibilities, many coming from people who make money from providing these things. If you were to participate in all of the training offered, you should receive a six-figure salary because you would need to quit your present employment.

There are several things you as a board member are not. You are not someone who is going to "fix that hospital." You have one-ninth of the authority to fix it, and your power is only in effect during the time between, "I call this meeting to order" and "the meeting is adjourned." Your job is to make and change policy, provide oversight, and make decisions about the organization's vision, mission, and strategies. The most important decision you make, as was ours, is in hiring a CEO. Your most important role is advocate for your hospital.

You are not someone who is going to secure employment for others. The hospital environment is no place for someone to be employed by the organization simply because you know them. Your desire is that your appointment to the board benefits the hospital only. I cannot imagine anything more detrimental to my role as a sailor on this ship than "bringing a rat on board."

You are not to be a channel for the public's anger. Any complaint you bring to your CEO that begins with, "What the hell is . . ." or "We need to fire . . ." is an example of a board member who lacks the capacity to help reconcile our shortcoming in meeting a citizen's expectations. You're part of a team that cares, and you love complaints brought to you by your public, especially when you can convince them to tell us before they tell others.

Possibly one of the most discouraging things for board members to hear is a story of their hospital's failure to succeed when you know how hard everyone is trying. This trying so hard together is what binds us as board members. Every time I attend a wider hospital function and meet another hospital board member, there is this same sense of commonality.

No, your hospital is not going to "run itself." Hopefully, the common sense and abilities of your fellow board members and you, with the effective group you form, will make it seem as if it does. Talented people make hard things look easy. The board's historic decision to become a critical access hospital and finally heeding the counsel of an individual who still serves the ICAHN network are "homeruns" among the decisions we've made. As a board member, don't ever forget the difference you can make. And don't forget to have some fun along the way.

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The Board Member's Role in Advocacy

by D. David Sniff

“Get the word out” is most appropriate in advocacy and for rural hospitals. There can be no better advocate than a board member. Why? For many reasons . . .

First, you, the board member, have an altruistic purpose in serving your hospital. Legislators, of course, know the CEO, other officers of the hospital, or association professionals who are paid to advocate for hospitals; it's their jobs! The fact remains that the legislators understand the difference in roles of a hospital board member versus a paid employee.

Second, many board members have advocacy experience in their own professions. Others are on a first-name basis or at least acquainted with elected officials in their districts. You may have worked with the legislator through the political party, his or her campaign, or even have a business relationship with the legislator.

Last, legislators know you are a volunteer taking time away from your job or business on behalf of the hospital.

Board members can be perfect advocates!

Where to start

Information is developed and provided to CEOs by the trade associations. Your hospital is often then asked to provide local and real-life anecdotal information so as to make the case more relevant to your legislator.

You can speak to your legislators from personal experience, which often has far more impact than statistical, financial, or other data they receive from the “hired advocates.” You can share real life stories of family, relatives, or friends. A word of caution: do not use names or other identifying information when sharing real-life stories. Use terms such as cousin, an aunt, etc. Tell them about how many people would have to travel great distances to access healthcare if it weren't for your hospital. Talk about how the hospital is a vital part of the local economy. Talk about the number of jobs that it creates. The personal stories should be easiest for you and make the most impact on your legislator.

Remember, we rural hospitals are dependent on government payors for survival. Simple math reveals that the financial and operating destiny of a CAH comes from federal and state government. For CAHs, most of the revenue comes from Medicare and Medicaid. This combined figure ranges from forty to eighty percent, depending on the hospital. It would be good for you to know some of the basic facts such as these about your hospital. Legislative and regulatory changes can have substantial impact on every aspect of the hospital from staffing requirements to physical plant. With that much at stake, it is incumbent upon all board members to participate in advocacy.

You have to be involved for the sake of your hospital and all rural hospitals . . .

The CEO or his or her staff will provide you with regular reports of local, state and federal actions that will impact your hospital. The CEO will periodically receive action alerts from a variety of associations. At times board members may be called upon to give that added touch that will help to get the hospital's story conveyed to the legislator.

But I am very uncomfortable or really can't do a face-to-face meeting with a legislator, so what can I do instead?

Being in front of an elected official face-to-face is generally preferred when critical issues are at stake, but some board members are uncomfortable in this role even if all the needed information has been provided to the board member. You may not be able take the time to be away from your job or business. That's understandable, but you can still be involved. Either call or e-mail your legislator with your concerns, thoughts, or experiences when asked by the CEO.

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The CEO may provide you with information ahead of time or can assist you in drafting an e-mail or letter. If you receive a “form letter” to send, it is best if you can alter some of the language to personalize the message so that all emails or letters don't appear as if they were run off a copy machine. When calling, have some crib notes in front of you. Generally, you should limit your message to two or three points. If you have an exhaustive list, your primary purpose will fail.

Further, if by phone, you may be referred to a legislative assistant for health or another L. A. In that event, you may be speaking with someone who doesn't have much depth in hospital operations. That's all right. If he or she asks you questions you cannot answer, jot them down and tell him or her you, or your CEO will get an answer for them. In any event, someone needs to follow-up!

Participate when your hospital organizes an advocacy day or hosts your elected official at the hospital. You don't have to give a “speech” or do anything more than meet and greet. Legislators are impacted by who is present and the number of participants. They need to know and assuredly will recognize that the governance and the community are truly behind their hospital.

Make it a point to visit when you don't have to.

If you are comfortable in calling on an elected official, you will have more impact if you make an opportunity to visit the legislator and key staff in his or her office at times other than when you are making a request. You may be seeing them as a part of your business or at other occasions. Thank the legislator for his or her support of the hospital.

In any event, when called upon, please get involved . . . Get the word out!

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Governing Board Development

by Charles A. Wells, Jr.

Postulates

1. The most critical success factor for a hospital is the performance of the board. Good boards attract, nurture, and retain good leadership. Bad boards do not.
2. A hospital in a rural community is one of the most important institutions, in close competition with the local school district for #1.
3. No hospital = no doctors = lack of access to care = loss of economic vitality and citizens' sense of wellbeing.
4. Good boards are made not born.

In presentations made at meetings attended by hospital board members, I refer to the Seven Deadly Sins of Board Governance:

- Poor board/CEO interaction
- Failure to act/think strategically
- Paralysis of consensus
- Personal agendas/conflicts of interest
- Failure to deal with destructive board member(s)
- Micromanagement
- Failure to understand the basics of the industry

Importance of Leadership

A high-performing board requires quality leadership in order to avoid these deadly sins. Many organizations design their board terms and term limits to facilitate an orderly progression of leaders, such as three three-year terms. New members with promise are observed and nurtured during their first term in preparation for a leadership role during their subsequent terms.

Leadership qualities should be important considerations in recruiting new members. Needs for differing viewpoints, work expertise, and diversity are important considerations of board recruiting, but leadership potential should rank foremost among these. Does the candidate have the potential to rise to board chair? It is important to build a pool from which future leaders can emerge.

Board leadership may be called upon for some of the most difficult tasks that a CEO cannot do: managing a crisis such as a major dispute with physicians, addressing a destructive board member, diffusing contentious conflicts among the board, and firing a CEO. Such a person should be smart and ethical, command respect in the community, be willing to manage conflict, and be willing to learn the business. The saying "lead, follow, or get out of the way" applies to hospital boards.

If you agree with postulates 1, 2, and 3 above, then the board should be able to make a case of the importance of getting the right people to serve. Seek the guidance of the smartest, most honorable people in town to either join the board or recommend talented people willing to devote the time to do the job well.

THE BOARD MEMBER'S ROLE

CEO/Board Relationships

The board has one, and only one, employee with a direct reporting relationship: the CEO. As such, a significant portion of the board's energy needs to be directed at this relationship. Establish a formal evaluation process for the CEO's performance. Work with the CEO to set measurable goals in critical areas: relationship with doctors, fiscal management, quality indicators, board relations, employee relations, community relations, professional characteristics, and strategic planning. Set realistic goals against which performance can be measured, require that each board member provide written input, and meet at least annually with the CEO to review the responses. The less quantifiable the goals and the more informal the process, the more vulnerable the CEO becomes to evaluation by anecdote or the crisis du jour. This process can also serve as a quasi-strategic planning exercise for the board.

Board Development

Board members should also assess their own performance. Spend time establishing norms of behavior: timeliness, preparedness, confidentiality, group dynamics, fiduciary duty, and the golden rule. Board orientation for new members is extremely important. The CEO should guide the educational process for new and existing board members to consider the following: **a)** the unique aspects of physician relationships, where doctors in your employ and on your staff are also your customers and indirectly your bosses; **b)** the varying bodies of law guiding all transactions: Medicare, HIPAA, Stark, IRS, Medicaid, medical malpractice, etc; **c)** the importance and liability associated with the credentialing process; **d)** the impact of payer mix on profitability and the difference between gross charges and net revenue; **e)** clinical complexities; **f)** contracting with insurance companies; **g)** the strategic importance of balance sheet management that will foretell the destiny of the organization; and, **h)** what it means to be an effective board member. A constructive member will invest the time to understand these complexities.

Conduct of the Board Meeting

The best meetings devote half of their time to board education and strategic issues. Minimize time on the trivial such as review of payables or detailed explanations of immaterial variances in the monthly financial statements. One of the most important tasks for board members is preparing themselves for the seminal moments in the life of the hospital, i.e. becoming a CAH, undertaking major financing, merging with a larger entity, adding or closing a service, and changing CEOs. A 30-minute discussion on a lone complaint in ER doesn't further that goal.

Time Horizon

Remember the differing time horizons of the various constituencies within a hospital. The physicians and nurses live with the immediacy of the needs of the patient they are treating. The CEO must ensure that the right people, material, and facilities are in place for the front-line care-givers. The board must look at the longer-term needs of the community and take the steps necessary to ensure the long-term viability of the institution.

Dealing with Destructive Board Members

A destructive board member undermines the efforts of the hospital, distorts positions in the community, leaks sensitive information, would rather destroy the organization than lose an argument, often seeks to fire the CEO, and may have serious conflicts of interest. The CEO cannot be put in the position of dealing with a flagitious board member. This is where the board leadership must rise to the occasion.

Specific Tips:

1. **Invest generously in board education** – Encourage members to attend industry sessions sponsored by AHA, state and regional associations, Greeley, Aspen Institute, Estes Park, etc. Focus on rural hospital meetings.
2. **Follow developments in national health reform closely**, particularly how it might impact Critical Access Hospitals.

3. **Develop** a *trust/confidence relationship* with outside professionals knowledgeable in matters pertaining to CAHs such as your auditor and attorney. Remember the auditor reports to the board.
4. **Resist** the *urge to be the expert* and impinge on management responsibilities.
5. **Engage** *board members in strategic planning*—Set aside a minimum of one day per year to this effort. Devote 50% of the time for education with outside/inside speakers and the remainder of the time actively engaging the board on the matters that keep the CEO awake at night.
6. **Create** a *forum for quiet board members*—The most vocal aren't necessarily the wisest. Work with the board chair to identify opportunities to seek input from the silent majority.
7. **Recruit** *several board members* who earn more money than the CEO. Salary envy can be a very destructive force.

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Community Relations: Up Close and Personal

by Bill Spittler & Curt Zimmerman

Governing board members serving hospitals in small rural communities experience unique challenges and opportunities not shared by board members that serve hospitals in larger communities. Community trust is vital to a small community hospital, and the members that govern the critical access hospital are the face of the organization that is more often seen by the public. This article will explore some of the dynamics of this unique situation. Governing board members act as a conduit of information which flows in both directions:

- Board members are often the first alarm to sound when there is a problem or situation that involves the hospital;
- They are in a unique position because they are so intertwined in the community;
- Board members need to communicate quickly with their CEO when a problem or community need is detected, as these can be both real or perceived;
- Board members are also responsible for representing the hospital within the community;
- They need to be the 'face out there'; to let residents of the community know that they are personally involved with and support the decisions made at the hospital. They need to interpret to the community what is happening at the hospital, and bring community feedback to the hospital leadership.

Every hospital has nay-sayers and critics residing within the community. These are people who simply do not like the hospital, and who rarely miss an opportunity to say something negative about the institution. They may be a disgruntled current or former employee. They may be a staff member of a physician who has had unfortunate dealings with the hospital or board. In most cases, their friends already know of their bias, and will take what they say with a "grain of salt." Often, these are the same people who are quick to run to a hospital in the next town, or go to the nearest larger city to get their hair done. Board members already know who these people are, and serve from an excellent vantage point to isolate them and the harm they may cause to the hospital and its operations.

Above all, governing board members need to prevent further negativism from the detractors by taking actions of questionable propriety, having or appearing to have conflicts of interest, sharing confidential information or spreading gossip within the community. If a board member's relative is employed at the hospital, a red flag is often raised. If the hospital purchases a car from a dealer who sits on the hospital board, motives may be questioned. Governing a small community hospital properly and fairly is difficult enough, without board members creating additional sets of problems and circumstances which may be interpreted by the community as being self-serving, or using their board position for individual personal advantage. [1] Board members always have a duty to place the interests of the hospital ahead of their own personal interests. [1]

Given the size of a CAH hospital's workforce and the relative population of the community served, as much as one-third of the people in the community can sometimes be either employed by the hospital, or have close friends or relatives who are employed there. Hospitals in small towns are virtual glass houses. Board members are often in a unique position to interpret to the community what is happening inside that house. People can see things happening, but they are often not certain of what to make of them.

Board members have an obligation to bring their best thinking and experience to the board table, so the best possible decisions can be reached. However, board members also have a duty to rally around those decisions, once made, and support them publicly. If a board member is unable to support the decisions of the board, then that board member may do the hospital great harm in the eyes of the public.

THE BOARD MEMBER'S ROLE

Governing board members and the CAH hospitals they serve embody a great voluntary spirit, and their contributions are invaluable. It is imperative that hospital leaders and governing boards give priority to maintaining the values and traditions of their community. To accomplish this, board members must understand the important roles that they and their hospitals serve and be good stewards and active spokespersons for their healthcare institutions.

End Notes

[1] "Fiduciary Duties of Non-Profit Board Members", by Floyd D. Perkins, Chief, Charitable Trusts Bureau, Illinois Attorney General, a monogram available from ICAHN.

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Understanding Financial Reports

by Hervey Davis, CEO and Howard Schou, CFO, Franklin Hospital, Benton, Illinois

When it comes to the presentation of the financial reports at the monthly Board of Directors meeting, there are a myriad of methods in which this presentation is made. There is no right or wrong method; it's what works best at each location. Each hospital presents different reports including the required balance sheet, income statement and statement of cash flows. Some may present fewer reports, some more. Other hospitals may include financial ratios, FTE reports, variances between budgeted figures and actual on a monthly and year-to-date basis, statistical analysis, patient loads by department, etc.

Board members come from all walks of life. They may be teachers, business owners, bankers, accountants, or attorneys, but all are concerned community leaders. Some may have more experience reading a set of financial reports than do others. The thing to remember is that each board member has the responsibility to get training in this critical area. Whether it comes from outside training or a hospital employee such as the Chief Executive Officer, Chief Financial Officer or Controller, knowledge of what is being reported and how the reports flow is imperative.

The key factor is that board members have the responsibility to obtain a good general understanding of what is happening at their hospital from a financial perspective on a monthly and year-to-date basis. Timely financial reports must be prepared accurately and should be clear and concise. The reports should be in the hands of the board members prior to the scheduled meeting to allow them to review the reports and ask questions either before or during the financial report portion of the meeting agenda. From a presentation prospective, it is always good to review the balance sheet and point out some of the areas that may vary from month to month such as accounts receivable, accounts payable, changes in short or long-term debt, accrued expenses or taxes payable.

The income statement is the most important document to review. Variances between budgeted figures and actual figures require explanations. Significant variances need to be explained as the income statement is presented in order of revenues, deductions from revenues, other revenues, expenses, non-operating revenues and expenses, and profitability. Time needs to be spent on the income statement as it is the heartbeat of the operation.

Another report that is required to be included in the financial presentation is the statement of cash flows. It is a difficult report to understand but shows the uses and sources of the hospital's cash. It reflects changes in the balance sheet accounts involving cash. Financial ratios are sometimes presented and discussed. Ratios which might be reported include profitability (i.e., "operating margin" and "return on equity"), liquidity (i.e., "days in accounts receivable" or "cash on hand"), and capital ratios (i.e., "long term debt to equity"). There are a number of other ratios that may be calculated monthly and presented. A breakdown of the activities in each hospital department may also be presented in terms of dollar amounts or as a percentage of variances for departmental statistics, revenues/expenses, or profits/losses. Many times Excel spreadsheets or graphs and charts can be prepared to better show these changes.

The financial reports presentation during the board meeting should not be rushed as it is one of the more important topics discussed. Board members should be comfortable to ask questions. If the answers are not immediately available, then they should be provided within a short period of time. Take time to become familiar with the information presented in the financial reports as it is vital to the direction and success of your hospital. It is imperative that if you need help understanding the financial reports, do not hesitate to schedule a time with the hospital's CEO, CFO, or Controller. They are there to help and answer your questions.

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Duty to Govern

by Lisa Harms Hartzler and Michelle P. Clatfelter of Sorling, Northrup, Hanna, Cullen & Cochran law office

Critical Access Hospital board members are well-respected community leaders who bring a variety of valuable experiences and skills to the board room. Few, however, have any specialized knowledge of the unique complexities of running a hospital or the intricate health care regulatory environment. Nevertheless, all board members can excel in their positions by remembering that they are called to govern the hospital, not operate it.

While the management team runs the day-to-day affairs of the hospital, the governing board bears the ultimate responsibility of holding the organization accountable to its corporate purposes and goals as stated in its charter. In the not-for-profit or public hospital context, a director is a trustee for the hospital's assets, which is the reason why many board members are called "trustees." In fulfilling this public trust, two questions will always be relevant to governing decisions: "How does this action or activity further our mission as stated in our Articles of Incorporation?" and, "Is this the best means for achieving those goals?"

In answering these questions, a board member is burdened under the law with a "duty of care." [1] This duty to govern with care requires each director to act in good faith, with the care an ordinary prudent person in a like position would exercise under similar circumstances, and in a manner the director reasonably believes to be in the organization's best interests. To fulfill this duty, a director must be familiar with the hospital's activities and know whether those activities promote the organization's mission and achieve its goals; be fully informed about the hospital's financial status; and have full and accurate information to make informed decisions. [2] In addition, a hospital director needs to be aware that many legitimate ways of doing business in other industries can be unlawful in the realm of health care. Directors should ask to be educated about these unique aspects of law for the health care industry. Armed with adequate information, each director will be able to apply his or her own knowledge and expertise to engage in governing with care.

Governing with care requires activities that fall into two categories. These activities are not management activities. Instead, they guide and review the management team.

1. **The Board sets policies.** Policies are rules and guidelines for making decisions—not actual day-to-day decision-making. Important financial policies for hospitals include those governing administrative expenditures, internal controls, purchasing, gift acceptance, fundraising expenditures, endowment spending, and permitted investments. Some policies may require certain decisions exceeding a dollar threshold to have board approval; some simply guide management's ability to run the hospital. Other important policies involve compliance with federal and state laws, charity care, conflicts of interest, and document retention and destruction.

The board must also take the lead in establishing a policy of compliance, transparency, and trust within the organization. It fosters this kind of environment by requiring procedures to report potential violations, reacting to reports in a non-defensive manner, and protecting whistleblowers. The board should establish a code of conduct for itself, the CEO and all employees or staff associated with the organization.

2. **The Board engages in active oversight.** Board members should avoid micro-managing the hospital's administrative team. At the same time, to fulfill their duty of care, they are required to engage in active oversight. They actively oversee in many ways. [3]

For example, a board should:

- select the top executive and assesses his or her performance (let the CEO do his or her job);
- review, authorize and recommend major changes and commitments;

COMPLIANCE & FIDUCIARY RESPONSIBILITY

- annually review strategic business plans, financial goals and objectives, policies, insurance arrangements, and risk management reports;
- assure that medical staff credentialing procedures are adequate;
- become educated regarding hospital licensure, health care fraud and abuse statutes, privacy laws, and other regulatory requirements;
- critically review reports and recommendations from staff;
- regularly review and understand financial statements;
- approve and engage outside auditors.

A board should expect competent reports, analyses and proposals from its administrators, but it needs to assess these documents in light of its duty of care: how do they fulfill the corporate mission, are they the right response to corporate needs, are they based on appropriate assumptions and data, and are there compliance, ethical, or other issues that have been overlooked? Reports are also a great way to get educated about the business of the hospital. A good director will be able to say, “I’ve always been a bit confused about ‘x.’ Can you spend a minute explaining where it comes from?”

Directors are responsible for the fiscal integrity of the hospital and, therefore, must demand a transparent and realistic financial picture. They insist on accurate records, complete financial statements, truthful IRS tax-exempt returns, and complete Illinois Attorney General filings. Outside audits and disinterested compensation committees help the board maintain this fiscal integrity, but every director must feel accountable for, and have confidence in, the financial information presented to the public and to the government.

Boards use committees to accomplish many oversight activities. The finance and audit committee is an important tool for analyzing the specifics of proposed budgets, salaries, audits and other financial information. A nominating committee can be charged with recruiting new board members and preparing officer nominations. Other committees will be able to review issues in more detail than the time allotted for board meetings. Directors should be able to review committee reports with confidence that the committees have done their jobs, but they also need to remember that they are ultimately responsible for assuring that the purpose and goals of the hospital are being met and that the hospital complies with applicable laws and regulations.

Serving up enough information to permit board members to exercise their duty of care without inundating them with the minutiae of running a complex organization requires vigilant work by the Board Chairman, the CEO and the CFO. Board members should insist on this balance that will enable them to govern the hospital, not operate it.

End Notes

[1] Directors also have a “duty of loyalty” to their organization. See the article in this Manual entitled “Conflicts of Interest.”

[2] See *Davis v. Dyson*, 387 Ill. App. 3d 676, 692-696 (1st Dist. 2008); *Stamp v. Touche Ross & Co.*, 263 Ill. App. 3d 1010, 1015 (1st Dist. 1993).

[3] For further information on governance, see the Illinois Attorney General's website under “Building Better Charities” at www.illinoisattorneygeneral.gov/charities/index.html; for a discussion of governance by the Internal Revenue Service, see “Governance and Related Topics – 501(c)(3) Organizations” at www.irs.gov/pub/irs-tege/governance_practices.pdf; more specific information can be found in “Illinois Nonprofit Principles and Best Practices” under Especially for Nonprofits at www.donorsforum.org; for detailed instruction on corporate governance, see *Guidebook for Directors of Nonprofit Corporations* (2nd Ed.) published by the American Bar Association and available for purchase at www.abanet.org.

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The Governance Role in Compliance—A Briefing

by Betty Kasparie, Compliance Officer, Illini Community Hospital, Pittsfield, Illinois

A compliance program is an active plan of action for how an organization reacts to regulatory requirements and changes in a proactive manner in order to keep an organization in good standing. The plan should address all payers, accrediting bodies, surveying bodies, etc. Compliance programs are not unique to health care, but have recently moved from voluntary status to mandatory for health care providers that accept Medicare or Medicaid payments, as a result of the new health care reform signed in 2010.

The governance role is to reasonably oversee the implementation of an effective compliance program to ensure that personnel are aware and take steps to comply with relevant laws and regulations. According to the U.S. Department of Justice memorandum in 2006, this oversight function is to determine “whether the program is adequately designed for maximum effectiveness in preventing and detecting wrongdoing by employees and whether corporate management is enforcing the program or is tacitly encouraging or pressing employees to engage in misconduct to achieve business objectives.” [1]

In 1998, the OIG (Office of Inspector General, U. S. Department of Health and Human Services) published compliance program guidance for hospitals, and in 2004 a supplemental compliance program document was released. The OIG has identified the following minimum elements for a compliance program:

1. the development and distribution of written standards of conduct as well as written policies and procedures that promote the hospital’s commitment to compliance;
2. the designation of a chief compliance officer and appropriate committees charged with the responsibility of operating and monitoring the program and who report directly to the CEO and the governing body;
3. the development and implementation of regular, effective education and training programs for all affected employees;
4. the maintenance of a process to receive complaints and the adoption of procedures to protect the anonymity of the complaints’ source and to protect whistleblowers from retaliation;
5. the development of a system to respond to allegations of improper illegal activities and the enforcement of appropriate disciplinary actions against employees who have violated internal compliance procedures and policies;
6. the use of audits and other evaluation tools to monitor compliance and assist in the reduction of problem areas; and
7. the investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals. [2]

The OIG has indicated a “one size” compliance program does not work. It is expected that each organization will assess risks and develop a plan around those areas of risk based on the organization’s size and scope of services offered. Regardless of whether a compliance program is voluntary or mandatory, if it is designed well and implemented effectively, risk to the organization will be reduced.

As a Board member, you should ask the compliance officer (or the person assigned the role of compliance officer as most critical access hospitals will not have a person full-time in this role) to educate you about the compliance program. The Office of Inspector General and the American Health Lawyers Association published a Resource for Health Care Boards of Directors entitled “Corporate Responsibility and Corporate Compliance.” [3]

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This seven-page document offers several questions Board members should ask under each of the seven required elements of a compliance program. You will want to know who in your organization has responsibility for the function, how does the compliance officer reports and interacts with the Board, what the organization is doing proactively to prevent compliance issues from occurring, and how the organization handles compliance issues when they do occur.

As a Board member you should be aware there are many laws and regulations that impact the board's decision process. It is not important that you fully understand these laws and regulations, but you **should have a good understanding of when to seek outside counsel or to ask leadership to identify compliance implications for recommendations presented to the board for action.**

The Society of Corporate Compliance and Ethics has published a booklet entitled "A Compliance & Ethics Program on a Dollar a Day: How Small Companies Can Have Effective Programs" [4] which offers valuable guidance to small organizations on the development of an effective program without a great deal of resources. This booklet can be downloaded from the Society of Corporate Compliance and Ethics.

In summary, the Board's role is to have oversight of the compliance program. In order to provide the oversight you will need to understand how the organization's compliance program currently operates and how that compares with the OIG's guidance of how an effective compliance program should look.

Below are listed three web resource sites for further information on compliance:

1. www.healthlawyers.org/Resources/PI/InfoSeries/Documents/OIG_IntegratedApproach.pdf
2. www.oig.hhs.gov/fraud.asp
3. www.corporatecompliance.org/

In addition, the Health Care Compliance Association provides training opportunities and networking for professionals in the field.

www.hcca-info.org

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- [1] U.S. Department of Justice, Office of the Deputy Attorney General, Memorandum to Heads of Department Components from Paul J. McNulty, Deputy Attorney General on Principles of Federal Prosecution of Business Organizations, December 12, 2006.
- [2] Publication of the OIG Compliance Program Guidance for Hospitals, Department of Health and Human Services, Federal Register/Vol. 63, No. 35/Monday, February 13, 1998.
- [3] Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors, The Office of Inspector General of the U.S. Department of Health and Human Services and The American Health Lawyers Association.
- [4] A Compliance & Ethics Program on a Dollar a Day: How Small Companies Can Have Effective Compliance Programs, The Society of Corporate Compliance and Ethics.

Transparency and Disclosure

by Nancy Newby

Providing transparency of information and patient charges is no longer an option for hospitals. There are many new and continually changing regulations which require hospitals to routinely disclose data about quality, performance and charges. In addition, this data is now being publicly displayed on websites that are accessible to patients and families so that they can compare facilities' performance to make informed decisions about their healthcare. People deserve meaningful information about the quality of care they can expect at their hospital and about the prices they will be charged for services rendered. I believe most hospitals are truly committed to share this information that will help people make these critical decisions.

Recent healthcare reform legislation, new reporting requirements and the incentives created for hospitals to implement electronic medical records create the foundation for integration of performance improvement initiatives, transparency of data for public review and pay-for-performance. Subsequently, hospitals find themselves disclosing more information about themselves and the care they provide each day. Some of the forces currently in place are as follows:

- national healthcare reform;
- federal ARRA requirements and the IT incentives for hospitals to attain "meaningful use" with their electronic health record;
- pending incorporation of the AHRQ Quality and Patient Safety measurements into *Hospital Compare* which is dependent upon Medicare claims data;
- additional initiatives that are moving forward, which suggest Medicare will continue to rely on claims data for additional performance and payment adjustments.

In order to implement health care reform and realize the savings desired, Medicare will have to depend on claims data for assessment of hospital quality and performance issues, as well as the process and outcome measures already reported. The reality is that, until at least 2017, the Electronic Health Records (EHRs) and the connecting networks will probably not be mature enough to be used for data abstraction, and Medicare will utilize the claims data to expedite expansion of diagnosis and procedure codes to implement pay for performance.

In March of 2007, the Illinois Report Card Act, (210 ILCS 86) was enacted, and the Illinois Department of Public Health has promulgated rules for implementation. This Act mandates public reporting of nursing staffing levels according to acuity of patients. It states, "Staffing patterns shall reflect consideration of nursing goals, standards of nursing practice, and the needs of the patients. Schedules shall be available upon request at each patient care unit." The Act also mandates appropriate orientation and training and that this orientation information is available for inspection upon request. The Act requires that individual hospitals report quarterly on direct care hours, the average daily census per clinical area and infection-related SCIP measures for Medicare PPS inpatient hospitals. In addition, individual hospitals must report to the Department annual nursing vacancy rates and nursing turnover rates. Even though the intent of this legislation was to provide the public with access to important information about healthcare, the failure of hospitals to comply with the provisions of the Report Card Act can result in significant penalties, including loss of license.

Working with member hospitals and health systems across the state, the Illinois Hospital Association (IHA) recently launched a new website (*Illinois Hospitals Caring for You*) at www.illinoishospitals.org for consumers. This interactive website provides current data on services provided at nearly two hundred Illinois hospitals and displays how they measure up in quality of care and patient safety, as well as other useful information about each facility. Information on this website includes a description of services provided, quality and safety performance results for each hospital, patient satisfaction

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survey results, community benefit programs, and useful resources to help consumers communicate effectively with providers. “This type of transparency breaks new ground in communicating and improving the quality of care provided to patients in Illinois”, reported IHA President Maryjane Wurth in a press release about the transparency website. The website includes quality indicators showing how Illinois hospitals rank on appropriate treatment for heart attack, heart failure and pneumonia (most common causes of hospitalizations in Illinois), on surgical care and special care available at each hospital.

Over the past several decades, many new regulations regarding pricing transparency have surfaced requiring hospitals make public what consumers can expect to pay for services. Prices charged reflect costs to the hospital which varies with the specific needs of each patient as services are provided to impact these needs. No two patients or hospitalizations are alike. Prices may also reflect the added costs of the hospital’s “public service role”–like fire houses and police stations – serving the essential needs of the community twenty-four hours a day, seven days a week. One hospital’s prices may include other critical costs like the cost of physicians or the write-offs that insurances do not pay while another hospital’s do not. All of these many variables make it even more difficult for consumers to compare “apples to apples.”

Federal requirements call for hospitals to post in a public place the prices for rooms and frequently used services, such as chest X-rays and certain frequent laboratory tests. Federal requirements also mandate that hospitals work with insurance companies to make information about enrollees’ expected out-of-pocket costs available in advance of medical visits. In addition, the newest federal regulations require hospital-led efforts to create customer-friendly pricing language on itemized patient bills and to provide an advocate available to assist with billing questions.

In summary, there are multiple new regulations that require hospitals to make public information about quality, performance and pricing. Consumers deserve accurate and easily understood data to help them make wise choices about the health of their families. Hospitals must comply with all of the new and ever-changing requirements, and I believe most will make a valiant effort to help consumers understand and make informed decisions about the healthcare they need. Information is knowledge for the consumer, and our challenge as hospital executives is to make it meaningful and present it in a format the general public can easily understand and accurately interpret.

Nancy Newby is Chief Executive Officer of Washington County Hospital in Nashville, Illinois. She has been involved with ICAHN since its inception, serving as President and two-term board member, and she has been active on several ICAHN committees. She may be contacted at (618) 327-2200.

Public Hospital Board Meetings

by Nancy Newby

Open meetings and public discussion are the foundations of a democratic government. The public has an inane right to see what governmental bodies are doing, and the open meetings laws mandate open board meetings to ensure the free open exchange of ideas. Harry S. Truman said it simply: "Secrecy and a free, democratic government just don't mix." The Illinois Open Meetings Act is intended to ensure the maximum level of participation by providing the maximum level of access to governmental operations. At the same time, the Act strives to balance the public's need for information against the governmental bodies' need for confidentiality in some matters. According to 5 ILCS 120/1, all public bodies whether State or Local, administrative, advisory, executive or legislative, committees and sub-committees are covered by the Open Meeting Act. Therefore, public hospitals must consistently follow the laws related to open meetings in their board meetings. These rules are fairly straightforward and will be summarized here for your review.

The prevailing interpretation is that the Open Meetings Act applies to the public governing board and committees of that board but does not apply to administrative committees and committees of the medical staff. The Joint Conference Committee, where it exists, is generally considered a board committee. Peer or quality improvement committees are generally administrative or medical staff committees, although their reports are made to the governing board, but always in executive session.

Schedules, Agenda, Notice

At the beginning of each calendar year, each governmental body covered by the Act must post a schedule of regular meetings. This posting should include the date, time and place of meetings planned for the year. All meetings, including committees, must be posted at the hospital's principle place of business and at the meeting place. Postings should also be sent to all media that are registered to receive such notice. If regular meetings are changed, notice must be given at least ten days in advance and advertised in a newspaper of general circulation. Agendas of public meetings must be posted forty-eight hours in advance of the meeting in both the principle place of business and at the meeting place. New business can be discussed only if it is noted on the agenda. Place and time of meeting should not be frustrating to the general public (i.e., on a holiday or in a room too small for visitors). Special meetings must also comply with posting forty-eight hour time limit and must follow a posted agenda. Emergency meetings can be called only for a bona fide emergency, and as much notice as possible must be given to general public.

Public Access

During an open meeting, the general public is allowed to listen to the presentations and discussions, and they are allowed to make audio, video or other types of recordings, unless special request to prohibit recording is made by a witness testifying before the body.

Minutes

All public bodies are required to keep minutes of all open meetings, which include date, time and place of meeting, members recorded as present or absent, a summary of all discussions and an exact record of all votes taken. The minutes should provide sufficient data to allow a person, body or court reviewing the minutes to ascertain what was discussed, the substance of the discussion, and action taken. Minutes must be available for public viewing within seven days of the approval of the minutes by the public body.

Closure of Meetings

According to 5 ILCS 120.2a, a public body may hold a meeting closed to the public, upon the majority vote of a quorum present and only for topics related specific to the following:

- Appointment, employment, compensation, discipline, performance or dismissal of specific employees and/or their legal counsel;

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- Collective negotiating matters between the employees and the public body or negotiations of salary for a specific class of employees;
- Selection of person to fill public vacancy or the discipline or removal of the occupant of public office;
- Evidence or testimony to a quasi-adjudicative body;
- Purchase or lease of property for use by public body;
- Setting of price for property for sale by public body;
- Sale or purchase of securities, investments or contracts;
- Security procedures involving safety of employees or the public;
- Student disciplinary case;
- Litigation against public body;
- Establishment of funds for a tort case;
- Complaints of discrimination in housing;
- Informant issues in criminal cases;
- Professional ethical issues;
- Board self-evaluation;
- Peer review issues and several other non-medical reasons specified in the statute.

Minutes must be kept for all closed session meetings, and, as of 1/1/05, all public bodies must “keep either a verbatim record of the closed session or an audio/video recording of the proceedings.” No voting can be accomplished in closed sessions, but rather all members must vote to leave closed session and return to open session for motions and voting. All closed meetings must begin in open session and can only go into closed upon roll call vote of all members present. Closed meeting minutes must be reviewed by the board every six months and, after review, may be released for public disclosure. Verbatim recordings may be destroyed after eighteen months if the body approves of the destruction and after the body has approved the written minutes. Closed session minutes are not discoverable under a Freedom of Information Act (FOIA) request.

Violations and Penalties

There are significant penalties for violating the Open Meetings Act. Illinois Statute authorizes anyone, including the State’s Attorney in the jurisdiction where the violation occurred, to file a civil action to enforce the Act within sixty days of the alleged violation. There may be criminal and/or civil penalties, and action taken during an illegal meeting may be disallowed.

Content of Websites

The Open Meetings Act requires those hospitals subject to its requirements which also have a website to post notices of meetings, agendas, and minutes of meetings on the websites. Public hospital governing board members are advised to familiarize themselves with the various requirements of this Act. (www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=84&ChapterAct=5ILCS120/&ChapterID=2&ChapterName=GENERAL+PROVISIONS&ActName=Open+Meetings+Act.&Print=True).

Governing boards are advised to seek local legal counsel in all matters related to interpretation of the law. In most cases, the best resource for questions or procedural issues is the State’s Attorney in your local jurisdiction.

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Conflict of Interest

by Lisa Harms Hartzler and Michelle P. Clatfelter of Sorling, Northrup, Hanna, Cullen & Cochran law office

Critical Access Hospitals are generally located in rural areas or small communities and quite properly draw their governing board members from the business leaders of their local communities. This situation, however, naturally leads to potential conflicts of interest between a director's personal business interests and the hospital's interests. For example, a hospital needing to replace its air conditioning system might obviously look to the local heating and cooling company. If the owner of that company is a member of the hospital's board, however, the owner has a conflict of interest. He has an obligation to seek the best business opportunity for his company, but he also has an obligation to obtain the best deal for the hospital. In other words, he has conflicting interests.

Not-for-profit or public hospital directors are often likened to trustees who bear fiduciary duties to put the interests of the hospital first and to refrain from seizing business opportunities for their own benefit. This "duty of loyalty" encompasses the need to avoid conflicts of interest (i.e., a director may not put his own interests ahead of the hospital's interests). [1] A director who is an officer, director or partner in a business entity, or who has a personal or financial interest in a business entity, will have a potential conflict of interest whenever he or his company proposes to transact business with the hospital.

Public hospital directors need to be especially aware of potential conflicts of interest because Illinois statutes prohibit any person holding an elected or appointed office from having a direct or indirect financial interest in any contract upon which he might be called upon to vote. [2] The statutes also impose criminal penalties for violations. In addition, any person elected to public office in a unit of local government must file a "statement of economic interest" to disclose various business interests and connections. [3] These requirements, enacted to instill public trust in governments and officials, demonstrate how important it is to address potential conflicts of interest. [4] This need is equally important to not-for-profit hospital boards, because they too have responsibilities to preserve the public trust.

While engaging in transactions with interested directors can have adverse consequences, board members are not always forbidden from doing business with the hospital. Some statutory exceptions are available to public hospitals, even though meeting these exceptions requires stringent disclosures and dollar limitations. [5] In a not-for-profit corporation, a director who discloses a conflict of interest and abstains from voting on relevant issues that are material to that conflict of interest will not violate his duty of loyalty to the hospital. The remaining disinterested board members must then take great care to ensure that the proposed transaction is fair to the hospital, that it is in the best interests of the hospital, and that it furthers the hospital's stated purposes. The board's meeting minutes must document these reasons for approving the transaction.

A transaction involving a conflict of interest with a nonprofit director can still be contested, but the Illinois Not-For-Profit Corporation Act provides that "if a transaction is fair to a corporation at the time it is authorized, approved, or ratified, the fact that a director of the corporation is directly or indirectly a party to the transaction is not grounds for invalidating the transaction." [6] A director is "directly or indirectly a party" if he has a material financial interest in or is an officer, director or partner of the other entity involved. As long as the interested director discloses to the board the material facts of the transaction and his interest or relationship, and a majority of disinterested directors approves the transaction, the burden of proving unfairness rests with the party contesting the validity of the transaction. [7] If the conflict is not disclosed, then the burden of proving the fairness of the transaction shifts to the corporation. Documenting the disclosure of the conflict and the vote of disinterested directors, therefore, becomes crucial.

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Board members of a 501(c)(3) tax-exempt hospital must also be conscious of maintaining the hospital's tax-exempt status by avoiding engaging in "private inurement." Under private inurement prohibitions, the board must ensure that no part of the hospital's assets or earnings is used for the private benefit of any individual. This restriction does not preclude reasonable compensation to employees or reimbursement of director expenses, but it directly applies to financial dealings that improperly benefit hospital directors, officers and key employees. To preclude private inurement, the IRS encourages a tax exempt entity's board of directors to adopt and regularly evaluate a written conflict-of-interest policy that requires directors and staff to act solely in the interests of the charity without regard for personal interests; includes written procedures for determining whether a relationship, financial interest, or business affiliation results in a conflict of interest; and prescribes a course of action in the event a conflict of interest is identified. [8] The IRS asks if the hospital has such a policy on its Form 990. The Joint Commission, which accredits hospitals, also requires written policies addressing conflicts of interest.

Whether it governs a public or not-for-profit entity, a Critical Access Hospital board needs to institute a clear conflicts of interest policy and disclosure procedure for all directors and officers. Each director should annually fill out a disclosure form and sign a statement that he or she has read, understands and agrees to comply with the hospital's conflict-of-interest policy. When a board member discloses a conflict of interest at a meeting at which a vote is taken, minutes should reflect the disclosure and abstention of the interested director, the reasons for the transaction, and the approval of the measure by a majority of disinterested directors. Public hospital boards must ensure that they satisfy a statutory exemption and document it.

End Notes

- [1] *Anest v. Audino*, 332 Ill. App. 3d 468 (2nd Dist. 2002). Board members also bear a "duty of care," which is discussed in the article entitled Board Members' Duty to Govern.
- [2] Illinois Public Officer Prohibited Activities Act, 50 ILCS 105/3; see also Illinois Municipal Code, 65 ILCS 5/3.1-55-10.
- [3] Illinois Governmental Ethics Act, 5 ILCS 420/4A-101 et seq.
- [4] *Stein v. Howlett*, 52 Ill. 2d 570 (1972).
- [5] Illinois Public Officer Prohibited Activities Act, 50 ILCS 105/3.
- [6] Illinois Not-For-Profit Corporation Act, 805 ILCS 105/180.60(a).
- [7] Illinois Not-For-Profit Corporation Act, 805 ILCS 105/180.60(b).
- [8] A sample conflict-of-interest policy can be found on the IRS website at www.irs.gov/instructions/i1023/ar03.html.

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CEO Recruitment and Selection

by Shannon L. McKay, Partner, Adkisson Search Consultants, Inc.

Finding the right person to manage a Critical Access Hospital can be an overwhelming task, but if a plan is put into place, followed and executed, one of the board's most important decisions can be made with minimal headaches and frustration.

First of all, the hospital board must form a search committee and appoint a Search Chair, who is "in charge" of the CEO search and must be given authority to make decisions involved. He or she is ultimately responsible for determining how the CEO search is going to be handled and will work with assigned individuals to make sure all of the key components needed to successfully recruit are in place. The person appointed as the Search Chair must be committed and be willing and able to dedicate a significant amount of his or her time to the CEO search.

Once a search committee has been established, the committee needs to review the past and present state of the hospital and determine where they see the hospital in the future. The search committee will want to conduct one-on-one interviews with each board member, members of medical staff and key personnel to gather input which will enable the search committee to determine the characteristics and experience needed in the new CEO. For example, if the hospital is considering consolidation in the future, the search committee will want to ensure that the new CEO has experience in mergers and acquisitions. Establishing the potential strengths, weaknesses, opportunities and threats allows the search committee to accurately create the CEO job specifications based on the findings in the interviews. What is the education, experience and job knowledge required by the CEO to successfully run the hospital? What type of person will fit-in, be respected and well-received by everyone? Are there particular abilities and/or interests the new CEO should have? Every hospital is different, and therefore it is extremely important to take the time in the beginning to understand the needs of your hospital to determine the qualities and attributes the new CEO must have in order to be considered for the job.

Next, the CEO search committee will need to develop a CEO recruitment packet to send to applicants who meet the parameters outlined in the job description. The packet will include: the detailed job description, financial summary of the hospital, community information and hospital information. The search committee also needs to develop the CEO contract and identify salary ranges and benefits. All of the parameters that have been established must be written out by the search committee and not deviated from when the application and interviewing process begins.

Now that the research and recruiting materials have been created, it's time for the search committee to find candidates. The search committee needs to post the position on various websites, submit vacancy information to journals and make phone calls to other hospital administrators to network and gather qualified leads. The search committee will gather the resumes of interested individuals and review thoroughly to determine who meets the qualifications. The number of applicants may vary greatly. In some instances there will be hundreds of applicants to weed through and other searches may receive very few applications. In both instances, it is critical to only consider applicants who have the appropriate education, experience or background. For example, if the search committee has agreed and written in the job description that the new CEO must have a masters degree in hospital administration and at least five years of experience as a critical access hospital administrator, the search committee should immediately eliminate anyone that does not meet these criteria. As the resumes are reviewed, the search committee needs to choose no more than ten qualified candidates to interview by phone.

A list of telephone interview questions should be created and used to ask the same questions consistently to each of the applicants so that everyone is measured equally. A couple of examples are: "What have you done in your previous position to produce additional revenue?" "What has been your specific role in developing and implementing a strategic plan?" "How would your medical staff, employees, colleagues or board describe you?" The search committee now needs

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to discuss the responses of the telephone interviews and once again review the resumes to determine who their top three choices are for a qualified CEO to manage the hospital. Depending on the candidate's degree of confidentiality, the Search Chair should begin contacting references and begin a background check on the three candidates chosen, as well as to invite each of them for an on-site interview.

Planning and preparation are key for the site-visit as the attention to details sets the stage for a memorable visit. The interviews should be arranged as close to each other as possible so that the interviewees remember each individual. The search committee will designate one person to act as the coordinator of the interview and will involve each board member, other administrators, medical staff and key personnel. Prior to the interviews, it is important for the search committee to inform the board and other interviewees of the job description created and the role of the CEO position that needs to be filled. The search committee also must explain the importance of each person's participation, define the roles and provide a list of questions each interviewee should ask the candidate to ensure all the necessary criteria are covered appropriately.

The candidate should spend at least 1-2 days in the community, and when not interviewing, appropriate social events for the CEO candidate should be arranged. The interview should also include a community tour and involve the candidate's spouse, since the spouse will influence the candidate's decision. Remember, the interview is not only the hospital's chance to interview the CEO candidate, but it is also the candidate's time to interview the hospital, community and the people to determine if it's a position he or she is interested in.

After each candidate's interview, the Search Chair will gather feedback, and then the committee will meet and evaluate to determine who they feel is the best CEO candidate to manage their hospital. It's important to rank a number-one and number two candidate as one may decline. It is critical to determine to whom the offer is going to be made during this meeting as most candidates are also considering other options. The search committee will make its recommendation to the Board, and final approval of the candidate, compensation range, benefits and contract will be made by the Board. The Search Chair will then call the CEO candidate to make the offer and negotiate the final package.

Following this sort of preparation and action plan will give the highest potential for an efficient and successful hire for your hospital.

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CEO Contracts & Performance Evaluations: A Primer for Hospital Boards

by Mark F. Rossi, COO & General Counsel, Hopedale Medical Complex

The purpose of this article is to provide members of hospital boards of directors and trustees with a basic understanding of what to include in a contract between the hospital and its CEO, and what to consider in the CEO's evaluation. In many cases, the hospital's board will appoint a CEO selection subcommittee which will identify the finalist and then oversee contract negotiations. For public hospitals, some of this process may need to take place in an open forum due to the requirements of the Illinois Open Meetings Act. For private, non-profit hospitals, the selection process can take place entirely behind closed doors as they are not subject to the OMA. Note: The CEO's compensation is a matter of public record for both public and private non-profit hospitals, as the Illinois Attorney General's annual report (AG990) requires this information, and is readily accessible to the public and news media.

It is recommended that the Board of Directors engage an attorney familiar with Illinois healthcare and labor law to prepare the CEO's contract, and perhaps assist in the negotiations. The CEO is likely the **only** hospital employee who actually has a written employment contract. All other employees are considered "employees at will", meaning that management can terminate them, with or without cause, at any time, without notice. The CEO's contract affords more rights than the "at will" hospital employee, and the basic elements include the following:

1. **Term/Severance Pay:** Typically, the CEO will want at least a two or three-year contract, especially if relocating his/her family from out of state or leaving a secure position. Multi-year contracts many times have early-termination clauses wherein either the Board or the CEO can terminate upon (for example) 90, 120, or 180 days written notice. There may also be a provision for severance pay in the event the CEO is dismissed by the board "without cause." The hospital's attorney can help define grounds for termination "with cause" (e.g. breach of contract, excessive absence, gross misconduct, commission of felony, violation of hospital ethics/ standards), but the overwhelming majority of CEO separations are deemed "voluntary." Severance pay is optional, and generally not paid when the employee leaves voluntarily, dies or is incapacitated. It is recommended that CEOs be required to give at least 60 days notice for a voluntary resignation in order to allow the Board sufficient time to select an interim replacement.
2. **Job Description/Duties:** It is important that the CEO's job description and duties be attached to the contract. The job description should leave room for flexibility and be well researched before the CEO search begins.
3. **Describe Evaluation Process:** The contract should set forth the process for performance evaluations. CEO evaluations many times are conducted by the board chair, a board committee, or qualified outside contractor. It is recommended that the evaluation form be attached to the contract so that the employee will have no question as to how his/her performance will be measured and what the board's expectations are. In the first year, it is common that an evaluation take place at 90 days and then on the employee's anniversary date thereafter.
4. **Compensation:** The contract will include a description of compensation and benefits. The CEO is generally an "exempt" employee, meaning that he/she is salaried and not paid overtime. Some hospital systems offer incentive bonuses based on goals tied to a percentage of the CEO's base salary (for example, 10-15%). If substantial moving allowances or "sign-on" bonuses are offered, a provision could be added providing that if the CEO voluntarily leaves before the contract term expires, he/ she will repay it pro-rata. It is strongly suggested that the CEO's first year's compensation package be reviewed and then checked periodically (every 2-3 years) by an independent firm. Hospital auditors and public accounting firms can help determine reasonableness of compensation to avoid IRS scrutiny, which could threaten a hospital's charitable status. Certain perks are now forbidden for non-profit charities (sports sky boxes, etc.). Moreover, issuing a company credit card or automobile allowance requires a detailed policy in place before doing so, and random audits of the CEO's expense reimbursement and adherence to Corporate Compliance policies are suggested.

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5. **Retention bonuses/Non-compete:** It has become increasingly popular for employers to offer a “retention bonus” to executives who have completed, say, three or four years of continuous employment. Also, consider including a “non-compete” and non-disclosure clause to prohibit your CEO from “switching sides” (joining your competition). These “non-compete” clauses are usually not enforceable if the board discharges the CEO “without cause.”
6. **Other considerations:** Consider adding language prohibiting dating within the workplace, nepotism (hiring family) and permitting limited alcohol consumption during social settings (as it is probably forbidden to all other employees). The CEO should be requested to provide proof of education and degrees, and pass a criminal background check and company physical. Pre-employment credit checks are no longer allowed in Illinois. Mandatory arbitration is also becoming popular.
7. **The CEO evaluation process:** Using objective goals to evaluate the CEO is the safest and most reliable method. Setting targeted goals such as hospital profit margin, employee turnover rate and market share are preferred over subjective tests. The CEO Evaluation Guide published by the Iowa Hospital Association is an excellent model to follow (www.ihaonline.org, select “publications”). Failure to properly evaluate the CEO’s performance annually is a major misstep for the board of directors and may create potential legal liability.

In summary, the selection of the hospital’s CEO is one of the most important decisions a hospital board will have to make. The new CEO will be expected to establish a clear direction for the organization and make important strategic decisions on a daily basis. A well-drafted contract and thorough evaluation process will greatly facilitate the success of the CEO by providing clear, established goals and an element of fairness.

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Board and Medical Staff Relations: Making it a Priority

by Jim Hood, President, Board of Directors, Gibson Area Hospital and Health Services

Albert Einstein once said, "The definition of insanity is doing the same thing over and over again and expecting different results."

Think about this quote for a second and ask your board of directors "Are we satisfied with our board's relationship with our medical staff? Do we have a high level of trust? Do we understand each other's concerns and priorities? Does the medical staff understand what the hospital needs to succeed and why they need it? Do they also understand that the hospital board wants them to be personally and professionally successful? Would our board members know our medical staff members if they met them on the street? If the answer to most of these questions is "No" and your board hasn't made a conscious decision to thoughtfully and purposefully take steps to improve board/medical staff relationships, then you can expect the same results year after year: conflicts due to poor communication; lack of trust; lack of cooperation and participation with hospital initiatives; high physician turnover and diminished success for the organization and the medical staff members alike.

Critical Access Hospitals, by virtue of their limited size, offer boards unique opportunities to forge strong personal, organizationally synergistic and collaborative relationships with members of their medical staffs. These relationships are so important and so critical to long-term success that strengthening and maintaining them should become an important part of your strategy. The world's largest businesses invest heavily in building and nurturing relationships with their best customers because it is a proven path to success. Likewise, the boards of CAHs need to work to enhance their relationships with their best "internal" customers, the medical staff, if they hope to meet their goals and objectives.

Sometimes board members forget that our medical staff members are fragile human beings, too, with the same feelings, fears and aspirations as everyone else, plus some additional ones related to their careers in medicine. Distrust among physicians, hospital administrators and boards is almost a given. Some would say that it is a natural phenomenon for physicians as they are a product of their training and personal experiences. If you could hear their thoughts . . . "Just who are those people on the hospital board? What are they like? Do they understand who I am, my challenges and what I'm trying to accomplish in my practice? Do they care if I am successful? Do they care what I think? I voice my opinions at the monthly medical staff meeting, but I don't know if they ever hear my concerns or understand my needs. Does cooperating with the hospital add any value to my practice, my patients' experience or my life?"

Similarly, for some board members, physicians can sometimes become just a name in the monthly meeting packet associated with income and admissions or name who is demanding some new piece of equipment or service. Maybe it's a name who doesn't use the hospital lab, radiology and other various services, yet the directors don't know why. If you could hear their thoughts . . . "Who are those doctors? What are they like? Do they understand what the board is trying to accomplish with the limited resources available? Do they understand that we want them to be successful? What are the things, the personal and professional satisfiers, which make them want to stay and continue practicing here? Does developing a stronger relationship with the medical staff members offer tangible benefits for the hospital?" If your board and administration are willing to commit to a process of thoughtful and intentional interaction with your medical staff, then most of the aforementioned issues from either side will diminish and begin to melt away over time.

Acts of intentional interaction between board and medical staff should include formal and informal opportunities. Our hospital board has an off-site strategic planning retreat every three years. Well in advance of the retreat all members of our active Medical Staff, hospital administration, Board of Directors and their spouses/significant others are invited to attend and participate in the retreat and the social activities that accompany it. At the retreat, Medical Staff members have a "place at the table" to collaborate with administration and the Board in discussing and shaping the vision of the organization and

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its strategic direction over the coming three-year period. It's a fascinating study to watch the light bulbs of appreciation and understanding turning on around the table as the group forges concrete goals centered on improved quality, enhanced patient care and the exploration of additional services desired. This single action, the act of including our Medical Staff, actively soliciting their input and making them part of the strategic planning process for the delivery of healthcare in our market has had enormously positive results.

Similarly, informal, purely social opportunities to interact often are the best ways to break the ice between the board and medical staff. Our hospital administration does an outstanding job of driving these events to assure they are interesting, fun and offer good food (very important) and an appropriate venue for conversation. Each summer, we look forward to the hospital steak fry, a carnival-atmosphere cookout event hosted by the Medical Staff that includes Medical Staff, Hospital employees, Board members and their families. Late summer brings the annual Labor Day Medical Staff/Board charter bus trip to a major-league ballgame and most recently a well attended Medical Staff/ Board holiday party held at the local golf course. Of course, not all Medical Staff members participate in every event, but many do, and their interaction with our Board members has proven to be extremely beneficial.

How beneficial? It has been years since we had to pay a recruiter to place a physician here. Our administration receives calls regularly from physicians across multiple specialties who, after speaking with members of our Medical Staff, want to practice in our community. Our Medical Staff members are involved and enthusiastically participate in hospital-driven quality improvement, EMR/CPOE and other initiatives. By getting excellent quality feedback from our physicians, our hospital administration is able to quickly address issues and reduce barriers to physician and patient satisfaction. Our senior Medical Staff members tell us that the relationship between the Board, hospital administration and the Medical Staff is the strongest that they can remember. We believe these results are the fruit of a thoughtful and intentional strategy focused on improving Board and Medical Staff relations. Are you making it a priority in your organization?

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Medical Provider Recruitment

by Carrie Galbraith, Director of Recruitment Services, Critical Access Recruitment Services (CARS)

Maybe your hospital is pro-active enough to have an effective medical staff development plan which shows the need for an additional physician in about twenty-four months. Or, maybe one of your main admitters suddenly and unexpectedly announced his or her retirement at the end of the month. Regardless of what brings hospitals to the recruiting table, here you are!

The process of recruiting medical providers in small rural Midwestern hospitals is very different than recruiting other personnel for other businesses. The first overwhelming fact to remember is that there are ten hospitals, medical groups, practices, and even WalMarts vying for every one candidate. Rarely is this dynamic seen in other industries. Second, the stakes are very high. Often the admissions and treatments generated by a single practitioner can determine whether a small hospital survives or closes.

Understand the Sources

Physicians come from two basic sources: those just finishing their residencies and those who are simply ready to move to another location.

Physicians in the United States generally complete their undergraduate work majoring in things like pre-med or chemistry. They then attend university-sponsored medical school for a period of four years. Once finished with medical school, they usually enter a hospital-based residency program associated with their chosen specialty. The length of residency programs varies with the specialty, (i.e., internal medicine programs are three years, while neurosurgery programs may be as long as eight years). Physicians may often complete an additional one or two-year fellowship, which will hone their specialty even more.

The overwhelming majority of residency programs are in metropolitan areas. The wild-eyed farm boy from Southern Illinois who vows to return to his roots after completing physician training is facing ten years of life in the city and will likely marry a city girl before he is ready to settle down. Now, you are starting to get the picture! Physicians who attended medical school overseas are required to complete residency programs in the United States before they can practice here. Competition for the non-primary care specialties is stiff, which drives many international medical graduates into primary care.

Of course, there are always a few physicians and other medical providers who have completed their training and are searching for a new location. Most physicians leave their first practices within two to three years. Also, most physicians establish practices within fifty miles of the sites of their residency programs. However, there is not nearly the amount of “moving around” among medical providers that we see in other fields. It is always critical for hospitals recruiting someone to understand why recruits are leaving their existing locations.

Understand the Medical Provider Marketplace

The medical provider recruitment marketplace continues to be very competitive. While ten years ago, urban hospitals seemed to be close to saturation with physicians, such is not the case today. Urban job offers equal or exceed what small rural communities can offer. The number of residents graduating yearly has not increased in 25 years. Small rural communities are generally looking for physicians in primary care, (i.e., family practice, internal medicine, pediatrics, and OB/Gyn). For a number of reasons, these specialties continue to decline in popularity among medical school graduates.

Governing board members need to understand the funnel which exists for medical personnel. In 2009, 3,100 physicians completed family practice residencies*. Fifty-five percent were female. About 350 began advanced fellowships, leaving around 2,300 to look for a first job. Of this number, 160 selected a “medically underserved area”, likely so they could

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satisfy government loans and grants. Only three percent will select a community of less than 10,000 population. That means there are around seventy family practitioners in any given year who want to settle down in a small rural town somewhere in the United States. In Illinois alone, there were 53 rural vacancies in 2010.

How Do We Compete?

What do young doctors look for? First, if they are considering a small town, they are probably ranking the quality of theirs and their family's lives first. But to recruit them, we need to be competitive with other offers before they can consider your practice location. On-call arrangements may be critical to someone who is primarily motivated by lifestyle. How often does the physician need to be on-call after hours? Is the physician responsible for all of the patients he or she admits to the hospital? Is there any back-up from this responsibility?

The Recruitment Process

The recruitment process varies by community, position, specialty, etc., but it generally follows the path shown on the attached flow chart. It is important for the CEO to be in a position to move quickly and forcefully with this process. Candidates who detect hesitancy on the part of a hospital may jump to the always present next best competitor.

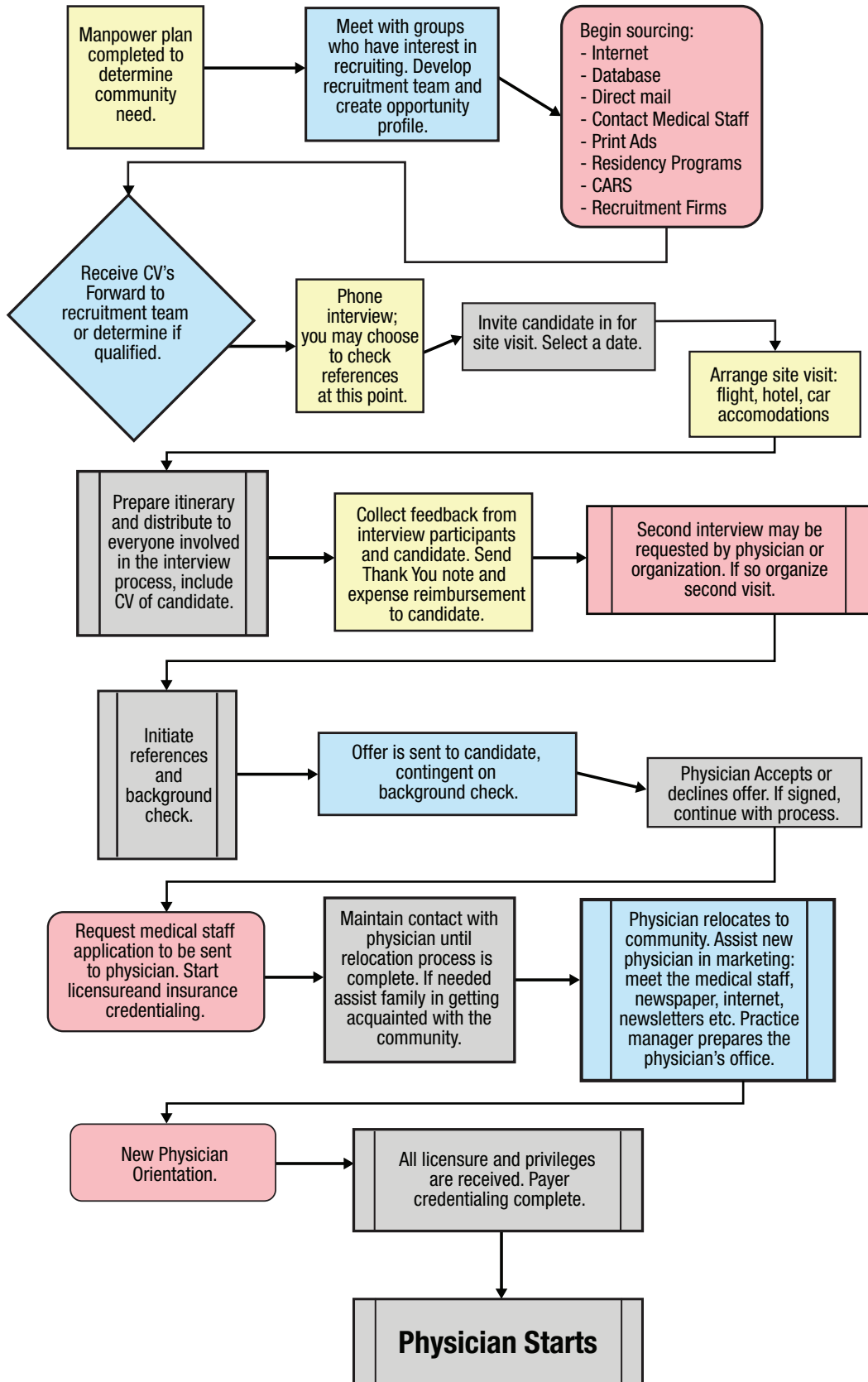
What Can Governing Board Members Do to Help?

First, understand what is happening. You are the principal link between the hospital and the community. You need to explain to your friends and business acquaintances why it is important for the hospital to recruit new physicians. Provide the CEO with the authority and resources to close the deal quickly. Help the CEO "wine and dine" candidates if requested. Think like a young physician and spouse coming to your community might think and help the CEO to "get out in front" of the visit. It truly is a team effort, and you need to understand that you are entering a very competitive field with the odds against you.

Understand that hospitals usually use the services of recruiting firms, and these are often very expensive. CARS is a recruiting service established by ICAHN members to serve as the high value recruiting service. Hospitals also individually may sponsor bulk mailings, run advertisements in journals, visit residency programs, etc. No one way works, and no way is quick. Hospitals should expect at least twenty-four months of searching for every primary care physician.

* Statistics presented in this paragraph are extrapolated from sources such as the FREIDA Online, Merritt-Hawkins 2008 Final Year Medical Resident Survey, etc. Additional sources are available on request.

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Medical Staff Credentialing and Recredentialing

by Kathy Matzka, CPMSM, CPCS

Joint Commission defines credentialing as “the process of obtaining, verifying and assessing the qualifications of a healthcare practitioner to provide patient care services in or for a healthcare entity.”

Why Do We Credential and Recredential?

Patient Protection – We need to do our best to see that only qualified practitioners treat our patients.

Risk Management Concerns – If the practitioner has problems that would have been revealed by credentialing, but credentialing was not performed, the hospital may be liable for any patient harm caused by the substandard clinician.

Required by Accrediting and Regulatory Agencies – Failure to comply with accreditation and regulatory requirements can cause a facility to lose its accreditation and licensure. (Joint Commission, Medicare Conditions of Participation for CAH, and Illinois Hospital Licensing Regulations)

Appointment vs. Privileges

Any individual permitted by law and by the organization to provide medical care, treatment, and services without direction or supervision should be credentialed and privileged through the medical staff process. In some cases, the hospital may grant clinical privileges, but not medical staff appointment. For example, if the practitioner is a teleradiologist located in another state or country, the hospital may choose to grant only privileges since this provider will never actually come to the hospital and would not be able to participate in the medical staff's governance or other activities. In addition, a physician member of the medical staff may employ a non-physician who will be performing surgical procedures or providing patient care in the hospital under supervision of the physician. In this case, the hospital may choose to grant privileges for these procedures but not grant medical staff appointment to this non-physician practitioner. The Interpretive Guidelines for the CoP [485.627(a)] require the “governing body (or responsible individual) must determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff.” The governing body (or a responsible individual) has the responsibility to “appoint, with the advice of the medical staff, the individual practitioners to the medical staff.”

The Credentialing Process

Application and Verification – Illinois law mandates a standardized application. All hospitals must use this form which cannot be modified. Hospitals can require medical staff applicants to complete additional facility-specific forms. The healthcare organization is obligated to make an effort to see that only competent practitioners provide treatment and services to its patients. They do this by verifying the information in the application and obtaining information used to determine that the practitioner is competent to perform all requested privileges. A copy of the requested privileges is sent to the applicant's peers and other healthcare facilities and these references are asked to provide substantive comments regarding the applicant's qualifications and competency. Information obtained from other facilities should include data concerning the procedures performed at that facility, and, if available, outcomes. Many times, other facilities do not want to provide this information. If that is the case, the applicant should be asked to assist in obtaining this information.

Medical Staff Review/Recommendation – After all verifications are completed, the application proceeds through the medical staff review and approval process. This typically involves review and recommendation by the department or section chairman (if one exists) followed by review and recommendation by the medical executive committee or by the medical staff as a whole.

Governing Board Action – Finally, the governing body takes action. Since the governing board is typically composed of non-clinical members, it relies heavily on the medical staff's review and recommendations regarding whether or not

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an applicant is competent and qualified. As such, it is very important for the governing body to feel comfortable with the thoroughness of the review performed by the medical staff. Prior to granting medical staff appointment and/or privileges, the governing board must determine that the practitioner meets the hospital's requirements for membership and/or privileges. If the governing body grants privileges to a practitioner who does not meet the medical staff's criteria for appointment and/or privileges, it may be found negligent in credentialing that practitioner. [See *Frigo v. Silver Cross Hospital and Medical Center* (No. 1-05-1240, Ill. App. July 26, 2007)]. The applicant should be notified of the board's decision. If the decision is adverse, the applicant should be provided explanation of the reasons for the adverse decision. Medical staff bylaws may include the right to request a fair hearing on the adverse decision. If such a right is granted pursuant to medical staff bylaws, this should be communicated to the applicant.

Recredentialing/Reappointment of LIPs

Illinois Hospital Licensing Regulations require that grants of privileges do not exceed two years. On renewal of privileges, the medical staff evaluates individuals for their continued ability to provide quality care, treatment, and services for the privileges requested. The process for renewal of privileges involves basically the same steps as for granting initial privileges. Additionally, the medical staff evaluates a practitioner's ability to perform the privileges requested based upon his or her performance during the period of time he or she has been practicing at the organization.

Considerations in Recruiting

When recruiting physicians, it is a good idea to perform as much credentialing as possible prior to offering a contract. Ideally, this will include at least National Practitioner Data Bank query, licensure verification, discussion with peers regarding competency, and verification of no Medicare/Medicaid sanctions. This is done to make sure that the applicant meets the criteria for medical staff appointment and privileges and that there are no concerns regarding the applicant's qualifications or competency.

Confidentiality of Information

Information reviewed and discussion occurring as part of the credentialing and privileging process is considered confidential. Governing body members are granted legal protection by the Illinois hospital licensing regulations (210 ILCS 85/10.2) which state that, in regards to performing peer review activities, they will not be "liable for civil damages as a result of the acts, omissions, decisions, or any other conduct, except those involving willful or wanton misconduct."

Additional suggested resources/reading:

- Joint Commission's standards for Governing Body (for Joint Commission accredited hospitals)
- CMS State Operations Manual Appendix W – Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals – Governing Body 485.627(a) cms.gov/manuals/Downloads/som107ap_w_cah.pdf.
- Illinois Hospital Licensing Act (210 ILCS 85/) Sec. 10.4. Medical staff privileges and (210 ILCS 85/10.2) – Peer review www.ilga.gov/legislation/ilcs/ilcs2.asp?ChapterID=21.
- *The Excellent Board II: New, Practical Solutions for Health Care Trustees and CEOs* – Published by the American Hospital Association
- *The High Performance Board*, Dennis D. Pointer, James E. Orlikoff, Published by the American Hospital Association

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Quality—How Does this Affect Me?

by Pat Schou, Executive Director, Illinois Critical Access Hospital Network

The core mission of a hospital is to provide quality care to its patients. Quality care can take on many dimensions, ranging from access to health care and professional competence to the appropriate environment for care. Any shortcoming in providing access or delivery of patient care can result in direct or indirect harm to patients and can be considered “substandard care.” The challenge is to instill a culture of quality within the hospital. Measures to prevent shortcomings must be established to include monitoring the provision of care and ensuring safe and appropriate services at all times. It is always easier said than done.

The oversight of patient care is the fundamental duty of hospital boards, whether elected or appointed. This is often difficult because members of boards of directors usually are individuals from the community who generally know very little about patient care and the operations of a hospital. In the past, the responsibility of hospital boards centered primarily on financial management, fund raising, and oversight of the administrator. The Darling Case in 1965 altered the focus when boards learned their hospitals were no longer immune from legal responsibility simply because they were a charity. Subsequent similar court rulings placed additional legal responsibility for patient care, including care rendered at the hospital by non-employed physicians, at the feet of hospital boards. In addition, quality requirements placed on hospitals in order to participate in the Medicare program and be licensed clearly lead to hospital boards of directors.

Often, hospital leadership and board members use a “dashboard” to sort out all the information on physician and staff performance, diagnostic testing, clinical quality delivery, patient safety, and patient satisfaction. Ask hospital management to use dashboards with patient numbers instead of statistics when there are no valid comparisons or relevance. Safety and performance targets should be ambitious and avoid setting low expectations such as being in the top half. It is no different than the airline industry where we expect a safe flight 100% of the time. Keep it simple, and align goals. Include the opportunity for patients to share their comments and opinions. Measuring quality will be an on-going process as there is a never-ending opportunity to improve care and service.

Hospital leadership will most likely report quality measures on a quarterly basis. Boards of directors should be prepared to ask questions and discuss the bad as well as the good. There should be full disclosure of adverse incidents, and board members should support hospital leadership in efforts to correct problems and create the proper environment. Board members should ask how the hospital compares with peer hospitals, both locally and nationally. By 2013, CAHs will be required to publically report on established national quality measures (www.hospitalcompare.hhs.gov) and potentially receive lesser reimbursement if determined to be continually providing substandard care.

Hospital boards should not be overwhelmed by the overall responsibility for quality of care but rather view this as an opportunity to represent the patient and provide an objective review of the information reported. Board members should be aware a good hospital quality program has qualified staff to implement and direct the program. Hospital management and quality staff are responsible to provide board members with tools and education so they can better understand measuring clinical and financial performance as well as identifying problem areas. It is inherent for board members to expect their hospital to be known for its quality of care and service. It is only natural board members take an active role in the review and evaluation process.

Hospital staffs can be consumed by this quest and actually become counterproductive unless the quality improvement system is effective and efficient. There can be too much data. Board members can best support hospital leadership by requiring a commitment to quality on all levels. The board should require management and medical staff to adhere to this commitment. Hospital stakeholders need to decide together what makes sense, what is practical, what best reflects the

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continuum of hospital services, and what is appropriate to measure. The board needs to set reasonable goals and ensure that reality is in sync with the hospital's mission of delivering quality care to its patients.

In the end, hospital board members are in a unique position to ask if all of these quality performance activities have really improved the care patients received. Governing board members are the only ones who have access to all of the information and who are “not so close to the forest that they can't see the trees.”

Overseeing programs aimed at making patient care better is the most solemn of board responsibilities.

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Effective Strategic Planning

by David C. Hoffman, Ph.D.

Introduction

General Dwight Eisenhower is credited with the quote: “Plans are worthless, but planning is everything.” The point being that in a constantly changing business environment—health care or non-health care—plans seldom endure for long, but the disciplined process of scrutinizing your business and subjecting your assumptions to constant critique and refinement are the real intangible benefits of organizational planning. What the General failed to add is that plans only work if they accomplish something; and herein lies the stumbling block for most hospitals—developing high-quality strategies and coming behind them with effective execution. Put another way, no matter how well you plan . . . something has to be accomplished at the other end.

The purpose of this article is to help hospital governing boards hone their approaches to strategic planning and develop the necessary linkages between planning and execution.

The Board’s Role in Strategic Planning

Hospital Governance 101 tells us that planning and business vision are two of the major responsibilities of any governing board. Hospital boards need to oversee, participate in, “own” their strategic planning process; and set the vision—or direction—that the organization will take going forward. An effective governing board will have sufficient knowledge and insight into the major issues facing the hospital industry, and especially their own hospital, to ensure that the most important business questions are asked and answered. The challenge most boards face is how to structure the process and engage key stakeholders in it. Traditionally, boards have formed Planning Committees to oversee the planning process, but contemporary planning—especially for smaller hospitals—is best done with the board serving as a Committee of the Whole for planning purposes.

The CEO and Senior Management’s Role in Strategic Planning

The role of the CEO and senior management team as co-participants (i.e., CFO, CNO, CIO, and other C-suite team members) is crucial to successful planning. These are the key health care professionals “on the ground” with ultimate responsibility for executing key plans and initiatives. While the board has the overall responsibility for the success, survival, and longevity of the hospital, the management team are the field generals that need to get the job done; so their opinions, insights, and perspectives as health care management professionals is vital to success. It is also the role of senior management to involve and bring other key stakeholders into the planning process; including, department managers and physicians. Once the plan is “inked” and approved by the board, it is management’s job to put the plan in motion and get the results.

Ideally, the board and senior management should shape and design the planning process together and agree on the desired outcomes (e.g., “we would consider our planning process to be successful if, at the end, the following objectives were met . . .”).

The Medical Staff’s Role in Strategic Planning

Because physicians are key to implementing any plan, their input, participation, and support is critical. Not all physicians need to participate, nor will all want to; however, key formal medical staff leaders and informal opinion influencers need to weigh in on the plan’s priorities and major initiatives. Many well conceived strategies have never been put into action because the planning process failed to adequately engage key physician leaders. Key areas to explore with physicians are clinical quality, recruitment and practice growth plans, clinical service line growth, facility issues, practice management and reimbursement challenges, and hospital-physician relations.

STRATEGY & LONG-TERM PLANNING

Meeting with physicians in small groups, at times conducive to their clinic schedules, is an excellent way to tap their ideas and insights. Involvement of the Medical Staff in planning not only generates good ideas, but helps foster better communication with physicians; and can often help to better align the hospital-physician business interests.

Putting Together an Effective Plan

Hospitals often approach planning as a cyclic event or ritualistic duty, conducted every three years or so, rather than an on-going business exercise. Good business planning is a constant process and generally consists of the following elements:

- Asking the critical business questions;
- Setting critical priorities;
- Creating a 3-5 year course for action;
- Assigning accountabilities; and,
- Measuring the results of the efforts.

Structuring the Process

Whatever time frame you select, it is essential to understand that you operate in a fluid environment that will change, based on your own market dynamics as well as national and state political and regulatory decisions. Consider reviewing and scrutinizing your plan, at least annually, to examine the underlying assumptions in order to make mid-course adjustments. This need not be an onerous, time consuming ordeal, and can be as simple as an annual board planning meeting/ retreat to examine current strategies, operating performance, competitive influences, and other changes in the operating environment.

Planning can be structured in a number of ways, but there are some essential ingredients that should be at the core of any plan:

1. **An Environmental Assessment** – A concise assessment that serves as a baseline for building organizational knowledge with the key stakeholders, taking into account financial, market, and utilization performance for the last 2-3 years; medical staff demographics, specialty mix, and key clinical service lines, and competitive factors.
2. **Key Business Questions** – A list of key questions that need to be answered regarding the future of the hospital organization. Typically, these questions fall across the main categories or “pillars” around which the hospital wishes to organize its strategies. Questions posed as “How” or “What” lend themselves to easy translation into action step answers. Here are a few sample categories and questions:
 - Growth (“How do we grow and in what areas?”)
 - Quality (“What do we do to ensure that we meet and exceed quality standards for clinical care?”)
 - People (“How do we recruit and retain the best qualified workforce?”)
 - Customer Service (“How do we ensure that patients and families have a signature experience at our hospital?”)
 - Financial Performance (“What are the most important things we must do to maintain or improve financial performance?”)
3. **An Action Plan with Defined Tasks and Accountabilities** – Key questions should lead to a clear and concise action plan that senior management will use to accomplish the plan objectives. The plan should be time-referenced and specific individuals should be identified as “owners” responsible for the results.
4. **Monitoring Plan Performance** – A variety of tools exist for monitoring plan results – Balanced Scorecards, Key Performance Indicators, Dashboards, etc. Each deals with agreed-upon metrics and targets. Pick one that is simple and that both the board and management can easily review and follow. Build performance reporting into the board agenda as a structured item, leaving adequate time to review results and discuss any steps that need to be taken.

Often, strategic planning has become a jargon-laden mind-numbing practice. Effective planning is a team effort between Board, Senior Management, and Medical Staff. Most important is that the plan focuses on the most significant long-term tasks that must be accomplished to sustain your hospital. It should involve participation from the key stakeholders, and a plan of action that the Board and Senior Management can monitor for results.

David C. Hoffman, Ph.D., is a former Partner of the Health Care Practice of Wipfli LLP, with more than 30 years of experience as a consultant to rural and integrated health care systems, specializing in hospital strategic planning and positioning. Dr. Hoffman has held leadership positions with both national hospital management companies. He consults on an independent basis as Hoffman Consulting, and he may be reached at davehoffman202@yahoo.com and 608.444.7009.

Mergers and Affiliations

by Donald G. Brown

Dr. Peter Ducker, renowned management consultant, university professor, and recipient of the *Presidential Medal of Freedom* award spoke about hospital organizations on many occasions. Some of his conclusions were:

1. Healthcare is *the* most difficult, chaotic, and complex industry to manage.
2. The hospital today is altogether *the* most complex human organization ever devised.
3. The four hardest jobs in America are U.S. President, university president, hospital CEO and a pastor.

Critical Access Hospital board members have an almost impossible job. Most are extremely busy people and are involved in many other community affairs. Yet, they are expected to contribute more than a few hours per month and make many difficult policy decisions regarding the community's most complex organization. In addition to the hours spent in board meetings, many additional hours are required for board education. I think Dr. Drucker should have added "hospital board member" as the fifth most difficult job.

In most communities with critical access hospitals, the hospital is the first or second largest employer. These hospitals are usually not only primary emergency centers, but they are the catalysts for all available medical care in the immediate area. They are truly "critical" in providing their communities with healthcare.

One of the most complex areas for hospital boards to deal with in these formidable economic times is consideration of merging or affiliation with another organization. This may mean joining in some manner with a neighboring healthcare facility, a referral hospital system, or a for-profit healthcare corporation. There are always positives and negatives for each alternative and the board is responsible for carefully exploring each alternative and making the correct choice.

Talking about mergers or being acquired by another health system is serious. Fundamentally changing ownership, governance, or management is not for the "faint of heart." Yet, continuing to provide high-quality healthcare to the community is an imperative which dictates considering the "unthinkable."

In these economic times, finding financial stability is almost impossible. In order to establish the most sustainable financial strength, mergers or acquisitions may become an important part of a well-thought-out strategic plan. This is a subject that must be given close study and consideration well in advance of a financial emergency. The best time to choose a partner will always be when you really don't absolutely require one.

Before considering a merger or affiliation, careful and comprehensive strategic planning must occur to determine the need and desirability of such action. This may require multiple planning sessions in addition to regular annual strategic planning meetings. During these sessions it may be advisable to seek outside expertise regarding the future healthcare needs of the service area, the impact on community perception, and the employment impacts.

Once the decision is reached to consider a merger with another organization, multiple candidates should be considered. The candidates list may be determined by geography, past relationships, and differences in operations and philosophy. Financial strength is obviously important. After review and consideration of available public information, the board and administration should ask potential partner candidates to present their views on future healthcare needs of the people in the hospital's service area and how these needs might be met. Hopefully, these presentations will help in narrowing the list of viable candidates. If at this point a potential partner can be chosen by the board and administration, then the board should direct the CEO to approach and initiate open discussions with that candidate.

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If the intended partner shows interest, then discussion should be of a general nature with a request that a proposal for the future relationship be made to the board and administration within thirty days. This proposal will lead to and become part of formal legal exclusivity and confidentiality agreements. These agreements should be prepared by legal counsel experienced in such transactions working with local legal counsel as appropriate. As progress moves toward a final decision, it becomes increasingly difficult to maintain the secrecy required to ensure the best possible outcome. The premature release of information can result in employees, medical staff or community who are not privy to the negotiations inadvertently or deliberately doing something to sabotage the effort.

While the various types of mergers and affiliations require different agreements, each hospital and potential partner will devise a list of topics which must be addressed by discussions before anything is finalized. The list will contain all sorts of community, governance, management, and “nuts and bolts” issues, but none more important than the future longevity of the hospital’s presence in the community. This must be apparent not only by perception but also in some legally protected way in the final agreements. If the final decision is to do a full sale or merger, then the future continued existence of the hospital must be a topic of critical consideration that must be addressed.

Other points that may cause significant contention include functionality in day-to-day decision making by the CEO and board. Board members may find that after the conclusion of the sale or merger, they feel shut out. The CEO may find that decisions that pertain to day-to-day operations now must go to “CORPORATE” before implementation. The CEOs of critical access hospitals are usually individual thinkers and accustomed to accepting the responsibility for solving major problems on a daily basis. This attribute, while very necessary for managing a free-standing facility, may not fit very well in a large corporate structure. Ultimately, the CEO may find that he or she has led the facility in the right direction for the facility, but it may not be the right direction for personal career satisfaction.

This is a very general presentation of a very complex subject, and any critical access hospital considering merger or acquisition should seek experienced accounting and legal advice. Discussion with other critical access hospital board members who have explored or concluded a merger or affiliation may be helpful.

Donald G. Brown is a hospital management consultant and the retired CEO of several ICAHN member hospitals. He served on ICAHN's original Board of Directors and has been active in state-wide and regional hospital activities. He may be reached at 105 Woodlake; Eldorado, IL 62930 at 618.273.3919 or dgb906@hotmail.com.

Employed Physicians and the Advent of Hospitalists

by Bill Spitzer, ICAHN Special Projects Consultant

ICAHN member hospitals are reporting a dramatic change in the relationship between the hospital corporation and physicians who serve on their medical staffs. With consistency and some regularity, ICAHN member hospitals report that they have hired a hospitalist or have begun employing physicians. The purpose of this paper is to further explore this phenomenon.

What Factors are Driving this Change?

1. Clearly, the old model of the completely independent medical staff is quickly eroding. The driving forces sometimes rest with the physicians themselves. Often, physicians assumed that when they reached retirement age, they could simply sell their practices to an eager young physician fresh out of residency who is willing to take up where the elder physician left off. These physicians are finding a totally new generation of young physicians. They do not want to pay to purchase someone else's practice. They do not want to be on call twenty-four hours a day, and they do want the income stability that only a salary can provide. The elder physicians are sometimes devastated. They have reached the point in their lives when they want to slow down, but their practices are often huge. They may not be ready to walk away from the practice, but they want to slow down and yet have a decent income stream. From the hospital's perspective, this situation is untenable, especially if the practice represents a significant portion of the hospital's admissions. Often the solution is for the hospital to take over the practice, employ the elder physician, and develop the practice into a hospital-based clinic.
2. Another scenario we often see is that hospitals awake one morning to learn that a physician's practice has been bought by a competing hospital. A typical reaction is for the hospital to hurriedly establish its own physician group to compete.
3. Hospitals often employ physicians simply because young physicians cannot be recruited to the traditional environment. In order to compete in the recruitment of physicians, hospitals have to provide a lighter on-call load by creating hospitalist programs. They may also establish clinics to provide new physicians with already-existing practices, a salaried income, and predictable hours.

This Isn't Your Father's Doctor

Young physicians leaving residency programs are far different from their fathers. Over fifty percent are female. They often have no aversion to receiving salaries rather than becoming entrepreneurs. They may not be willing to invest themselves in the business side of medicine. They just want to practice good medicine without the "hassle." Unfortunately, the model of medical practice which exists in most rural areas is in conflict with this scene. However, the physician marketplace offers plenty of opportunities for new physicians to find what they seek in larger communities. Consequently, CEOs who have only the traditional model to offer are immediately at a marked recruitment disadvantage.

Aren't Hospital-operated Clinics Always Financial Losers?

Conventional wisdom dictates that hospital-operated clinics lose money, and this is usually true. Hospital boards have to look at a much larger picture when evaluating the desirability to open a clinic. "What happens if we don't open a clinic?" is most often the real question confronting hospitals. "Will we be able to recruit new doctors without offering them a salary?" "What are the chances that our existing doctors will continue to slow down or retire?" In the end, the question is often "Do we open a clinic or do we close the hospital?" The answer is both strategic and binary.

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There are some ICAHN hospitals that claim to be operating profitable clinics, however, these are exceptions rather than the rule. The mindset of successfully operating a medical clinic is generally far different from operating a hospital. The skills simply do not easily translate from one milieu to another. Merely reassigning hospital personnel to the clinic may create a fine clinic, but one that is also very expensive to operate. Hospitals that are evaluating the issues are advised to seek expert clinic and practice management consultants who can provide guidance.

Hospitals that operate primary-care clinics in their communities often report that seventy-five to ninety percent of the hospital's admissions come from clinic physicians. It can work, and several CAHs owe their success to decisions their boards made to open clinics.

The Natives Are Restless

It is critical for hospitals who contemplate opening a clinic to have their existing physicians involved in those discussions. Certainly, physicians feel threatened if they open up the newspaper to learn the hospital has decided to open a clinic which is in direct competition with their practices. Nothing will drive these physicians to the hospital's competitors faster than such a threat. Boards need to insist that the discussion occur with all of the stakeholders to the greatest extent possible, but boards also need to recognize there has to be a time when discussions end and decisions are made for the welfare of the hospital. There are also considerable community-relations implications of these decisions, and how these are addressed must be added to the equation.

Hybrid Hospitalist Programs

A 2009 Study conducted by ICAHN* showed that sixteen per cent of ICAHN member hospitals currently operate hospitalist programs. Another fifteen hospitals requested additional information on the topic because they have a high level or interest on the topic. In a nutshell, a hospitalist is a hospital-employed physician whose job it is to treat hospitalized patients rather than the patient's primary care physician. That same study noted that it is financially very difficult for a "pure" hospitalist program to be successful simply because of the low volumes of patients most CAHs treat. However, when the hospitalist also covered the emergency department and/or clinic, then finances improved significantly. Hospitals that used such models reported a significantly increased ability to recruit physicians. In the end, this author believes that this hybrid model of hospitalist/ED/clinic is the physician wave of the future for CAHs. For most CAHs, this topic at least ought to be an item on their strategic planning agendas.

* "Rural Hospitalist Study: The Advent of Hospitalists in Illinois Critical Access Hospitals: 2009" by William Spitler, Available from ICAHN; May, 2009.

William Spitler serves as the Special Projects Consultant for ICAHN. He served as CEO of Perry Memorial Hospital, Princeton, IL, and hospital management consultant since leaving Perry in 1999. He may be reached at 309.463.2906 or abpitler@hotmail.com.

External Resources for Consulting and Management Services

by Tim Putnam DHA, FACHE, President/CEO of Margaret Mary Community Hospital, Batesville, IN

In the world of healthcare today, it is common for challenges to exist that create the need for expertise beyond the scope of the existing hospital staff. Examples include:

- Administrative/Management
- Financial (e.g. coding, billing, collecting or financing)
- Physician Relations and Recruitment
- Quality/Safety/Compliance
- Government relations support with CMS, NGS, IDPH, IHFSRB or other entities
- Legal Counsel
- Information Technology
- Corporate Compliance

1. **Professional Consulting/Interim Management Firms** – Several consulting firms exist to offer expertise in almost every field imaginable. Their resources range from immediate replacement due to unexpected absences of senior management to providing expertise in area hospitals need expertise infrequently such as dealing with the Illinois Health Facilities and Services Review Board (IHFSRB).
2. **Long-term Management Resources** – A few firms specialize in providing a full array of management staff ranging from support services for the CEO to employment of the entire Executive Team. These organizations can also bring an array of resources such as group purchasing contracts, continuing staff education, as well as, standard practices and procedures. The intent of this type of organization is to provide a permanent management resource for the hospital.
3. **Support from ICAHN and Statewide Resources** – Occasionally resources can be made available through neighboring hospitals or from resources available through ICAHN. Some of these resources include recently retired executives or individuals wanting only interim work. The advantage of working with someone familiar with working in Illinois is the ready access to resources within the State. For example, finding someone willing to serve as Interim CEO who already has contacts within IDPH, IHA, tertiary hospitals and ICAHN can be more immediately effective than someone from an interim management firm from another state.

Finding a Good Management Consultant

ICAHN is a good resource for finding companies and individuals able to provide the aforementioned services, and they may also be able to provide references from member hospitals or other CAHs that have used these services. References from other hospitals should be a paramount consideration in your choice for a consultant. Do not rely exclusively on marketing pieces with testimonials. It is important to perform thorough reference checks with a consultant's prior clients and be comfortable with their ability to place your needs first.

Practical Information Regarding Consulting Management Services:

1. **They are expensive** – Expect to pay close to triple the regular hourly rate of full-time staff for a consulting or interim management service. Travel time may also be included plus travel and housing expenses. It is prudent to get a list of all estimated rates prior to the engagement of their service.

It is important to recognize that even though they are expensive, these costs may easily be recouped if the consultant provides insight, resources or connections that the hospital cannot achieve on its own.

STRATEGY & LONG-TERM PLANNING

2. **Loyalty** – Good consulting firms will become a seamless part of your hospital's team for the duration of the engagement. They will function as one of your staff and work your problems as if they were their own. The best will attempt to help the hospital find long-term solutions to the challenges that created a need for their service in the first place, hopefully leaving your hospital in much better shape than when they started. Conversely, the primary focus of some consulting firms is to create some level of dependence on the services they offer. Be wary of the consultant who states "I will do such a great job that you will never want to see me go."
3. **Develop clear expectations** – Be extremely clear with the consulting firm exactly what you expect including deliverables you have. Identify in advance or with the consultant prior to engagement exactly what services you need and what outcomes you expect.

For example: a consulting firm engaged to reduce the amount of days in accounts receivable can obtain the desired effect through aggressive patient collection practices or by classifying accounts that are potentially collectable as bad debt. Either scenario may be unacceptable to the hospital, but unless expectations are clearly stated in the contract, it is possible for the consultant to fulfill the contract while violating the spirit of the hospital intention.

Tim Putnam DHA, FACHE is President/CEO of Margaret Mary Community Hospital in Batesville, IN, and can be reached at tim.putnam@mmch.org or (812)933.5150. He is passionate about the need for great leadership in community health and the need to work together in a cooperative manner, and is willing to help other small hospitals be successful.

ICAHN Organizational History

by Pat Schou, Executive Director, Illinois Critical Access Hospital Network

In the Beginning . . .

Illinois Critical Access Hospital Network (ICAHN) began operations in 2003 as the vision of the chief executive officers of twenty Illinois critical access hospitals who had envisioned a network which would support and strengthen CAHs. The organization was incorporated in the State of Illinois and a request for not-for-profit status was submitted to the Internal Revenue Service. Nine CEOs agreed to serve on the first ICAHN board. Each of the original CAHs became members of the organization and paid an initial assessment fee, followed by annual dues. In December 2003, the ICAHN executive director was hired, and the ICAHN office was opened in Princeton, Illinois. ICAHN initially provided information technology services, educational programs, user group activities and administered both the Medicare Rural Hospital Flexibility Grant and the Small Hospital Improvement Performance Grant for the Illinois Department of Public Health Center for Rural Health.

ICAHN Mission – 2006

In March 2006, the ICAHN Board expanded its mission to read “The mission of our organization is to strengthen Illinois critical access hospitals through collaboration. ICAHN will accomplish its mission through core network activities by:

- Ensuring appropriate funding and financial resources;
- Continuing efforts to be the recognized resource on critical access hospitals in Illinois;
- Promoting efficient use of information technology services for the network and members alike;
- Maintaining and further developing specific-type user groups, activities and list serves that promote hospital operational efficiencies and connectivity;
- Offering on-going educational opportunities and resources;
- Developing and offering projects that are self-sustaining and which add value to the organization and its members;
- Developing and offering shared services that offer value to members.

Membership

Any Illinois CAH is eligible for membership with each CEO hospital member having one vote. The nine-member board of directors is elected by the general membership at the annual meeting in January. Board members may serve two consecutive three-year terms and elect the corporation officers (president, president-elect and secretary/treasurer) each year.

ICAHN Organizational Structure and Services

ICAHN is a 501 (c) (3) tax exempt corporation, is membership-based, and has its own bylaws. The annual membership dues is \$7,000 per facility and may be paid in full in January at the beginning of the ICAHN fiscal year or through an approved payment plan. Members have the opportunity to participate in all ICAHN activities including user groups, committees, list serves, educational events and activities, and have access to grants and group pricing products/services such as tele-pharmacy. ICAHN members have access to ICAHN shared services programs such as IT direct services, physician recruitment, and managed care services at special member rates. In addition, ICAHN members may participate in its provider external peer review network and CAH quality and operational benchmarking program providing statewide and regional CAH comparisons. Members may receive survey assistance, access to employee health insurance products, health information exchange, education and training assistance on meaningful use. ICAHN publishes a quarterly newsletter and publications on current topics such as the hospitalist program.

GENERAL INFORMATION ABOUT ICAHN & CRITICAL ACCESS HOSPITALS

Value of ICAHN Network

The intrinsic value of a network of fifty like hospitals is the ability for staff, department managers, senior leadership, professional staff and board members to connect with peers through educational meetings, list serves, workgroups and advocacy efforts. Members can share best practices and problem-solve issues and situations together. ICAHN can develop and provide high quality shared services at a lesser cost as a group. Often, the answer to a situation is just a phone call or email away from another CAH member.

ICAHN Impact as a CAH Voice

As a network of the fifty Illinois CAHs, ICAHN has become a voice for the CAH community in Illinois and nationwide. ICAHN represents collectively \$3 billion in gross revenues, 10,000 employees, 2,500 providers serving a rural population base of over 1.2 million residents.

ICAHN Partnerships

ICAHN has established partnerships with Illinois Department of Public Health, Illinois Department of Healthcare and Family Services, Illinois Rural Healthnet, Illinois Hospital Association, Southern Illinois University, Northern Illinois University, Western Illinois University, University of Illinois, Western Illinois AHEC, Illinois Foundation for Quality Health Care, American Heart Association, Illinois Pharmacists Association, and many other state organizations.

ICAHN has partnered with the National Rural Health Association, Illinois Rural Health Association, and the Illinois Hospital Association to advocate with Illinois General Assembly and Congress for CAH and other rural health issues.

ICAHN Office

The ICAHN office is located at 245 Backbone Road East, Princeton, Illinois 61356. The office phone number is 815-875-2999/fax 815-875-2990. The web site is www.icahn.org. Office hours are Monday through Friday from 7:30 am to 5 pm.

Pat Schou is Executive Director of the Illinois Critical Access Hospital Network; 245 Backbone Road East; Princeton, IL 61356; 815.875.2999; pschou@icahn.org.

Critical Access Hospital 101

by Pat Schou, Executive Director, Illinois Critical Access Hospital Network

Legislation enacted as part of the Balanced Budget Act of 1997 authorized states to establish a Medicare Rural Hospital Flexibility Program (Flex) under which a small rural facility could apply to become a critical access hospital (CAH). A CAH is a separate Medicare provider type with its own Conditions of Participation, provider number, and a separate payment methodology.

Definition and Eligibility

A CAH is a small, rural acute care hospital located in a state participating in the Flex program which has met the following criteria to achieve CAH designation status by the Medicare program as of January 1, 2011:

- Be located in a rural area or be treated as “rural” under a special provision that allows qualified hospital providers in urban areas to be treated as “rural” for purposes of CAH;
- Furnishes 24-hour emergency care services, using on-site or on-call staff;
- Provides no more than 25 inpatient acute care beds; however, a CAH may also operate a distinct part rehab or psychiatric unit of up to 10 beds;
- Have an average annual length of stay of 96 hours or less; and
- Be located either more than 35 miles from the nearest hospital; more than 15 miles away in areas with mountainous terrain or only secondary roads; or by December 31, 2005, be state certified as a “necessary provider” of health care services to residents in the area.

Prior to January, 2006, states were permitted to establish their own rural hospital eligibility for the CAH program through a program called “necessary provider of health services” and most rural hospitals, particularly in the Midwest, are located less than 35 miles from another acute care hospital. All Illinois CAHs were approved as necessary provider of health services because of this distance issue. Illinois CAHs met either one or all four of the Illinois necessary providers criteria (i.e. > % elderly; > % residents over 200% federal poverty level; health professional shortage area; physician shortage area). There are 1,350 CAHs across the country as of 2010, and only those small rural hospitals that meet the distance requirement can be approved as a CAH. There are 51 CAHs in Illinois.

Payment System

Medicare reimburses CAHs for providing most inpatient and outpatient services to Medicare beneficiaries on the basis of 101% of the hospitals’ allowable and reasonable costs. CAHs are not subject to inpatient and outpatient prospective payment systems, are not paid on the basis of diagnostic related groups or ambulatory procedure codes, and not required to “bundle payments.” The Medicare Part A and Part B deductible and coinsurance rules applicable to hospital services also apply to CAHs. All outpatient CAH services are subject to Part B deductible and coinsurance except for identified clinical lab services, vaccine and colorectal cancer screening service. Observation services and swing bed (skilled nursing services) are paid at 101% of reasonable costs. Medicare beneficiaries are responsible for co-pays for each service used. CAHs are required to follow Medicare billing and coding guidelines for hospitals unless exceptions are noted. CAHs are subject to recovery audit contractor reviews and must be particularly careful with documentation for observation services, medical necessity and Medicare beneficiaries requiring three inpatient days for swing bed services.

An important element of the CAH program is the opportunity to expense capital building and equipment based on the percentage of Medicare beneficiaries using that department’s service. CAHs have been able to upgrade their facilities, build new facilities and vastly improve their diagnostic and patient services as a result of this provision. The Medicare cost report is the major determinant for identifying capital expenses and establishing rates for inpatient/outpatient per diem charges along with swing beds.

GENERAL INFORMATION ABOUT ICAHN & CRITICAL ACCESS HOSPITALS

Hospital Operations

CAHs must comply with the CAH Medicare Conditions of Participation, which includes swing beds regulations if the CAH has a swing bed program. The Illinois Department of Public Health is responsible for surveying hospitals to ensure these Conditions are met unless a CAH has another approved accrediting body such as The Joint Commission conduct the survey. This URL is www.cms.gov/manuals/Downloads/som107ap_w_cah.pdf.

CAHs must also comply with the State Hospital Licensing Act; but for the most part, state and practice act requirements take precedence. This URL is www.ilga.gov/commission/jcar/admincode/077/07700250sections.html. CAHs are subject to other regulations such as Emergency Medical Treatment and Active Labor Act; Sexual Assault Act; Emergency Preparedness; Maternal Services Plan if providing obstetrics.

CAHs can have no more than 25 beds set up and staffed; however, they may have a few additional beds for observation patients and outpatient services as long as those beds are not used for inpatient care. An observation patient may be placed in an inpatient bed, but an inpatient cannot be placed in an outpatient bed if there are more than 25 beds. Surveyors will monitor these bed counts. The Illinois Department of Public Health allows CAHs to have up to three beds in reserve for emergency situations and must staff at least two beds to be considered an acute care hospital in Illinois. There is no limit on outpatient services provided at a CAH.

It is vitally important for CAHs to have an active case management program to monitor average length of stay (ALOS) and observation patient stays. CAHs are required to have an annual ALOS of less than 96 hours for inpatients. The ALOS does not include observation, swing bed or observation patients and is reported in the hospital's Medicare cost report each year.

Key Issues

- The intent of the CAH program is to focus on primary and emergency care, outpatient diagnostics and therapeutics, along with swing bed services as opposed to a hospital offering a full array of services. The CAH program is afforded flexibility in its staffing and regulatory requirements to accommodate limited resources. A CAH must have a transfer agreement with at least one resource/tertiary care hospital.
- The CAH program does not require any changes to hospital governance or medical staff structure.
- A CAH is paid on cost by Medicare and negotiates contracts for services with all other payers except for Medicaid, which will soon be paid on cost for its outpatient services and fee for its inpatient services.

Pat Schou is Executive Director of the Illinois Critical Access Hospital Network; 245 Backbone Road East; Princeton, IL 61356; 815.875.2999; pschou@icahn.org.

Board Self-evaluation

by John Perushek, Chief Executive Officer, Morrison Community Hospital

The following are specific objectives that will be met as a result of performing a governance self-evaluation:

1. To assess the board members' knowledge, understanding, and commitment to the facility's current mission.
2. To determine the board's intentions regarding the facility's mission in the event the current mission is inadequate.
3. To assess the board members' knowledge base, governance skills, and dedication regarding their ability to make informed decisions on behalf of the facility.
4. To comply with Joint Commission requirements.
5. To assess the board members' perceived role as it pertains to board/administrator relationships, medical staff relationships, community involvement, quality assurance, political involvement, strategic planning, fiscal responsibilities, and evaluating all phases of hospital performance, for the purpose of enhancement of all of these factors.
6. To assess the need for various board educational opportunities and pursue various tools designed to increase the knowledge base of the board members.
7. To determine the board members' perceptions of the role of the administrator for the purpose of clarification and delineation of what that role should be.
8. To establish a formal performance evaluation process for the administrator.
9. To evaluate an ideal makeup for the board for the purpose of creating an effective structure which would recognize and make use of the talents of individual members as well as future members.
10. To evaluate the procedures for conducting business of the board for the purpose of establishing an efficient and effective system.
11. To establish an effective system of setting policies and goals of the hospital.
12. To establish an ongoing method of evaluation for the board's performance.
13. To assess the board members' understanding of the "medical staff function" for the purpose of fostering cooperation in achieving the goals of the facility.
14. To assess the board members' understanding and commitment to the quality improvement process for the purpose of governance through quality initiatives.

An example of a typical governing board self-evaluation and CEO survey follows as **Exhibit 1**.

John Perushek, CEO of Morrison Community Hospital, has been in hospital administration for 40 years and has gained much knowledge through his many experiences along the way. John can be reached at (815)772-5502 or jperushek@machstaff.com.

GENERAL INFORMATION ABOUT ICAHN & CRITICAL ACCESS HOSPITALS

Exhibit 1 – Board Self-evaluation

PERFORMANCE EVALUATION

BOARD OF DIRECTORS OF GOTHAM CITY COMMUNITY HOSPITAL

The following is a survey instrument designed to evaluate the performance of our Board of Directors. In order to be effective in our jobs, we must be made aware of the things we do well, and those which we do not. By determining our strengths and weaknesses, we position ourselves to excel areas in which we excel, and correct deficiencies. From these evaluations, we will establish the goals and objectives that we want to achieve for the coming year.

Please complete all of the questions to the best of your ability. Return the survey to Ben Franklin, Chairman of the Board. The responses will then be compiled and the results made known at a special Board meeting.

I. MISSION	YES	NO
1. Do you feel comfortable enough with your understanding of our mission so you can adequately explain and defend it to someone who asks questions regarding our purpose and philosophy?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you agree with our mission as stated in our current mission statement?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you agree that defining and supporting a mission is one of the most important functions of a board of directors?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you agree it is important to review and modify the mission statement annually?	<input type="checkbox"/>	<input type="checkbox"/>
II. EDUCATIONAL NEEDS		
1. Do you believe that you have been offered adequate educational opportunities to improve your knowledge base regarding all phases of hospital matters?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you agree that the “hospital should initiate comprehensive, systematic information programs for the Board members” aimed at familiarizing themselves with all phases of hospital matters?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the Board have adequate access to information materials such as journals, books, newsletters etc?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you believe that the Administrator “should be made responsible for this education and held accountable for its effectiveness”?	<input type="checkbox"/>	<input type="checkbox"/>
5. Should the Administrator “summarize lengthy documents, laws, and reports” to save Board members’ time?	<input type="checkbox"/>	<input type="checkbox"/>
III. ORIENTATION		
1. Do you feel that the current Board Orientation Program is effective?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are the responsibilities, time commitment, and duties of the Board fully understood before a Board member is nominated to run for the Board of Directors?	<input type="checkbox"/>	<input type="checkbox"/>

GENERAL INFORMATION ABOUT ICAHN & CRITICAL ACCESS HOSPITALS

IV. BOARD ADMINISTRATOR RELATIONSHIP	YES	NO
1. Has the Board clearly informed the administrator regarding its expectations of him?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the Board agree that it is the responsibility of the Board to determine what has to be done, and it is the Administrator's responsibility to determine how to do it?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is there a formal, effective system of evaluating the performance of the administrator?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is there a formal, effective method of selecting a qualified administrator should the need arise?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is there adequate communication between the Board and the Administrator?	<input type="checkbox"/>	<input type="checkbox"/>
6. Will the Board willingly accept the Administrator's contribution to policy formulation?	<input type="checkbox"/>	<input type="checkbox"/>
7. Will the Board actively support and assist the administrator should the need arise?	<input type="checkbox"/>	<input type="checkbox"/>
V. COMPOSITION OF THE GOVERNING BOARD		
1. Is the number of Board members sufficient to be effective?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do the bylaws adequately stipulate the process for which a Board member is appointed?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the above process followed?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are Board members appointed based on needed talents and skills?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the Board made up of people representing the health care community's interests?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the Board have a physician member?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the Board adhere to the bylaw provision regarding attendance?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the Board appropriately use the disciplinary procedure?	<input type="checkbox"/>	<input type="checkbox"/>
9. Are the current terms of office provisions appropriate?	<input type="checkbox"/>	<input type="checkbox"/>
10. Is the current conflict of interest policy effective?	<input type="checkbox"/>	<input type="checkbox"/>
VI. PROCESS		
1. Is the recording of business being adequately kept?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the present committee structure effective?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are meetings conducted in a clear, organized, efficient manner?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are Board members sufficiently prepared to discuss all matters and make informed decisions prior to Board meetings?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the Board work together in a cooperative, harmonious, team-oriented manner?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are the number of meetings adequate to fulfill the needs of the Board?	<input type="checkbox"/>	<input type="checkbox"/>

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VII. BOARD/MEDICAL STAFF RELATIONS	YES	NO
1. Is the procedure for Medical Staff appointments effective?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the process by which conflicts are addressed effective?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are the bylaws pertaining to the medical staff adequate?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are the medical staff bylaws adequate?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is communication between the Board and Medical Staff effective?	<input type="checkbox"/>	<input type="checkbox"/>
6. Is there adequate physician representation to the Board?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the Board make the appropriate effort to recognize the concerns of the Medical Staff?	<input type="checkbox"/>	<input type="checkbox"/>

VIII. OTHER

1. Do the members of the Board of Directors effectively represent the hospital to all?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the Board making effective and appropriate financial decisions?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the Board an effective participant in strategic planning decisions?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is the Board politically influential in matters pertaining to the hospital?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the Board adequately involved in quality assurance issues?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the Board effectively promote the hospital?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the Board always strive to make itself better?	<input type="checkbox"/>	<input type="checkbox"/>

BOARD/ADMINISTRATOR INFORMATION EXCHANGE SURVEY

(To be completed by the CEO)

Indicate the number of the response that matches your answer most of the time.

(1. = always 2. = most of the time 3. = half of the time 4. = almost never 5. = never)

CEO's RESPONSE

1. I feel that I provide the Board with adequate information necessary for them to make informed decisions. _____
2. I feel that the Board understands my role as the Administrator of our facility. _____
3. I understand my role as the Administrator of our facility. _____
4. I feel that the Board gets too involved in the day-to-day operation of the facility. _____
5. I feel that I get the necessary feedback from the Board regarding my performance. _____
6. I feel that the Board is supporting and assisting me to my satisfaction. _____

GENERAL INFORMATION ABOUT ICAHN & CRITICAL ACCESS HOSPITALS

7. I feel the Board is committed to taking advantage of educational opportunities that present themselves. -----
8. I am satisfied with my efforts in presenting educational opportunities to the Board. -----
9. I feel that Board members are adequately prepared to sit on the Board. -----
10. I feel that the Board gives me an opportunity to express myself when it comes to decision making and policy making. -----
11. When evaluated by the Board, I am given an opportunity to discuss my evaluation. -----
12. My contribution to the above discussion carries sufficient weight. -----
13. I feel that I listen well when Board members offer their suggestions. -----
14. I feel that the Board listens well when I offer suggestions. -----
15. Should disagreements arise, I feel that some Board members take it personally. -----
16. I feel that the reporting system to the Board is effective. -----
17. I feel that the Board has been fair and honest with me. -----
18. I feel I have been fair and honest with the Board. -----
19. I feel I have established credibility with the Board. -----
20. I feel that I have sufficiently kept up with the changes in the health care field. -----
21. I believe that the Board has kept up with the changes that have occurred in the health care field. -----
22. I sometimes feel intimidated by the Board. -----
23. I feel that the committee system allows for adequate information flow necessary to make informed decisions. -----
24. I provide information to the Board regarding changes in regulations, reimbursement, and other governmental concerns as needed. -----
25. I encourage the Board to become politically active to help influence health care legislation. -----
26. I provide needed information to the Board regarding matters pertaining to the Medical Staff. -----
27. I review all matters pertaining to meetings with the Executive Committee. -----
28. I provide assessment to the Board concerning its effectiveness. -----
29. I give the Board an opportunity to express itself and seriously consider those expressions. -----
30. The Board gives me equal consideration when I express my concerns. -----
31. I feel that I have a good working relationship with the Board. -----

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Additional Resources

by Bill Spitzer

American College of Healthcare Executives, (www.ache.org): National professional society of hospital CEOs; repository for Code of Ethics.

American Hospital Association [www.aha.org or American Governance and Leadership Group (AHA and four consultants) (www.americangovernance.com): On the AHA website, click on “Trustee and Governance Resources” for a list of “Governance Initiatives and Activities.”

Board Source, (www.boardsource.org), formerly “National Center for Nonprofit Boards”, presents books and workshops.

Credentialing Resource Center, (www.credentialingresourcecenter.com): Resources for hospital credentialing of medical staff.

Estes Park Institute, (www.estespark.org): present major conferences on non-profit governance for board members, CEOs, and physician executives.

Governance Institute, (www.governanceinstitute.com): founded in 1986 by Charles Ewell and now owned by Housatonic Partners, provides educational events and publications to hospital governing boards.

Greeley Company, (www.greeley.com): Educational events for hospital accreditation, credentialing systems, peer review, etc.

Illinois Attorney General, (www.illinoisattorneygeneral.gov): information on Open Meetings and Freedom of Information Acts.

Illinois Critical Access Hospital Network, (www.icahn.org): Network of fifty Illinois critical access hospitals. Provides educational activities, links to other CAHs, etc.

Illinois Hospital Association, (www.ihatoday.org): Key resource for information on Illinois governmental activities related to hospitals. See section on “Small and Rural Constituency.”

Illinois State Health Facts, (www.statehealthfacts.org) provides new and updated data on Demographics & the Economy, Health Status, Health Coverage & Uninsured, Medicaid & CHIP, Medicare, Health Insurance & Managed Care, Providers & Service Use, and Women’s Health Disparities.

Institute for Healthcare Improvement, (www.ihl.org): “A global community dedicated to improving health care for all patients.” Excellent source of continuing education regarding patient safety and quality.

National Rural Health Association, (www.ruralhealthweb.org): Member-driven organization that provides advocacy at federal level and educational programs. Your hospital is likely a member.

Trustee Magazine, (www.trusteemag.com): The one essential monthly read for every hospital board member. Current and past issues can be accessed from this website. Published by a subsidiary of the American Hospital Association.

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