

Critical Access Hospital

# **Governing Board Manual**

Volume III – 2020

# Foreword



Rural hospital governing board members are special people and are to be held in the highest regard. They are rarely in the limelight, and this is their chance to shine. They spend countless hours every year preparing for, then attending and participating in, their respective board meetings. Hospital governing board members are teachers, car dealers, pharmacists, bankers, store owners, local attorneys, carpenters, electricians, farmers, moms, and retirees, to name a few. These wonderful individuals are thrust into a very complex, highly-charged environment – *where the stakes could not be higher* – asked to make tough decisions and ultimately, assume total responsibility for the overall care provided by the hospital.

Governing board members represent the community and are the barometer for identifying hospital issues and community healthcare concerns. In small, rural Illinois communities, the hospital is most often the largest or nearly the largest employer. It is well known that the local hospital success and sustainability are critically important for the growth and stability of that same local community served.

Hospital governing board members serve with no financial reward, and yet, they do so out of respect and duty for their communities. Most agree to serve with little idea of what the job entails and wonder, after the first couple of meetings, why they agreed to serve. The good news is, after several months, board members become fascinated with the healthcare business and quickly realize how much their rural hospital depends on their leadership and commitment. Regardless of tough times, they remain loyal and steadfast and are the hospital cheerleaders within the community. Hospital governing board members deserve our gratitude and thanks for their willingness to ensure access and quality services for their local communities.

We sincerely hope the articles in this manual help board members better understand their tasks and reassure that their problems are far from unique. *We are all in this together.* Hospitals are all about people helping people. The Illinois Critical Access Hospital Network (ICAHN) is all about helping our hospital governing board members help others. We welcome your feedback/suggestions and thank you for your continued support.

Joann Emge, ICAHN Board President

Pat Schou, ICAHN Executive Director



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*A special thank you to the authors for their contributions and to Curt Zimmerman, ICAHN Senior Director of Business Services and Development, and Stephanie DeMay, ICAHN Communications and Media Specialist, for the organization, editing, and design of this document.*

## I. Hospital Governance: *The Board Member's Role*

# *So you want to be a board member...*

By TOM VAUGHN

*Former Board Member, Franklin Hospital, Benton*

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 made the motion to close the county's only remaining hospital. The large area healthcare corporation had given up trying to make it a viable entity and was leaving. It was about as low as I've ever felt.

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.

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

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*"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."*

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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 a hospital the board visits only monthly.

The board member generally serves with a diverse group of individuals who each brings 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.*

You take personal possession of everything in this environment. It's "your hospital," "your CEO," 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**. 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.

### **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 health-care in general will make you a better board member every year.

There are several things you as a board member are not. You are not someone who is going to "fix that hospital." Your job is to make and change policy, provide oversight, and make decisions about the organization's vision, mission, and strategies. You are not someone who is going to secure employment for others. Your desire is that your appointment to the board benefits the hospital only. 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 a shortcoming in meeting a citizen's expectations.

So no, your hospital is not going to "run itself," but 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 the hospital runs itself.

# Selecting a New Board Member: *Finding an Effective Community Voice*

By MARY ROONEY SHEAHEN, MS, RN  
Board Chair, Midwest Medical Center, Galena  
President, The Sheahen Group

Every board works to be effective, to be engaged in meaningful work, and to be supportive to the work of the organization. To achieve those goals, a board must continue to recruit other new directors who will work for those same goals.

The recruitment process must be organized, thoughtful, and ongoing. Developing a thorough approach will help to streamline the process and will ensure that each potential candidate will be treated the same.

The governance committee or a board development committee can be responsible for the creation of a process. Bylaws will outline the committee structure and identify which committee will have the overall responsibility for recruitment. Boards generally have nominating committees who assume the implementation of the recruitment activity. Before an active recruiting process is begun, there are several steps that will support the work of the nominating committee.

First, it is important to develop a board member job description. This will be very useful when a prospective director is considering joining the board. Some questions to explore include:

- What is expected of a board member?
- What is the attendance requirement?
- How many committees will a director be expected to participate in?
- What is the expectation for philanthropy?

This is an expectation that is often not clear and for some, it could be a barrier to joining the board.



It is best to speak of this upfront, so there is no misunderstanding. Board terms should be clearly spelled out. Once a job description is completed, consider developing a matrix of desired skills and the skills that are present on the board with current directors. Some questions to explore include:

- What areas of expertise might be needed?
- Are you seeking to become more diverse; whether it be ethnicity, gender, or age of members?
- Do you need members who have certain community connections?

The matrix can have any categories that the board values in its members, and the matrix will be used as a cross reference with a board candidate's qualification. An application form should contain key areas that have been identified in both the job description and the matrix. The application will help the committee discern applicants that may fit the identified matrix of potential new members.

The next part of the process is the identification of potential new members. All board members are asked to identify possible candidates to share with the nominating committee. The CEO must be included actively in the process.

Having a robust pool of potential candidates allows the board to be very selective. In a smaller community, most applicants will be known to many, if not all, current members. In some larger communities, the board may engage a search firm to identify and screen candidates. The nominating committee takes responsibility to review the identified potential candidates and to recommend who should be approached to ascertain their interest in joining the board.

Once an individual indicates an interest, an application should be sent. The applications are reviewed by the committee, and there needs to be a consensus about who should be interviewed. The interview process should be rigorous and consistent. Candidates will gain a sense of the seriousness of the board through this interview.

An important thing to note: people should be asked if they wish to be considered for a position so it does not appear to be guaranteed. There could be an issue or a conflict that is identified in the process, and the committee needs to be able to say no if necessary.

Recruitment is often in response to vacancies or board members who have reached their term limits. But it is wise to continually have an active process. Board size is dictated by the bylaws and it is helpful to have an up-to-date list of candidates. You may want to invite potential candidates to join a committee, such as finance

or quality. That allows a future member to learn about the organization and how it functions. Once new members have been interviewed and have been asked to join the board, a robust orientation is important. It is through this process that expectations can be reiterated, introductions to the organization's team members are made, and the new member will gain an understanding of the board functions and operations.

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"The interview process should be rigorous and consistent. Candidates will gain a sense of seriousness of the board through this interview."

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Every new person should have a mentor. This mentor is available for questions, for introductions to all other board members and for ongoing support as the member becomes involved and engaged.

An evaluation at the end of the first year will allow discussion of the member's engagement and will offer the member an opportunity to share concerns or to ask questions. Not every board member works out, and an organized process will make a difficult discussion a bit easier. Time and effort to create a consistent and thoughtful recruitment process will be time well spent.

All members are responsible to contribute to the ongoing success of the board. Planning for that success will reap great rewards.

*Mary Rooney Sheahen, MS, RN, Board Chair, Midwest Medical Center, Galena, and president of The Sheahan Group, has more than 30 years of healthcare leadership experience, with 20 years at a senior level in hospitals.*



# The Role of Advocacy in Hospital Board Governance

By **DOUG FLORKOWSKI**

*Chief Executive Officer, Crawford Memorial Hospital, Robinson*

All too often hospital board members are so caught up with the day-to-day challenges of trying to survive in today's healthcare environment that they lose sight of their ability to personally impact their hospital at a local, state, and federal level.

Advocating for your hospital is not an option: it's a necessity. We expect hospital administration and employees to be able to speak of their commitment to the community, the quality of healthcare that is being delivered, and the overall impact we have on our community economically. The same holds true for the board of trustees. Being able to communicate what's right with your hospital builds trust and understanding within your community. Bottom line – this doesn't happen enough.



In their book *The Source: Twelve Principles of Governance that Power Exceptional Boards*, Board Source explains that "members of an exceptional board extend the reach of the organization by actively using their own reputations and networks to secure funds, expertise, and access. They bring social and political capital to the organization, thereby enhancing its reputation and capacity. They use their personal and business relationships to expand awareness of the organization and actively participate in cultivating partnerships and collaborations. Serving as the community face of the organization, they advocate on behalf of the organization in appropriate public contexts."

## Never underestimate your impact locally

When advocating locally, more is better. As it pertains to the general public, one of the biggest challenges facing critical access hospitals today is that too few people know our story. We don't do a great job in tooting our own horn.

Repeatedly spreading the word of the incredible care being provided by your hospital is so impactful coming from a board member. Everyone in your community expects the CEO to carry this message. It's their job. When a board member carries that same message: *it's powerful*. It's the message of a volunteer advocating for something they believe in. Community members recognize unbiased opinion when there is no personal gain. Advocacy for the greater good of your community is the best kind.



This is certainly true when discussing the delivery of high quality healthcare. As a hospital board member, you are a leader within your community. A board member's perspective may explain in a way that your community can better relate. Oftentimes, it takes hearing the same message a number of different ways to understand the impact of decisions or to effectively communicate the benefits of your hospital to your community. A board member has the ability to personalize the care that is being provided because it is usually being provided to family, friends, or neighbors. Your connection to the community is one of the best ways to influence loyalty, gain trust, and understanding.

### **Priority over quantity, politically-speaking**

Many of the end results of advocating in your community apply politically but with a little bit different approach. As it pertains to legislators, board members should be a bit more measured in how much they communicate. It is imperative to collectively prioritize what is important to your hospital and to focus on specific issues instead of focusing on all of your challenges. The last thing you wish to see happen is your message falling on deaf ears.

Legislators are inundated with requests from their constituents and, right or wrong, they will make their own opinions whether we have gone to the well one too many times. This holds true for all levels of government. Whether it is advocating for changes in policy/regulations or seeking support at the local, state, or federal level, it is important to have an informed, laser focus when speaking to legislators and their staff. They should be able recognize the sincerity of your message and the priority that you have placed on it. This will always make a more significant impression. This is the heart of grassroots advocacy, and this is how a meaningful impact occurs.

### **If it was easy, everybody would do it**

The hardest part of advocacy is stepping outside of your comfort zone and putting yourself out there when the opportunity arises. But the more you do it, the easier it gets. When you are well informed on a specific message you are communicating, it really becomes second nature. Whether it's setting up a meeting with legislators, speaking to civic groups, at public forums or community events, being willing to say 'yes' to these opportunities is the first step to being an effective advocate for your hospital.

Advocacy is about building relationships. Advocacy is about passionately supporting the hospital that you believe in. Whether it involves a member of Congress, a state senator, or your neighbor down the street, advocacy can produce a positive influence on behalf of your hospital, instill confidence in your community, and be incredibly rewarding at the same time.

*Doug Florkowski serves as chief executive officer of Crawford Memorial Hospital. Prior to being named CEO at Crawford Memorial Hospital in 2017, Mr. Florkowski had served as CEO at Lawrence County Memorial Hospital since 2006.*

# An Effective Recruitment Strategy for Hospital Providers and their Workforce

By **MICHELLE S. HOUCHIN, MSL, CMPE**  
*President, Adkisson Search Consultants*

More than ever before, the demand for healthcare providers is increasing, causing a daunting challenge to healthcare organizations who are already preparing to replace retiring providers or expand their services to meet the needs of the community.

Today, the composition of the U.S. population is attributing to the unusual dynamics of healthcare. The millennials, those born between 1981 and 1997, have surpassed the baby boomers (born between 1946 and 1964) as the largest age demographic in the country. This younger generation is at the age that they will be looking to establish a healthcare provider for their personal and family needs.

Similarly, the boomers, who are still a significant portion of the population, are retiring (providers included – which decreases the number of practicing providers) and will need more medical attention as they age. This is a classic example of demand exceeding supply. In today's market, providers can go wherever they desire, pressing healthcare organizations to become even more creative and think outside the box to attract new providers.

There are many factors to consider in developing an effective and successful recruitment strategy. It begins with the healthcare organization and medical staff working closely together in determining how they define who they are, why they

are recruiting, and what characteristics are being sought in their next recruit. In other words, staying true to your mission, vision, and values when deciding who will fit best in the organization will guarantee the right candidate is hired. The strategy then includes selecting and building an interview team that will plan, prepare, and structure a thoughtful interview process. This process plays a significant role from the first telephone interview up to the time the candidate signs. Providers will be paying attention to how well the organization communicates and if they demonstrate who they say they are.



Michelle S.  
**HOUCHIN**  
MSL, CMPE

## Selling Intangibles

Stressing the importance of selling the intangibles: those things available in your area for families in terms of activities, education, cultural diversity – anything that would be appealing to a potential candidate and his or her family are things that should be highlighted. The provider will seek a place to live that offers good schools for their children, recreational and entertainment opportunities that suit their

personalities, vacation time, continuing medical education, and access to necessary technology, and facilities.

### Timing is Critical

The timing of beginning a search is critical. Once a healthcare organization knows a provider is planning to leave the practice or they are expanding their organization, even if it is a year or two in the future, the search should begin immediately. Recruitment takes time and dedication to find the right fit. There is a process involved in matching the needs of the healthcare organization with the desires of the physician. It literally may take months to work through the sourcing process to capture the attention of a viable candidate who exhibits the qualities the entity may be seeking.

Internal resources may appear successful initially, but if too much time passes and there has been no interest in the opportunity and contracts are not signed, the situation may require the consideration of utilizing an outside search firm. Many times, by the time a search firm is retained, the organization is in panic mode and expects candidates right away, but that is not always possible. If an outside search firm is chosen, it is imperative to understand the role of the recruiter. **When a candidate is presented, it is up to the healthcare organization to immediately call the candidate to let them know the organization is interested in considering his or her application.**

It is important to establish a rapport and provide the “warm and fuzzy” feeling of belonging to the right candidate to convince them the position is one they will be happy with.

### Transparency and Communication

Keeping the candidate engaged will become extremely important throughout the entire search process ... even more so once the candidate has been on-site to interview. Remember to keep communications frequent, be transparent with expectations, past, current and future plans of the organization, and be creative when it comes to salary expectations, sign-on bonuses, and student loan reimbursements.

In other words, when a candidate expresses interest, and the client believes they are the right cultural fit, the client must be willing to adjust and be flexible.

### Recommendations to remember

- **Be patient** – understand from the beginning of the process that it will take time. Finding, vetting, and preparing the perfect candidate for the position is a process that takes time.
- **Communicate** – be transparent and respond immediately when either the recruiter contacts you or when you have a candidate who is interested in the position you are offering.
- **Be creative** – think outside the box instead of being rigid regarding salary and benefits. Be open and consider what the candidate is offering and asking.
- **Stay engaged** – Keeping your candidate engaged is critical from the inception of the relationship up to when the candidate begins employment.

*Michelle S. Houchin, MSL, CMPE, President, Adkisson Search Consultants, has more than 30 years' experience in the healthcare and the executive recruitment industry.*



# Hiring CEOs and Conducting Annual Performance Reviews

By **MICHAEL LIEB**  
*Vice President, HealthTechS<sup>3</sup>*

## Selection of the CEO

The selection of the management team, and in particular of the chief executive officer or CEO, is the single most important duty of the hospital board. It is through the CEO that the strategic plans approved by the board are to be implemented. It is the CEO, and his or her team, that executes the operational functions of the hospital, keeping the board at the strategic level, and out of day-to-day management functions.

A thoughtful vetting of candidates, using a seasoned executive search professional, is critical to the successful placement of a good leader. A well-crafted search process can help determine the specific traits and experience levels needed to lead the hospital. These include not only the administrative and financial training to manage a complex entity but, and perhaps most importantly, the “fit” to the organization and to the community. The successful leader should be an active member of the local community (or rapidly become one), should move fully into the service area, and should be expected to participate in the regional community organizations (Rotary, Chamber, etc.).

## The Search Process

Typically, a detailed search will screen 80-100 interested candidates; weed those down to around 10 solid contenders, and then present

those detailed resumes and summary information to the board in closed session.

Quite often, these candidates are searching for opportunities quietly, and cannot afford to have their present employers become aware of their interest in leaving. The board, following this review, generally will select two to four candidates for face-to-face interviews on-site. Care will need to be taken to keep the candidates from crossing paths during the interview process. One to two true finalists are then invited back with their spouses and families for a second round of on-site interviews.

During this round, the administrative team, medical staff leadership, and hospital staff should be participants in the process. Community and school tours should be provided, including time with a trustworthy local real estate agent. Assuming there is a consensus on a candidate, the board should be prepared to make an offer in writing shortly following the second round of candidate visits. The offer should be very specific in terms of compensation, bonus potential, relocation, start dates, and reporting lines.



If there isn't consensus on a candidate, then rinse and repeat. Take your time. You need to ensure that you hire the very best fit for this very important position of the executive leadership. The search executive will help with compensation recommendations and generating the offer letter.

## CEO Evaluation

Now that you have hired and placed your CEO, it falls to the board to provide ongoing evaluations. Remember, you as board members, are not evaluating the CEO based on his or her specific functions; rather, you are evaluating the performance of the organization as a whole, and in the implementation of the strategic plan.

An approach that has worked well is to have the board surveyed in writing anonymously as a first step. This can be done easily via a targeted email survey questionnaire, or with a written evaluation form which includes questions about the performance of the organization, financial and strategic successes (and failures), progress against goals for the year, and ideas for goals for the coming year.

In addition, it is useful for the CEO to be asked to complete a self-evaluation using this same tool as was sent to the board. The board chair (or management company as appropriate) will then compile those board comments in a summary and complete a written evaluation of the CEO. This is usually presented one-on-one to the CEO, either by the board chair or the executive committee of the board, depending on the organization.

Lastly, the board will need to make, and approve, compensation recommendations for the CEO. Fair market benchmarks are available from a number of sources, and can be obtained from groups like ICAHN, healthcare professional organizations, the management company (if you have one), or through the local human resources (although this is the least preferred option).

## Summary

Remember, the selection and employment of management is the vital function of the board. Having a well-planned search process and fair compensation package is important to identifying and maintaining a strong leadership team in your organization.

As a board, you need strong, capable leaders who are vested in the success of your hospital. Making certain you hire and retain the right person(s) will carry enormous benefits to your hospital.



*Mike Lieb serves as regional vice president, where he provides consultation to senior leadership of HealthTechS<sup>3</sup> client hospitals and to medical practices nationwide. He brings more than 25 years of healthcare experience, providing operational and organizational guidance to healthcare organizations. He has served as CEO in health systems of all types; large community hospitals, public hospital districts, and critical access hospitals.*

# The ABCs of Hospital Finance for Critical Access Hospital Board Members

By RALPH LLEWELLYN, Partner-in-Charge of CAHs  
Partner, Eide Bailly LLP

*"How different can hospital finances be from the other organizations I have either owned, operated, or been a part of the board?"*

Not an uncommon question to hear from a board member as they begin the journey as a critical access hospital board member. The answer, unfortunately, is "very different."

No other industry operates in the same manner as healthcare. And within healthcare, no other healthcare entities operate like a critical access hospital. The differences begin in how critical access hospitals are reimbursed by the various payors. The most common methodologies of reimbursement are: fee schedules, charge-based, and cost-based.

## Fee Schedules

Payors that reimburse under fee schedules are usually commercial insurance companies and worker's compensation. Most physician services are also reimbursed under fee schedules, except for Medicare and Medicaid reimbursement for services in the rural health clinic setting.

There are a variety of forms of fee schedule reimbursement models. Inpatient services are often reimbursed based on diagnostic related groups (DRGs). This is a fixed payment based on the reported diagnoses of the patient. This reimbursement is made without regard to the length of stay or the cost incurred by, or charges submitted by, the hospital.

This reimbursement methodology promotes the efficient provision of services.

Fee schedule reimbursement for outpatient and physician services is based on the reporting of Common Procedure Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes. These alpha numeric codes provide a common language to report the various services provided to patients.

The reimbursement services under this methodology are typically based on the lower of the charge or the assigned fee schedule. In this model, it is most important to focus on proper capture and reporting of services with CPT and HCPCS to allow for the proper capture of payment.

Since payment is limited to the lower of the fee schedule or charge, it is important to monitor all fee schedules to ensure charges are above the highest fee schedule payments. Some payors have expanded the use of this form of reimbursement to bundle various CPT/HCPCS code combinations into payment groups or bundles.





In these models, the fee schedule reimbursement includes the payment for multiple CPT and/or HCPCS codes. It is often possible for a provider to receive multiple group/bundle payments during a single patient encounter.

### Charge-based reimbursement

Payment under a charge-based payor can either be based on 100% of the charge or on a contracted percent of charge. These payors are often more desirable as they allow the hospital to control their reimbursement levels to a greater extent through the monitoring and setting of charges.

While these types of payors are rare in larger markets, they can be more prevalent in many rural markets. And while there can be greater freedom in the setting of charges/reimbursement under these models, the contracts may limit the annual increase in charges. This emphasizes the need to look at pricing adjustments each year versus larger increases every couple of years. Essentially, self-pay patients fall under this methodology as their charges and payment expectations originate based on gross charges. However, the payment that is actually received may be adjusted based on charity care or other financially-based discounting.

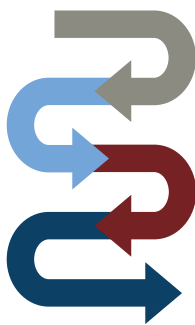
### Cost-based reimbursement

Cost-based reimbursement is the underlying basis of reimbursement from Medicare for the critical access hospital. This payment methodology relies on the submission of an annual cost report (similar to a tax return) to reconcile interim estimated payments to a final settlement. While the submission of a cost report would seem to imply the critical access hospital receives full-cost reimbursement, that is not the case.

First, the cost-based reimbursement methodology only applies to hospital-based services under the critical access hospital provider number. This would include inpatient, swing bed, outpatient ancillaries, and rural health clinics. It excludes nursing homes, home health agencies, most ambulance services, hospice, psychiatric and rehabilitation sub-units, and professional services not billed under the rural health clinic methodology. These other services are typically reimbursed under a fee schedule or other bundled payment methodology by Medicare and other payors.

For services provided under the critical access hospital provider number, Medicare will reimburse the facility for allowable costs based on the Medicare percentage of volume on a department by department basis. Direct costs in patient care areas are reimbursed in addition to the allocated overhead costs to the individual departments for items such as depreciation, benefits, administrative and general, maintenance, utilities, housekeeping, laundry, dietary, nursing administration, and health information management. Since there are many allowed methodologies that can be approved for the allocation of overhead expenses, providers must periodically review these allocations for appropriateness.

It is important to note that only allowable costs are included in the reimbursement calculation. Medicare rules require the offset of any costs determined not to be related to patient care or for miscellaneous non-patient revenues that are considered to be recoupments of expense. Examples of unallowable costs include phones and televisions in patient rooms, advertising to influence patient selection of service providers, physician recruitment (except for rural health clinic physicians) and lobbying.



Examples of miscellaneous revenue offsets include charges for medical record copies, miscellaneous supply sales, and rebates.

To complicate matters, the Medicare Administrative Contractors (MAC) and Medicare frequently issue changes in interpretations to existing regulations that can result in the disallowance of previously accepted costs. These changes in interpretation can lead to significant recoupment of previously made payments and can apply to several outstanding years of cost reports open to audit.

As previously noted, the payments throughout the cost report year are made based on estimates with a year end settlement. These estimates are based on prior year submitted cost reports with periodic adjustments for known changes in volumes and costs.

However, they are estimates, and the actual final determination of payment can lead to significant receivables or payables for the critical access hospital.

To assist in better estimating the receivables or payables, many critical access hospitals utilize an interim settlement estimator model. These models allow the facility to input year-to-date information into the model to better estimate settlements and provide for improved financial management and planning.

Since this is a cost-based model, changes in costs will change reimbursement. In difficult financial times, facilities may find it discouraging to decrease costs when a portion of the decrease will also result in a reduction in Medicare cost-based reimbursement. Cost control is still very critical, but it may take a significant reduction in costs to result in a sizable change in the financial performance of the organization.

### **The Challenge**

The big challenge for critical access hospitals is that all of these reimbursement models occur at the same time and require different strategies to maximize financial performance.

So,..."how different can hospital finances be from the other organizations I have either owned, operated, or been a part of the board?"  
*Different, very different.*

*Ralph Llewellyn is a partner with Eide Bailly LLP and serves as their partner-in-charge of critical access hospitals. He started his career as a rural hospital CFO for a 49-bed hospital with a 116-bed nursing home, clinics, and assisted living facility. For the past 23 years, he has been with Eide Bailly where he assists providers in developing strategies for maintaining compliance with Medicare and other regulations in the rural healthcare setting.*

## II. Quality and Fiduciary Responsibility

### *Understanding quality and patient satisfaction*

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One of the overarching requirements of hospital directors is ensuring quality of care is being provided and that the organization has processes in place to measure and deliver quality care. A 2014 study<sup>1</sup> of over 802 rural hospitals found that board members may not understand their responsibilities, that many lacked understanding in quality of care/patient safety committees, and that orientation is lacking on education of responsibilities and roles in reviewing quality reports. This study concluded that, in some instances, board roles needed to be clarified, rural hospital board development is urgently needed, and boards require champions and support. This article will assist in providing education and insight to board quality of care oversight.

#### **Understanding the Quality Continuum**

An effective quality program exhibits a healthy balance of work, workflow, and activities by all departments that focus on quality assessment (QA) and performance improvement (PI). Quality improvement (QI) had been a component in three areas of the previous program, but the current one has since been blended into what is now known as the QAPI program.

**Quality Assessment:** Activities are focused on delivering high quality care and services daily; also ensures compliance standards and practices, as defined by Conditions of Participation, are met and provides policies, procedures, regulations, and professional standards for all disciplines

#### **Quality Improvement:**

Involves continuous assessment of current activities; focuses on the betterment of current practices and can be seen in departmental quality improvement activities



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**Performance Improvement:** Identifies organizational improvement efforts that make the healthcare system stronger and better prepared to meet the demands of an ever-changing healthcare environment, often in the form of strategic plans, best practice changes, and innovative models of care

#### **Responsibility and Elements of QAPI**

**Board members are legally responsible for the quality of the healthcare delivered within their organizations.** The board is ultimately accountable for the actions both taken, or lack of actions performed, by every person within the healthcare system. This includes medical staff to dietary aides. The board is responsible for ensuring that an effective system exists for evaluating and improving the delivery of high quality care as noted by the five elements of the QAPI program.<sup>2</sup>



## Five Elements of the QAPI Program

Element	Key Features/Actions
<b>Design and Scope</b>	<ul style="list-style-type: none"> <li>• Ongoing and comprehensive program that includes all services by all departments</li> <li>• Includes contracted services</li> <li>• Review and approved annually by the board</li> </ul>
<b>Governance and Leadership</b>	<ul style="list-style-type: none"> <li>• Must demonstrate input from facility, family/patient representatives</li> <li>• Culture of safety in reporting errors or near misses</li> <li>• Oversight in development, implementation, and evaluation of policies and procedures for entire quality program</li> <li>• Set of priorities with consideration of high-volume, high-risk services and/or problem-prone areas</li> </ul>
<b>Program Activities</b>	<ul style="list-style-type: none"> <li>• Measures related to improved health outcomes</li> <li>• Trended data, analysis, and ongoing performance is reported to the board</li> </ul>
<b>Performance Improvement Projects (PIPs)</b>	<ul style="list-style-type: none"> <li>• Facility has PIP program addressing complexity and scope of services</li> <li>• Can be written or electronic</li> </ul>
<b>Program Data Collection and Analysis</b>	<ul style="list-style-type: none"> <li>• Method for systematic approach to quality, such as the Plan-Do-Study-Act</li> <li>• Demonstrate proficiency to performing root cause analysis (RCA)</li> <li>• Method to demonstrate continual learning and current evidence-based solutions</li> <li>• Board must approve frequency and details of the data collection on an annual basis</li> <li>• Benchmarks and data comparisons must be provided to demonstrate quality of care for board members</li> </ul>

## How to Evaluate Your QAPI Program

The following questions adapted from *The Board's Role* (Bainbridge, 2006) are still good foundational questions that can assist a new board member in fully understanding the quality of care provided within an organization.

- To what degree does your organization have a healthy quality program that has an effective balance of quality assurance and performance improvement?
- To what degree, as a board member, do you understand your role in assuring quality of care? How is information shared with you to meet this expectation?
- How satisfied are you with the reports received? Do the reports provide meaningful information to demonstrate quality improvement and improved outcomes?
- What metrics, benchmarks, and/or resources are used to determine a performance indicator?
- Who are the key leaders and management involved in the quality programs?  
What medical staff members are involved in quality?

## Quality of Care Includes Patient Feedback

Board members play a vital role in the governing strategy and business operations of the healthcare organization they serve and are also deemed essential in the voice of the community and stewards for accountability of the overall performance. While ensuring highest quality of care is provided, board members are also responsible for being vested in overall patient experience.

Patient experience has evolved over the years from simple patient satisfaction surveys to a more robust framework of evaluating patient experience through a standardized, national rating system – a rating system which is publicly reported on a national database for consumer consideration in selecting a healthcare provider and hospital. In this age of value-based purchasing (VBP), hospitals are evaluated and rewarded on clinical processes of care, efficiencies, outcomes, and the patient experience of care. While this does not directly impact critical access hospitals, the overall reporting and ratings of these surveys does indicate market trends and utilization. There are now eight areas measured in the patient experience survey, including the following:

- Nurse communication
- Doctor communication
- Responsiveness of staff
- Medication communication
- Cleanliness/quietness
- Discharge information
- Overall satisfaction (scored from 0 to 10)
- Likelihood to recommend

Many healthcare organizations engage outside vendors to administer patient satisfaction surveys and report the results. These vendors provide more up-to-date information as well as much deeper insight into the experience beyond the prescribed HCAHPS

(Hospital Consumer Assessment of Healthcare Providers and Systems) questions. In addition, they collect comments and valuable benchmark data allowing an organization to compare performance against peer groups.

Keep in mind that medical practices and emergency services are the front doors to the entire system; patient experiences here can make or break the reputation and financial well-being of the entire organization.

In its 2018 *Consumer Health Insights Survey*, McKinsey found that access to care, when and where consumers want it, is important in the total experience. Therefore, understanding access is important to the board's understanding of the experience. Consumers want shorter wait times for appointments and quicker access to appointments.

## Key Questions Board Members Could Ask

- What are our patient satisfaction scores? How do they compare to the organization's goals?
- How do our CAHPS compare to those of our closest competitors?
- What are our leaders' top priorities for making improvements?
- Does our executive sponsor have the resources allocated to help the organization achieve its goals? If not, what is lacking?
- How should board members handle complaints from community members?
- How is the hospital monitoring consumer feedback through social media?

1. Is Your Hospital's Board Prepared to Govern? Rural Acute Care Hospital Boards Of Directors: Education and Development Needed. (2010). South Carolina Rural Health Research Center. [www.raconline.org/search/search\\_results.php?key-word=board+of+directors&Submit2=Search](http://www.raconline.org/search/search_results.php?key-word=board+of+directors&Submit2=Search)
2. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/qapifiveelements.pdf>

# Board Fiduciary Responsibility: The Nuts and Bolts

By **DEANNA S. MOOL**

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The operation of a hospital is a shared undertaking between the board of directors, administration, and medical staff. It can be argued that the responsibilities of the hospital board of directors fit into three areas of responsibility.

## Board Responsibilities

The first responsibility of the board of directors is to provide an organizational identity and direction for the hospital. The second responsibility of the board of directors is to assure that the hospital has the resources necessary to operate. The third responsibility of the board of directors is to provide oversight to the hospital so that it operates with legal and ethical integrity. In contrast, it is not the responsibility of the board of directors to engage in overseeing the day-to-day operations of the hospital.

## Fiduciary Duty

A duty is a type of conduct that one owes to self or another person. In general, a fiduciary duty can be described as a duty to act in the best interest of another party. A board member must act within their fiduciary duty to the organization for which the individual serves. Each member of a hospital board of directors owes a fiduciary duty to the hospital. A board member who does not act in accordance with his or her fiduciary duty can be liable for this failure.

A person with a fiduciary duty must act with honesty and without conflict of interest.

In other words, a member of the hospital board of directors must not put their personal interests above that

of the hospital. One can view a fiduciary duty as being comprised of several duties: a duty of acting with due care, a duty of loyalty to the organization, obedience to the ideals of the organization, and keeping appropriate confidences of the organization. The type of ownership of a hospital can create additional fiduciary duties for each board member beyond a general fiduciary duty. In a government-owned hospital, the board will have duties related to open meetings and the proper preservation of public records.

However, a government-owned hospital could have immunity from certain litigation due to its status as a public entity. In a privately-owned not-for-profit hospital, the board of directors will need to assure that the federal and state tax exemptions are maintained.



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Keeping this tax exemption will require the board to further the charitable purposes of the organization. In a private for-profit hospital, the board of directors has more flexibility, however, if income to the organization is taxed, the hospital must comply with the variety of corporate and securities laws, and the board of directors has a fiduciary duty to act for the benefit of the shareholders.

Each board member must carry out their individual responsibilities keeping in mind the fiduciary duty owed to the hospital.

### **Organization and Direction**

The board of directors provides strategic planning for a hospital. In order to engage in this forward thinking, the hospital should have a mission and values for carrying out the mission. The board of directors is involved in creating and approving the hospital's mission statement and approving policies that reflect the values of the hospital and vision for its future.

The board of directors may also provide advice to enhance the public standing of the hospital. Individuals are frequently asked to serve on the board of directors of the hospital due to their business acumen, loyalty to the local hospital and community, and their leadership qualities. Board members are frequently asked to use these skills to improve the hospital's relationships with the local community. Board members can use their knowledge of the local community to provide advice on community reaction to hospital changes.

### **Sufficient Resources**

The hospital board of directors is entrusted to make sure that the hospital's funds and

property are used in a manner such that the hospital continues to operate. One function of this financial oversight is approval of the hospital budget. While most of the budget development will occur at the staff or committee level, the board will be asked to give its overall approval of the budget. A good budget maintains financial stability for the hospital while allowing for investment and growth.

In order to provide informed input on budget issues, it will be necessary for board members to have a general understanding of the different payment methods used in healthcare. Hospitals can receive wide-ranging reimbursement depending on the type of payor. Hospitals tend to see greater reimbursement from private payors (insurance companies) over that provided by government programs. The payor mix for each hospital can greatly affect its available resources, and by extension, the annual budget of the hospital.

Another duty of the hospital board is to approve contracts over a certain dollar threshold. This threshold will be set by board policy. In the critical access hospital setting, this threshold for board review could range from \$25,000 to over \$100,000.



It is imperative that board members acting to approve contracts have no conflict of interest when voting. A conflict of interest in approving a contract would violate the board member's fiduciary duty to the organization. Thus, if a board member is a local business owner that would gain business from the successful awarding of the contract, the board member must abstain from voting and should not participate in the discussion of the contract. This type of benefit is called private inurement.

**A board member who is the recipient of private inurement can be subject to personal liability. In addition, this specific type of conflict can jeopardize the hospital's tax-exempt status.**

The board of directors also verifies that the past use of hospital resources was appropriate through the audit process. Each year, the hospital board of directors, through its audit subcommittee, will select an audit firm to conduct an annual audit of the hospital. Once the audit is complete, the audit report will be shared with the board of directors for review and to make appropriate policy changes. As part of ongoing duties, the board of directors will receive reports to confirm that any audit findings have been corrected in a reasonable amount of time to avoid repeat findings.

## **Oversight**

The hospital board of directors provides general oversight to the hospital in many areas. A hospital operates in a highly regulated environment. Hospitals are primarily regulated by federal and state government. As part

of this regulatory process, they receive accreditation from organizations such as the Joint Commission on the Accreditation of Health Care Organizations (TJC) or the Health Facility Accreditation Program (HFAP) in order to participate in government-funded health-care programs. The hospital may be inspected by regulators from the federal Department of Health and Human Services or state licensure agencies. The hospital's billing practices can be audited by both federal and state government programs.

A private health insurance company may conduct a review of the utilization of services at the hospital, or bills received from the hospital. Errors found by any of these reviewers or regulators may impair the hospital's ability to function at its highest level. The board of directors must be cognizant of these interested parties and provide sound advice to the hospital when issues arise.

A hospital board of directors has input on the quality of care provided at a hospital. This input is provided by approving the processes that are used in credentialing medical staff and other providers and approving specific programs of the hospital.

While the medical staff will have significant input on the bylaws governing the credentialing process and the award of privileges, the board of directors may negotiate certain requirements in their approval of staff bylaws to assure the quality of services provided. In addition, the board of directors hires, supports, and evaluates the chief executive officer of the hospital.

Some board of directors also approve the hiring of key administrative staff. These oversight functions are not designed to have the board of directors engage in managing the day-to-day operations of the hospital. Rather, these functions provide direction to the hospital leaders.

**Over the past 10 years, the role of the board of directors in providing compliance oversight has greatly increased. This change stems from the fact that the United States Department of Justice has indicated that a hospital with an effective compliance program may avoid criminal charges in some cases of wrongdoing.** For a compliance program to be deemed effective, the board of directors must be involved in compliance activities.

This stance, by the United States Department of Justice, has resulted in the formation of a board-level compliance committee at virtually every hospital. This committee is typically comprised of some of the members of the board of directors, the hospital compliance officer, and other key staff.

The job of this board compliance committee is to verify that the hospital is complying with various state and federal laws. These laws include the False Claims Act, the Anti-Kickback Statute, Stark Law, the Emergency Medical Treatment and Active Labor Act (EMTALA), the Health Insurance Portability and Accountability Act (HIPAA), and antitrust laws. In order to assist board members in completing their duties related to compliance activities, many boards of directors undertake annual

training to educate board members on these laws and their duties with respect to hospital compliance.

## Conclusion

Service on a hospital board of directors can be challenging and rewarding. Members of the community who are committed to the success of their local hospital are an integral part of the hospital. Each member of the board of directors must act in accordance with the fiduciary duty owed to the hospital in order to become a trusted advisor.

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# Value of Healthcare Surveys: *Measuring Experience and Satisfaction*

By **LANCE W. KEILERS, MBA, CAPP**  
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It seems that everywhere we turn these days, someone is asking us to rate their service, complete a survey, or share a review. Whether it is an Amazon purchase, a restaurant experience, or a doctor visit at a local clinic, companies and caregivers want our opinion. Technology and the use of data have opened the door to organizations surveying consumers to gather feedback, so they can develop their services, grow market share, and improve quality measures.

Today, hospital leaders understand that measuring satisfaction and experience, whether it involves patients, employees, governing boards or physicians, will provide important information for identifying gaps and developing an effective action plan for quality improvement within the organization. To be successful, a hospital must work diligently to improve satisfaction and experiences for all stakeholders as they continue the transition to value-based care.

## **Patient Satisfaction Surveys**

More than ever, patients have a choice in where they go to receive their care. Hospitals are keenly aware of this and employ several strategies to influence care decisions and provider selection. Patient satisfaction surveys provide a consistent platform to gather feedback and a data collection methodology for measuring how patients perceive their hospital, clinic, and provider experiences.

The Institute for Health-care Improvement has developed a framework known as the Triple Aim, which describes an approach to optimizing health system performance. Working towards achieving Triple Aim, healthcare organizations must develop new methods to simultaneously pursue three dimensions:

- Improving the patient experience of care, including quality and satisfaction
- Improving the health of populations
- Reducing the per capita cost of healthcare

It is apparent that patient satisfaction surveys play an important role in enabling healthcare providers to measure patient experience and attitudes about the services they receive.

The quality of care that is tracked and measured, not only in the clinical outcomes but also through the results of patient satisfaction surveys, allows healthcare organizations to identify gaps in care and make continuous improvements in quality and performance.



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## Employee Engagement Surveys

Employee retention is a significant challenge in healthcare. According to a national healthcare consultant, *Advisory Board* explains healthcare organizations on average experience a 30.3 percent first-year turnover rate. It is in the hospital's best interest to seek input from employees to keep a pulse on what motivates them, and to identify issues that may cause disengagement.

An employee engagement survey provides hospital leadership with an anonymous, consistent, and objective method of gauging employee engagement and satisfaction in the areas of leadership, work environment, and overall job satisfaction. Feedback received from staff surveys will complement the overall theme of employee engagement by informing administration on issues of which they may and may not have been aware. The survey also gives employees a voice to provide candid feedback pointing to areas of strength within the organization and to areas where the organization might improve. C-suite leaders and boards will find this insight especially useful in addressing hospital operations and for strategic planning.

## Provider Engagement Surveys

According to the *Annals of Family Medicine*, estimates of clinician turnover rates vary widely based on setting. Although the American Medical Group Association estimated a national annual turnover rate of 6.8% for physicians and 11.5% for advanced practice clinicians, higher rates have been documented in certain settings. There is also concern that burnout and low engagement in the workplace may adversely affect patient care, destabilize the workforce, and increase turnover.<sup>1</sup> A provider engagement survey is a tool that healthcare organizations can use to evaluate and engage

physicians and advanced practice professionals to assess, on a local level and in real time, the satisfaction of the providers that are directing the care teams for patients.

## Governing Board Surveys

With the complexity of hospital operations, changing regulatory environments, increasing costs, and decreasing reimbursement, it is vital that board members not only be engaged, but work to increase education in areas of healthcare that affect the organization. This includes board ethics, board member recruitment and retention, budgeting, finance, CEO relations, and overall healthcare governance.

In order to fulfill the board's fiduciary duty of care, boards should periodically examine whether their current governance structure and processes allow them to carry out their responsibilities efficiently and effectively. At the core of this concern is the impact that rapid change and increasing complexity can have on governance. Boards need to ask themselves whether they can continue to make well-informed decisions, maintain adequate oversight, and raise board members' engagement to keep pace with transformation. There is a legal expectation that boards review their governance size and structure to ensure they adequately support the board's ability to carry out its work.

## Conclusion

In this ever-changing healthcare environment, small and rural hospitals must do everything within their power to operate efficiently, grow market share, and provide the highest quality of care possible. Engagement on all levels gives hospital leaders the ability to ask, think and act on information that is critical for their success.

1. Shanafelt T, Goh J, Sinsky C. The business case for investing in physician well-being. *JAMA Intern Med.* 2017; 177(12): 1826-1832.  
THT's Governance Thought Leadership Series 2019 Hospital Board Governance Trends

# Hospital Compliance: *How Effective Is Your Program?*

By **MARGARET SCAVOTTO, JD, CHC**  
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A compliance program contained in a binder of yellowing pages is not enough. Long gone are the days when providers could 3-hole-punch a code of conduct, shove it on a shelf, and forget about it for years at a time. Compliance programs must go beyond the binder to be effective in reducing risk.

## Why you need a compliance program

The federal government has been advising (and warning) providers for decades about the need for effective compliance programs. The Federal Sentencing Guidelines, the Office of Inspector General (OIG), and the Department of Justice (DOJ) Criminal Division have weighed in.

The Federal Sentencing Guidelines are used by federal judges and prosecutors to assess penalties, such as those against a corporation accused of violating the False Claims Act. Section 8B2 of the Guidelines helps courts and prosecutors assess whether a defendant has an "effective compliance and ethics program," and includes the following criterion (among others): "The organization shall take reasonable steps ... to evaluate periodically the effectiveness of the organization's compliance and ethics program...."<sup>1</sup>

The OIG has published the Compliance Program Guidance for Hospitals (CPG for Hospitals)<sup>2</sup> and the Supplemental Compliance Program Guidance for Hospitals (Supplemental CPG for Hospitals).<sup>3</sup> These CPGs represent the gold standard in compliance program design, and both documents emphasize the importance of an effective program. The CPG for

Hospitals uses the phrase "effective compliance program" 13 times and touts the benefits of an effective program for providers facing federal investigation: "The OIG... will consider the existence of an effective compliance program that pre-dated any governmental investigation when addressing the appropriateness of administrative policies" (emphasis in original).<sup>4</sup>



The Supplemental CPG for Hospitals likewise uses the phrase "effective compliance program" 11 times. For example: "In today's environment of increased scrutiny of corporate conduct and increasingly large expenditures for healthcare, it is imperative for hospitals to establish and maintain effective compliance programs."<sup>5</sup> In April 2019, the Department of Justice Criminal Division issued a Guidance Document for Prosecutors: Evaluation of Corporate Compliance Programs.<sup>6</sup> In this document, the DOJ outlines questions prosecutors should ask when making an "individualized determination of a corporate compliance program's effectiveness."<sup>7</sup> The federal enforcers have made their expectations clear: hospitals need to have effective compliance programs – and those who do will fare better in an investigation or prosecution.

## How do you measure your program?

A successful compliance program is entrenched in your organization's culture, and prevents, detects, and corrects compliance shortcomings. Hospitals can find out if their compliance program is working by conducting an effectiveness review. This process has been recommended by the OIG since 1998 and stands today:

An effective compliance program should also incorporate periodic (at least annual) reviews of whether the program's compliance elements have been satisfied, e.g., whether there has been appropriate dissemination of the program's standards, training, ongoing educational programs and disciplinary actions, among others.<sup>8</sup>

## Review Strategies

The following tactics should be included in your review:

1. Verify that your compliance program addresses the seven elements outlined in the CPGs:
  - Compliance standards, policies, and procedures
  - A designated compliance officer and a compliance committee that meets regularly
  - Communication (anonymous reporting)
  - Compliance training and education for your workforce, board, volunteers, vendors, and students
  - Auditing and monitoring processes for all risk areas
  - Discipline that is fair and consistent, and employee and contractor screening processes
  - Policies for responding to compliance violations and taking corrective action
2. Assess your risk areas. The CPGs list hospital areas of risk, which can be generally grouped as:

- Quality of care
- Billing and cost reporting
- Employee and contractor screening
- Kickbacks, inducements, and self-referrals
- HIPAA
- Records
- Additional risk such as OSHA compliance or discrimination

3. Use your data. Identify the compliance data you have available, and mine it for trends. For example, all hospitals should have compliance report data. Review this data to identify any pain points: Are reports increasing or decreasing? Are reports concentrated in a certain department (like nursing)? Or risk area (like HIPAA)? Another good source of data is investigation reports: Are investigations seen to completion? Is corrective action and follow-up documented? Can you identify any repeat (unresolved) issues? Finally, your PEPPER (Program for Evaluating Payment Patterns Electronic Report) is an excellent source of data that can be used to identify where your organization might be an outlier (with high compliance risk).
4. Ask! Use an anonymous survey to evaluate your compliance culture. In other words, ask your workforce if your compliance program is effective. For example:
  - Do you feel comfortable reporting non-compliance to the compliance officer?
  - Do you know the compliance officer's name?
  - Do you fear retaliation in response to good faith reporting?
  - Do your co-workers and supervisors show ethical conduct?
  - Have you ever witnessed a compliance issue? Did you report it?If you can do so without betraying anonymity, look for variances at specific facilities and departments.

5. Don't forget about the board:

- Has the board made a formal commitment to compliance?
- Does the board receive regular live and written compliance updates?
- Does the board have the training required to effectively oversee a hospital compliance effort?
- Does the compliance officer have a direct line of communication to the board?

After all, the board members (and/or executives) are ultimately responsible for the success or failure of your compliance program – so the role of leadership cannot be overlooked.

6. Keep your goals in mind:

- Verify that compliance tasks are completed.
- Verify you can prove tasks are completed.
- Make sure you can prove this immediately if government enforcers show up with documentation.
- Identify program strengths and weaknesses.
- Establish a game plan with actionable items to implement.

## Maintaining success

A strong compliance program identifies problems and fixes them – and a good compliance program review will find areas to improve. Weaker programs will have more items to fix, and more broad categories to address. Stronger programs will still identify improvements; however, they will be fewer and more nuanced. All compliance programs require continuous innovation and advancement to stay effective.

Share the results of your review with your compliance committee, board, and other leaders. Use the results to come up with a compliance action plan for the next 12 months. Assign risk levels to each actionable item, and decide who will implement each item. At least quarterly, follow up on the action plan to hold your organization accountable for progress.

Once you implement your corrective actions, celebrate your progress. And then ... plan to do it all again next year. Effective compliance – unlike a yellowing binder – is a process that is never complete.

1. United States Sentencing Commission, *Guidelines Manual*, Section 8B2.1(b)(5)(B), November 2018, available at <https://www.ussc.gov/guidelines/2018-guidelines-manual/annotated-2018-chapter-8#NaN> (last checked November 7, 2019).
2. Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, February 23, 1998, available at <https://oig.hhs.gov/authorities/docs/cpghosp.pdf> (last checked November 7, 2019).
3. Supplemental Compliance Program Guidance for Hospitals, 70 Fed. Reg. 4858, January 31, 2005, available at <https://oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf> (last checked November 7, 2019).
4. CPG for Hospitals at 8988 footnote 2.
5. Supplemental CPG for hospitals at 4876.
6. U.S. Department of Justice Criminal Division, Evaluation of Corporate Compliance Programs Guidance Document, updated April 2019, available at <https://www.justice.gov/criminal-fraud/page/file/937501/download>.
7. Id.
8. CPG for Hospitals at 8997.

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# Healthcare Acronyms...

## What the Heck Do Those Terms Mean?

By **STEPHEN T. MOORE**  
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Sometimes it seems like hospital administrators and healthcare providers are speaking a foreign language. Acronyms – words formed from the initial letters of words in a set phrase, such as NATO (North Atlantic Treaty Organization) or ASAP (as soon as possible) – are regularly used in healthcare to reference diagnoses, procedures, medications, government agencies, and organizations.

While many of these acronyms (or initialisms – acronyms that don't technically spell a word) are familiar to us – MD, RN, DNR, CDC – not all acronyms are as commonplace. DME? EHP? PPS? It can be difficult to keep track of an ever-growing list of healthcare lingo.

We all use acronyms in our daily speech. We rarely say The United States of America. We say USA. We don't say American Broadcast Company. We say ABC. We all know FBI stands for Federal Bureau of Investigation but rarely use the full name. The same goes for TV, CD, DVR, and CIA. We understand the meanings of common acronyms without much thought.

But acronyms can be confusing, and can even communicate the wrong message when we don't recognize them or when they stand for more than one abbreviated term. For example, HCP is a commonly used acronym for healthcare professional, but is also an acronym for healthcare provider, healthcare practitioner, healthcare proxy, health communication partnership, hydrocephalus, hereditary coproporphyrin, host cell protein, and even hard-core pornography.

Medical acronyms lack consistency and their use too often results in errors, adverse events, and harm to

patients. The Joint Commission, which accredits hospitals and other healthcare providers, has developed a list of acronyms, abbreviations, symbols, and dose designations which should be prohibited from use, and prohibits use of acronyms and other abbreviations in patient materials and documents, such as consent forms and discharge instructions.

The Joint Commission also requires hospitals to establish lists of acronyms and abbreviations which are approved for use and a separate list of do not use acronyms, and calls on hospitals to monitor their use to improve communication and understanding among healthcare providers and to achieve safer and more effective care for patients. Like it or not, the use of acronyms and other forms of abbreviations in healthcare is here to stay. Hospital board members need to develop a familiarity with and working understanding of commonly used acronyms. Healthcare acronyms have an important place in conversation, so take time to learn the jargon. Take a look at the attached list on the following pages, see how many acronyms you recognize, and help yourself by learning a few more.



# Medical Acronyms and Abbreviations All Board

Acronym	Meaning	Acronym	Meaning
ABN	Medicare Advance Beneficiary Notice of Non-Coverage	CMS	Centers for Medicare and Medicaid Services
ACA	Affordable Care Act	CNO	Chief Nursing Officer
ACO	Accountable Care Organization	CPT	Current Procedural Terminology
ACP	Advance Care Planning	CVA	Stroke (Cerebrovascular Incident)
AKS	Anti-Kickback Statute	DC	Discontinue or Discharge
AO	Accreditation Organization	DME	Durable Medical Equipment
AWV	Annual Wellness Visit	DNR	Do Not Resuscitate
BMP	Basic Metabolic Panel	DON	Director of Nursing
CA	Cancer	EHR	Electronic Health Record
CAH	Critical Access Hospital	EMR	Electronic Medical Record
CC	Chief Complaint	ER	Emergency Room
CCM	Chronic Care Management	FDA	Food and Drug Administration
CDC	Centers for Disease Control	GHP	Group Health Plan
CHIP	Children's Health Insurance Program	GI	Gastrointestinal
CHNA	Community Health Needs Assessment	H&P	History and Physical
CIA	Corporate Integrity Agreement	HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
CME	Continuing Medical Education	HHS	Department of Health and Human Services
CMN	Certificate of Medical Necessity	HIM	Health Information Management
CMO	Chief Medical Officer	HIPAA	Health Insurance Portability and Accountability Act
CMP	Civil Monetary Penalty	HMO	Health Maintenance Organization

## ard Members Should Know

Acronym	Meaning	Acronym	Meaning
ICAHN	Illinois Critical Access Hospital Network	OT	Occupational Therapy
ICD	International Classification of Diseases	OTC	Over the Counter
IDPH	Illinois Department of Public Health	PA	Physician Assistant
IHA	Illinois Health and Hospital Association	PECOS	Medicare Provider Enrollment, Chain and Ownership System
IP	Inpatient	PHI	Protected Health Information
IPA	Independent Physician's Association	PPACA	Patient Protection and Affordable Care Act
IRCCO	Illinois Rural Community Care Organization	PPO	Preferred Provider Organization
LTC	Long Term Care	PPS	Prospective Payment System
MA	Medicare Advantage	PRN	As Needed (Latin Term: Pro Re Nata)
MCO	Managed Care Organization	PSA	Professional Service Agreement
NDC	National Drug Code	PT	Physical Therapy
NH	Nursing Home	RD	Rural Development
NP	Nurse Practitioner	RT	Respiratory Therapy
NPI	National Provider Identifier	SNF	Skilled Nursing Facility
NPPES	National Plan and Provider Enumeration System	ST	Speech Therapy
OBS	Observation	SWB	Swingbed
OIG	Office of the Inspector General	U/A	Urinalysis
OP	Outpatient	URI	Upper Respiratory Infection
OR	Operating Room	WC	Workers Compensation

*Stephen T. Moore is a partner at Hinshaw & Culbertson LLP, where he currently serves as the leader of the firm's national Health Care Practice Group.*

# Healthcare: A Cyber Fraudster's Dream

By CYNTHIA ZIMMERMAN, RPLU

Senior Vice President, Socius Insurance Services

The frequency of cyber breaches is rapidly increasing, with the healthcare industry being one of the favored targets. According to the 2019 NetDiligence Cyber Claims Study, and as further depicted in the charts below, 18% of cyber claims against small enterprises involved companies within the healthcare sector. In the large company space, 40% of cyber claims were the result of attacks against healthcare organizations.



## So why do hackers and fraudsters favor the healthcare industry?

### 1. *Insufficient investment in security*

Historically, healthcare organizations have allocated more funds to acquisitions than to network security. Often software and/or systems are outdated, as the cost to upgrade to more secure systems quickly exhausts IT budgets.

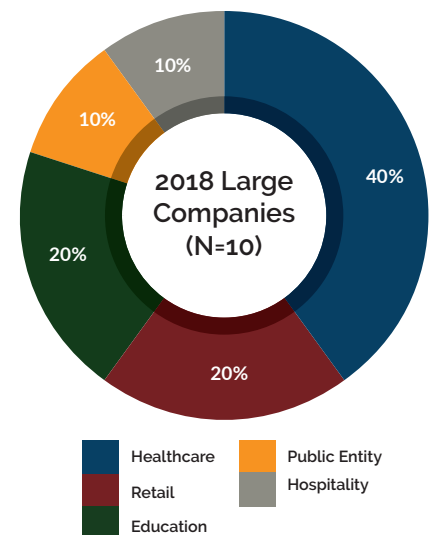
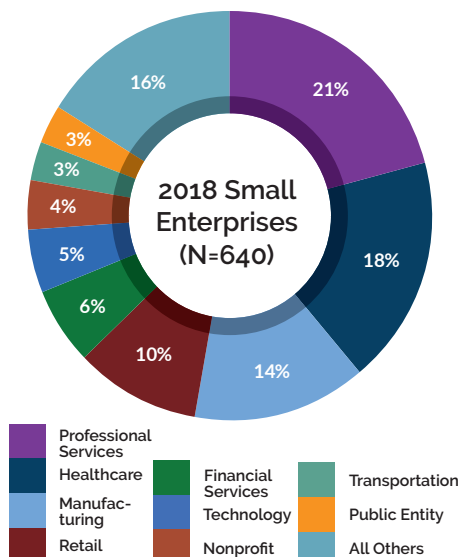
### 2. *Insufficient employee training*

The NetDiligence charts below show causes of cyber loss, most of which often tie back to an employee.

Some cyber-breaches include:

- a. **Social engineering** – an employee is tricked into transferring or paying funds (or other property) to an unintended party
- b. **Phishing** – an employee is lured into providing information to an unintended party
- c. **Malware/virus** – often launched by an employee clicking on a link or website they believed to be safe

## Percentage of Cyber Claims by Sector





- d. **Wire transfer fraud** – fraudsters gain enough information (often from employee phishing) to convince a bank that they are authorized to effect a transfer
- e. **Lost/stolen devices** – an employee leaves a device at a coffee shop, where it is stolen, or perhaps is able to retrieve it... however, it is unknown whether or not a hacker gained access to confidential information
- f. **Business email compromise/phishing** – a fraudster often will spoof an executive's email to conduct a social engineering attack on the employee
- g. **Other staff mistakes** – an employee erroneously sends an email containing PHI (protected health information) to an outside party because they didn't notice they entered the wrong email address

It is imperative to not only implement secure systems to protect from true hacking events, but to also continuously and frequently educate and train employees on the various fraud schemes and avoidance techniques.

### 3. *Valuable data*

Medical records contain credit card information, date of birth, social security number, and other information that is much more difficult (or impossible) to change. This means the data has a longer shelf life, and thereby can generate more revenue for hackers.

### 4. *Volume of data*

Healthcare organizations not only hold valuable data, they store large quantities of it, especially in facilities such as hospitals, walk-in clinics, and other facilities where there is a constant influx of new clients/patients. Hackers often sell data on the dark web.

### 5. *Disruption of operations*

The fraudster may install a virus or malware to take systems offline or alternatively may encrypt the provider's database to prevent them from accessing data. This interruption in access could impact the ability to properly treat patients and can be fatal to people and businesses. Hackers may further impact treatment by altering settings on medical equipment, or perhaps turning them off.

### 6. *Extending their reach*

Not only can hackers/fraudsters use information obtained in a healthcare breach to conduct identity theft, they can and do often use the information to conduct financial fraud or to craft highly convincing phishing attacks against other parties.

All the systems and training in the world will not provide complete protection. Organizations of all types and sizes are compromised daily.

Healthcare organizations and their directors and officers are exposed to significant costs not only in defending themselves against potential claims by patients, regulators, and other third parties, but also to expenses such as notification of a breach, credit monitoring, public relations, crisis management, forensic investigations, extortion payments, social engineering loss, reputational loss, loss of income, damage to systems/data, and more.

It is recommended that the board work with an insurance broker specializing in cyber liability insurance, who is qualified to fully review, educate, and guide board members towards the selection of a comprehensive policy.

*Cynthia A. Zimmerman is a Senior Vice President with Socius Insurance Services. She also acts as Socius' East Coast Cyber Practice Leader. Prior to joining Socius, she worked for 14 years on the insurance company side, as a management and professional liability underwriter, and subsequently, underwriting manager.*

### III. Strategic and Community Initiatives

## *Be What You Say You Are:* How to Build Your Brand

By **RANDY "RJ" JACOBS**,  
*President, TAG Communications Inc.*

Building your brand is partly the result of a conscious effort to articulate your particular promises, to live those promises, to communicate those promises, and to stay alert and responsive to your patients' changing needs.

Your success can only be measured by your public's perception of your organization. That is, your brand is what your employees, patients, patients' families, and the larger community say it is.

Here are some key concepts to help you think about what branding means for you.

#### **Branding Defined**

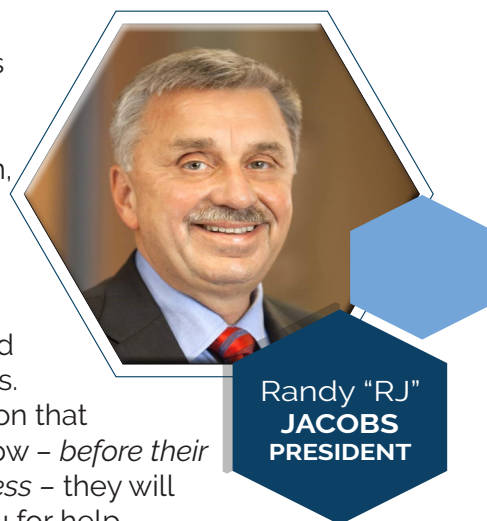
Branding is not a new concept. It's been around as long as marketing has been a business discipline. As important as it is, though, its meaning and value is often lost or misunderstood.

Branding is NOT a clever advertising or communication idea. It's not a cool logo or graphic word mark, an identity manual, or TV campaign production. It's not a website. Those are all good communications tools. We use them to share key attributes of your brand. *But they are not your brand.*



Branding is nothing less than the soul of your organization, as defined by your employees, customers, patients, and their families.

It's the reason that patients know – *before their injury or illness* – they will come to you for help.  
*(Ron Soto, Sr. V.P. Marketing, Northwell Health)*



**Randy "RJ"  
JACOBS  
PRESIDENT**

Your brand is the emotional connection your patients have with you. It is built through their experiences with you. Good experiences mean good emotional connections. Bad experiences? You know that story. To build your brand, begin by positioning yourself so you and your employees know who you are, or intend to be. What can you promise? What can you deliver?

#### **Questions to Consider**

Effective marketing is the art of sacrifice – *and it begins with positioning*. Brands can't be all things to all people. You must know where you can make a real impact, and build on it. That's positioning. It will allow you to consistently communicate your brand.

How do you want patients to think of your hospital or clinic operation in comparison to your competition? Do you have the most consistent delivery of quality outcome, or the best technology, or the perception of optimum care? Is your care process pampering, or fast and streamlined? What's important to your patients?

Once you can answer these questions, you're ready to move on to the next phase. (If you cannot answer these questions, you are not ready to position your hospital. You are ready, on the other hand, for a solid dose of market research).

### Make Promises – and Keep Them



There's nothing more critical to branding than making promises that you keep. To visualize what this looks like, imagine climbing a ladder. The first step establishes your identity as a utilitarian, basic healthcare provider. You are not yet distinguishable from any other basic healthcare provider. That is, there is no point of difference between you and anyone else.

The next rungs establish your promises, or the points of difference between you and your competition. Each step builds on the previous one and is part of the work of your positioning, or the conscious effort to be what you say you are. Remember, it's not what you say you will do – or what your staff says they will do – that's important. It's how your patients perceive their experience that defines your brand, either positively or negatively.

When you are successful, you create a strong emotional connection between your entity and your patient. In the words of marketing guru Seth Godin, "If you have more connection and trust today than yesterday, you are moving forward. If you have a lot of connection and

trust you will never have trouble making a living, you will never have trouble making a difference."

### It's Your Foundation

The best positioning is stupidly simple. The best brands are brilliantly complex. Positioning is the foundation of your brand, but your patients are the final arbiters. Do they want what you are promising? Do you live up to your promises? Your brand is defined by your patients in relation to your competition.

Al Reis and Jack Trout noted in *Positioning: The Battle for Your Mind*, "Positioning is not what you do to a product. Positioning is what you do to the mind of the prospect."

Often overlooked and mismanaged by marketers today, positioning is one of the most critical challenges facing your brand. It must align your offer with your patients' wants and needs. In fact, mind share leads market share, which is critical to sustainability for your healthcare enterprise. You build your brand by deploying a consistent strategy founded on your positioning and commitment to deliver on your promises.

### Communicating Your Promises

Strategic communications will drive interest, growth and patient retention – but only if your patients' perceived experiences are consistently positive and based on reality and authenticity. Communication touch points are necessary to help establish and underscore those emotional connections. Words matter! Images matter! They share and emphasize the experiences you deliver, from how the phone is answered to how easy it is to find a department or service. Such touch points can support and impact your brand, or undermine it entirely if not positive.



Note that your target audience is not defined simply by demographics or psychographics, but by anyone at all who comes into contact with your organization. Patients' families – many of whom live miles outside your geographical location – are major influencers. Your own staff comprise a key part of your target audience. If they are proud to work for your organization, they become key influencers, too!

Your communications must convey your promises simply and honestly. Whether in external ads and marketing, or in internal memos and signage, communications will help deliver the promise you make. It will be up to you to keep them.

## Brand Test Guide

The following rules are a good litmus test to determine if your brand has strength with your target audiences:

1. A successful brand is based on a single idea. It stands for something already residing in the audience's mind and evokes an emotion.
2. A successful brand consistently conveys your value. What value do you strive to deliver?
3. A successful brand is narrow in scope. Too often enterprises – including hospitals – add too many services, losing their focus on personal care and doing a few things extremely well.
4. A successful brand evokes leadership. Credentials and awards communicate leadership when made by credible sources. These should be intelligently promoted – with some humility.

5. A successful brand uses communications strategically. Your audiences should receive relevant messages that create and enhance an emotional connection through a variety of platforms that reinforce each other.
6. A successful brand promotes and builds categories. The best way to dominate a category is to create a new one to serve. How can your hospital do this?
7. A successful brand will focus on building a powerful perception of quality. Do your patients perceive your organization and services as delivering quality?
8. A successful brand will be strategic about sub-branding. The easiest way to destroy a brand is to add products or services that bring little value to the brand. The business environment is littered with examples.



My writing in this document was derived from developing several presentations for clients over time. There are also lots of great resources available for guidance on brand positioning. I recommend The Roland Hiebing Group and various Trout and Riese writings, including *Positioning: The Battle for Your Mind*.

*For 30 years, Randy "RJ" Jacobs, President/Chief Strategy Officer, TAG Communications Inc., has been vital to the marketing success and business growth of many clients. His talent, energy, and expertise have resulted in major contributions to many clients including ICAHN, Genesis Health System, UnityPoint-Trinity (Quad Cities), and the Quad City Health Initiative.*



# Seamless Medical Staff Alignment:

## *High-Level Observations on Medical Practice Planning*

By R. KYLE KRAMER, G. CHRISTOPHER LOUIS,  
AND CHRISTOPHER FETE

*Directors, Pinnacle Healthcare Consulting*

Healthcare organizations in rural markets face unique challenges related to physician alignment initiatives. The continued shift from traditional inpatient services to outpatient settings has created significant challenges and opportunities for hospitals and health systems across the country related to budgetary and facilities planning. In addition, physician engagement in and ownership of ambulatory service/surgical centers has further challenged hospitals and health systems to become more nimble and flexible with service delivery mechanisms.



Within the rural setting, service delivery, service mix, reimbursement, and the ability to effectively recruit and retain necessary physicians all represent legitimate challenges to management teams and boards. When contemplating medical staff in a rural community, it is critical to start from the perspective of community health needs. A comprehensive community health needs assessment (CHNA) provides a roadmap to ensuring that rural organizations understand and are able to address population needs.

Utilizing U.S. Census and state data offers the ability to gather and break down the composition of the local population into meaningful categories – age bands, gender, race, and socioeconomic status. These cohorts provide the ability, utilizing evidence rates among specific demographics, to project the need for specialty services beyond routine primary/family care.

It is equally important to consider population management from the standpoint of regional variations in access to care, including outmigration and disease prevalence. Once a comprehensive population analysis has been completed and an inventory of available resources has been evaluated, it becomes possible to determine what mix of providers will be necessary to fulfill the hospitals' short and medium term goals related to health services within the service area.

**Rounding out a medical staff strategy to meet population needs can also involve the development of aligned relationships with other healthcare organizations (often larger hospitals or health systems).** When considering employing physician groups in the rural setting, organizations must be careful in developing acquisition proposals and compensation arrangements. Hospitals should focus on securing a referral base, enhancing revenue opportunities, and realizing efficiencies and economies at practice and hospital operations.

Rural healthcare facilities serve as the primary point of care for most residents within a non-urban region. Although primary care services are often more readily available (internal medicine, family practice, pediatrics, obstetrics/gynecology), specialty physicians such as cardiology, orthopedics, otolaryngology, and others, can provide access and services in the rural setting through alternate arrangements besides employment.

In instances where direct employment may not make sense or where the population will not support fulltime access to services, it is reasonable to develop more interim aligned relationships with other organizations to implement service access (e.g., timeshare lease arrangements for cardiac specialty clinics, professional service agreements for leased services for select days of the month, etc).

Physician employment or alignment compensation arrangements must be made with careful consideration of fair market value. Tangible and intangible asset acquisitions should also be considered in the same manner. The development of fair market value opinions involves a considerable number of factors and must take market need and commercial reasonableness factors into consideration.

When entering into arrangements with physicians, organizations must ensure compliance with longstanding federal and state healthcare compliance laws, such as the Stark Law and Anti-Kickback Statute. An important element of structuring compliant financial arrangements is to ensure the financial terms, whether compensation or purchase price, is consistent with fair market value and the terms are commercially reasonable.

Typically, physician practices are acquired through the acquisition of practice assets in conjunction with an employment arrangement with the physicians. The financial terms related to physician transactions cannot, whether a practice valuation or employment valuation, take into account the volume or value of the physician's referrals to the hospital. **In other words, when establishing fair market value payment rates related to the transactions with the physician, the parties cannot use information related to the downstream referrals to derive the compensation models.**

In addition to published benchmarks, market data is critical for a logical, sequential, and supportable fair market value conclusion. Urban and suburban areas benefit from active markets with an abundance of comparable data, while rural markets have limited comparable data. **Often in rural markets, the comparable data is less similar to the benchmark and consequently, availability of rural data is infrequent and not readily available.** This requires the valuator to make appropriate adjustments to normalize the market data. The application of these adjustments is critical to a credible determination of fair market value. When assessing fair market value, valuers will often use one or more of the three industry accepted methodologies:

- income approach
- cost approach
- market approach

For assessing the value of assets, the cost approach or the Adjusted Asset Based Approach is often utilized. Real estate assets are valued individually, and the influence of referrals can be removed. Typical assets include furniture, fixture, and equipment, real estate, non-physician work force, medical records, and other assets.

When assessing furniture, fixtures, and equipment, the valuator can employ a market approach technique based on a known direct sale comparison. Under the market approach, an asset value is determined based upon actual market pricing from either new equipment sellers or from secondary market

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"Valuation considerations do not end upon the completion of the acquisition transaction. Often, the physician whose practice was acquired will become an employee of the healthcare organization, and the physician's go-forward compensation must be consistent with fair market value."

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transactions of similar equipment. In determining the value of the non-physician work force and medical records, a valuator typically employs a hybrid technique that applies a market-based and cost-based approach.

When acquiring a physician practice, there may often be real estate components that need to be addressed. In determining the value of real estate, a combination of the cost, and market approaches are often utilized. Valuators will perform market research to identify comparable transactions/pricing for real estate.

Rural markets present challenges regarding identifying local comparable transactions. These differences might include age/time, location, building characteristics, type of space (e.g., not medical office space, and other items of adjustment). While local transaction data may be available, adjustments are typically made to normalize the market comparable data to the subject property.

These adjustments might incorporate different techniques, such as costs and income. A cost technique might apply data from available resources, such as the Marshall Valuation Service. Similarly, an adjustment using a direct percentage adjustment between zip code household incomes can be utilized to normalize the market data to the subject property. The assimilation of these varied techniques under the Adjusted Asset Based Approach concludes to a valuation of the physician practice assets.

Valuation considerations do not end upon the completion of the acquisition transaction. Often, the physician whose practice was acquired will become an employee of the healthcare organization, and the physicians go-forward compensation must be consistent with fair market value. The employment of physicians requires careful planning and the development of an organizational philosophy on compensation and ownership arrangements.

Rural communities may create challenges that can have a significant impact when determining appropriate compensation levels for employed physicians.

Taking a strategic and purposeful approach to developing, replacing, or expanding leadership of their medical staff is a helpful perspective. Documenting these transactions can be complex; therefore, it is important to apply quantitative and qualitative data to advance the physician alignment initiatives with appropriate fair market value analysis.

# Community Health Needs Assessments:

## *What is the Value to the Hospital and Community?*

By **TERRY MADSEN**, Attorney, Public Health Planner  
*CHNA Consultant, Illinois Critical Access Hospital Network*

At the base of every consideration made by a hospital director is the question of how the hospital and its community will benefit. When the Patient Protection and Affordable Care Act was signed into law in 2010, it contained a provision deep in the midst of its 906 pages requiring hospitals that receive not-for-profit status through designation as a 501(c)3 organization to conduct a community health needs assessment (CHNA) following guidelines established by the Internal Revenue Code every three years.

In many early discussions about the CHNA requirement in critical access hospital board rooms and others, there were struggles seeing exactly how the process was going to benefit charitable hospitals, especially small rural hospitals. With time, however, the CHNA experience has proven to benefit hospitals and their communities in many ways that were unforeseen in those early discussions. Many hospitals that had initially assessed the CHNA as another unnecessary government intervention have now embraced the process – to the point that many hospitals that may not be required to conduct the CHNA because of their tax status, do so anyway – as a matter of best practice.

Participating in a CHNA gives the hospital the opportunity to understand the health concerns of the community and to move in the direction its customers need it to go. It gives the community, including those that may be

considered underserved or unserved by healthcare services, the understanding that the hospital is a fully committed member of the community and interested in their common success. The CHNA provides the hospital avenues to apply principals of wellness and population health to better serve its patients and its bottom line.

The CHNA process begins with an initial planning meeting, typically a conference call with the CEO and/or project lead. At that conference, hospital representatives and the consultant will:

- Define the scope of the project
- Address the project timeline
- Discuss whether the project will be conducted by the hospital alone or coordinated with partners
- Address any special needs or concerns
- Discuss data sources
- Identify key contact(s) and working group(s)
- Define the community (hospital service area), geography, and target populations)
- Define the scope of inquiry (focus) and health needs





The consultant will then begin gathering quantitative data about the hospital's service area, including information on demographics, health issues, social determinants of health, and other relevant information. At the same time, the consultant will arrange to convene focus group meetings and/or key informant interviews.

When the data gathering process is complete, the consultant will create a summary for presentation to a group of community representatives that will determine the significant health needs currently facing the community. Those conclusions are then presented to the hospital for consideration for a reasonable and practical implementation strategy to attempt to address the identified needs and to identify potential community partners for the efforts ahead. The consultant then prepares a report on the entire project for consideration and approval by the hospital board.

Through the years since the creation of the CHNA process, hospitals take the lead in addressing significant health issues facing their community both directly and through attempting to address the conditions in the community that are negatively impacting its health and wellness. In the recent past alone, these issues beyond the traditional services of small hospitals have included:

- Access to food and nutrition education
- Access to mental healthcare
- Improved substance abuse prevention
- Access to services for substance use disorders
- Access to senior services
- Improved access to transportation
- Services for the homeless

The solutions to these needs have been creative and reasonable and involve a range of local partners to achieve. In some cases, the hospital takes the lead in the community effort and in some cases, it plays a supportive role for other, better-suited partners. In every case, the hospital sends the message to the community that it is interested in finding ways to improve the overall health of the community while maintaining its core mission to provide quality direct medical services.

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"CHNAs play an important role in the sustainability of the hospital by identifying and prioritizing needed direct services."

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In addition, CHNAs are resulting in the exploration of new ways to provide services through new collaborations, service integration, and billing strategies. Small, rural hospitals that have known skepticism and criticism have – through their actions to further their implementation strategies – achieved a role where the community turns to the hospital for participation or leadership in addressing important local issues reaching beyond the hospital's walls.

This, in turn, improves the community's view of the hospital and enhances recognition of the role of the hospital in the well-being of the community.

CHNAs play an important role in the sustainability of the hospital by identifying and prioritizing needed direct services and, by addressing community health issues, improving the hospital's position in the eyes of its community. The CHNA is a painless process with the potential for high dividends for the hospital and its community.

# Moving Towards Value-Based Care: Learning about ACOs

By **GREGG DAVIS, MD, MBA**

*Chief Medical Officer, Illinois Rural Community  
Care Organization*

It is widely known that healthcare in America is quickly moving towards a value-based care (VBC) system which links quality to outcomes rather than the number of services provided. VBC also links quality to performance and identifies ways to control healthcare costs which is a number one priority for everyone. So how can a rural hospital begin to learn and participate in a value-based care program and be ready? One option is to participate in an accountable care organization.

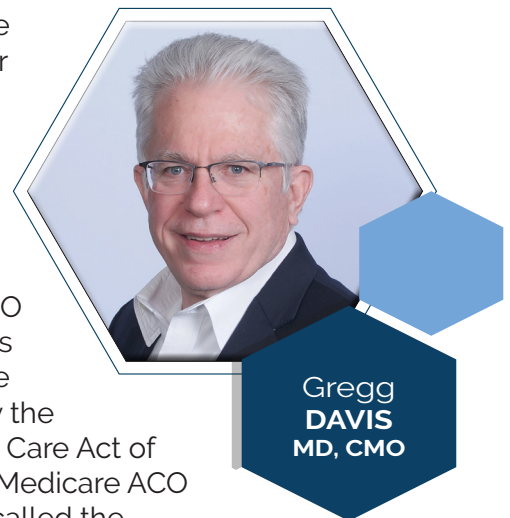
So what then is an accountable care organization (ACO)? An ACO is a group of doctors, hospitals, and other healthcare providers who have come together voluntarily to give coordinated high-quality care to their Medicare or commercial patients. The goal of coordinated care is to ensure patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

When an ACO succeeds both in delivering high-quality care and spending healthcare dollars more wisely, the ACO will share in the financial savings it achieves from Medicare or the commercial payer. The payment system to providers does not change but rather the coordinated efforts to improve outcomes and performance ultimately reduces individual healthcare costs.

In 2012, the Centers for Medicare and Medicaid Services (CMS) launched its own ACO program as an initiative created by the Affordable Care Act of 2010. The Medicare ACO program, called the

Medicare Shared Savings Program (MSSP), is designed to incentivize medical communities to enhance the quality of care provided to Medicare beneficiaries/patients while reducing the total individual cost of care.

ACOs focus on best practice, implement strategies to prevent unnecessary utilization of services, and incorporate better care management of patients through the healthcare system. As of July 2019, there were 559 Medicare ACOs serving more than 12 million beneficiaries, with hundreds more commercial and Medicaid ACOs serving millions of additional patients. Thus far, the Medicare ACO program has produced net savings of \$739.4 million to the overall Medicare program and made major changes in the management of care delivery.



## **Illinois rural ACO experiences – What have we learned?**

In 2015, 21 Illinois Critical Access Hospital Network (ICAHN) member hospitals came together to form The Illinois Rural Community Care Organization, LLC (IRCCO) and participate in the Medicare ACO program.

At the time of its formation, medical payment was driven by the volume of service provided to patients. Today, IRCCO has 27 ICAHN member hospitals and several independent physician practices, and its members are watching medical care transition to contracts incentivizing providers to provide a higher quality of care at less cost.

IRCCO hospital members have prepared themselves to be ready for the value-based care system and have learned a great deal about how their local population uses healthcare.

The impact of financial pressure to deliver higher quality care at a lower cost brings new challenges for hospitals and providers. Fifty percent of emergency department visits could be prevented or cared for in less intensive sites. Traditional models of care emphasized and rewarded the volume of service provided to patients with acute and chronic diseases. New models stress and reward preventive care.

This transition requires a new model for the delivery of care, which is focused on maintaining a patient's health by services provided in an outpatient, primary care setting.

Market pressure is rewarding alternative sites for the care of low acuity illness and injury. IRCCO hospitals have developed team-based care and focused on coordinating the care of Medicare and other patients. Care coordinators facilitate the transitions of patients from primary care to specialty care to post-acute care and reduce the burden of chronic disease.



# What is the Illinois Critical Access Hospital Network?

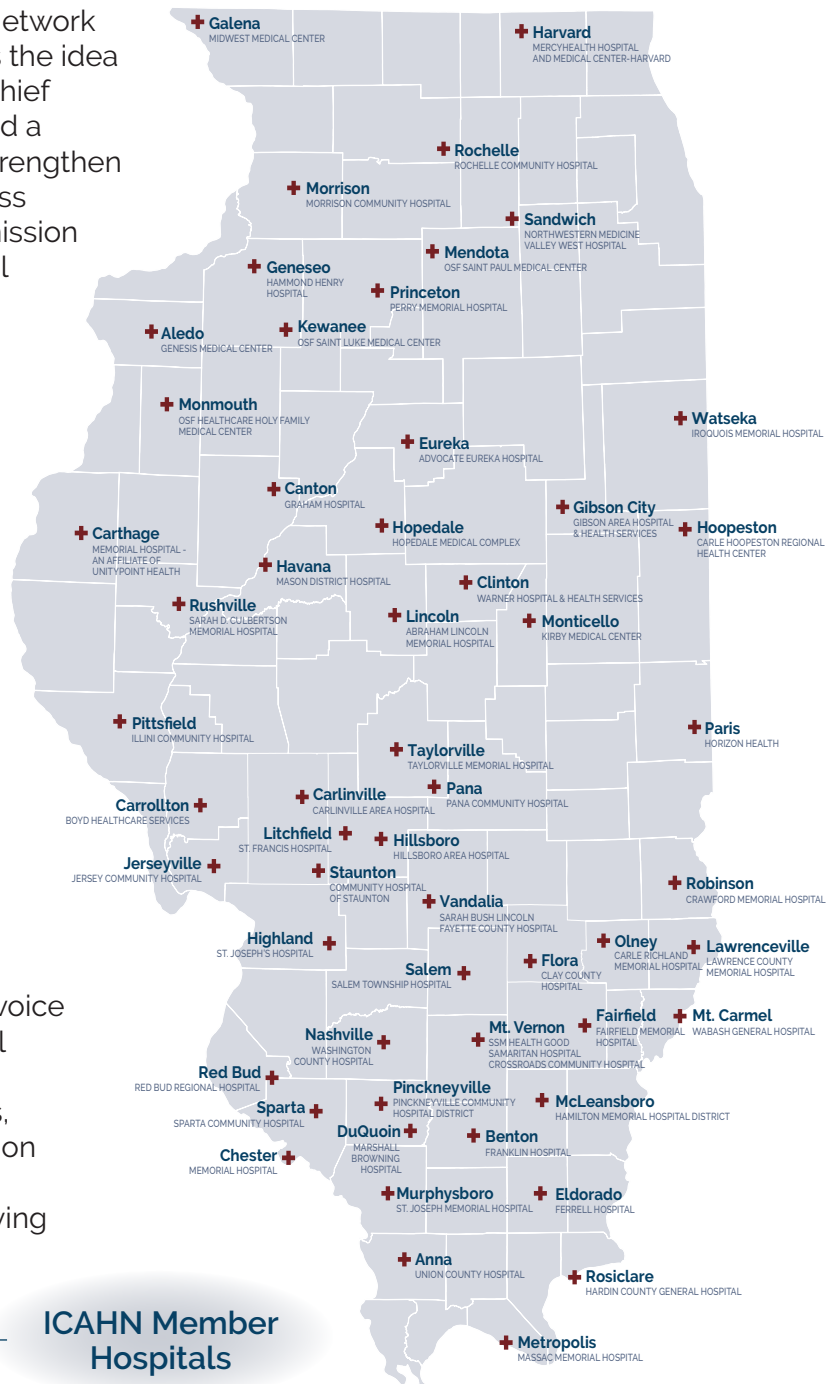
## The ICAHN Story

The Illinois Critical Access Hospital Network (ICAHN) began operations in 2003 as the idea of 20 Illinois critical access hospital chief executive officers who had envisioned a network which would support and strengthen these newly designated critical access hospitals. Since that time, ICAHN's mission has been to strengthen Illinois critical access and small, rural hospitals through effective collaboration.

The intrinsic value of this network of like hospitals is the ability for staff, department managers, senior leadership, professional staff, and board members to connect with peers through educational meetings, Listservs, work-groups, and advocacy efforts.

Members share best practices and problem-solve issues and situations together. Additionally, ICAHN offers a number of high quality shared services to meet the needs of its hospital members.

As a network, ICAHN has become a voice for the critical access and small, rural hospital community statewide and nationally. Together, ICAHN hospitals, now 57, collectively represent \$4 billion in gross revenues, more than 15,000 employees, and 3,000 providers serving a rural population base of over 1.3 million residents.





## IV. Expert's Vision on The Future of Rural Healthcare

### *Rural Hospital Board Members...* **Looking into the Future**

By PAT SCHOU, FACHE

*Executive Director, Illinois Critical Access Hospital Network*

As a rural hospital board member, it has to weigh on your mind as to what to expect the future for rural hospitals and healthcare will be.

- Will there be "Medicare for all?"
- Will all hospitals be merged into five or six large healthcare systems?
- Will there be a movement to smaller, more independent facilities?
- How far will technology advance to improve surgical outcomes?
- Will there be limits to healthcare resources?
- Will medicines cost more?
- Will healthcare be local?
- What about my community?

While no one can accurately predict the future, there are a number of observations I would like to make for board members. First of all, **healthcare is still local** whether it is through technology or face-to-face visits. People still need primary care and services as well as access to quality emergency services 24/7. It is well documented that 80% of healthcare is simply primary care and can be managed through office visits or clinic settings.

Emergency Medical Services (EMS) are critical for people living in the local community and, without access to EMS, it would be difficult to recruit and maintain local businesses.

Regardless if a board member is part of a system or an independent hospital board, it is important for your hospital to provide primary care and access to EMS services and specialty care. If your hospital has a strong primary care hold keeping as many primary care and support services locally, your hospital will be well-positioned for the future.



The second observation is that government and now, commercial payers, will **push heavily to control healthcare expenses**. Both state and federal government will continue to consider global payment type programs where there is a capped fee or use managed care organizations to control the hospital and other healthcare costs. The better performing organizations will have a greater advantage, because there will be incentives for quality and performance and penalties for overutilization and poor performance.

The “fee for service” payment system is quickly being replaced by value-based care where healthcare is measured and paid accordingly. Hospital boards need to challenge their administrative teams to ensure there is constant improvement in quality and financial performance. Rural hospitals can be very competitive and a valued care provider that the government and commercial payers will want to use.

The third observation is that **rural hospitals must connect with their communities** and provide services that meet the healthcare and social needs of the local population. Rural hospitals are economically linked to their communities and must be prepared to be flexible, providing programs and services for better health.

If there are substance use disorder issues, new immigrant families, lack of EMS, or an increase in diabetes, rural hospitals need to respond. Of course, hospitals have to be fiscally responsible; however, there are opportunities for partnership with local organizations or businesses to help meet those needs.

If the rural hospital is aligned with its community, then partners will come to the table. Rural hospitals can no longer survive without partners but rather must be a key player in the local care system or part of larger health system. Rural residents need their local hospital for access to the healthcare system, and the growth and viability of the community depends on having a strong healthcare system in place to attract business and families into the future.

As a rural hospital board member, you are the eyes and the voice of the community.

The fourth observation is that **rural hospitals can be innovative and lead**. Because rural hospitals are smaller, they are often the testers of new healthcare delivery models. The government will be looking for new ideas and places to pilot new delivery models such as outpatient care centers and expansion of home health services.

In fact, there is a growing movement to move kidney dialysis away from centers to care in the home. Hospital board members need to be open-minded and encourage their administrative teams to be a pilot and look for new revenue opportunities. Also, boards should ask questions about current services and programs that impact the different generations. As the baby boomers age and new generations come into the work environment, how can we be creative to meet the needs of many?

The fifth observation is the **impact of technology**. Eventually, all electronic records will be connected. Unfortunately, we are years away from that goal. In the meantime, hospitals will spend a lot of money on electronic medical records and cybersecurity to keep information safe. It is a necessary expense now to have cybersecurity insurance and constant training for hospital staff to protect healthcare information.

Hospital boards need to be responsible and ask questions of their administrative teams to ensure information is safe. We need to be good stewards of the money spent on electronic medical records and know that there is value to that expense. The good news technology brings is that healthcare providers have greater access to information so healthcare can be better managed and coordinated.

Technology in surgery and medicine will continue to advance. Rural hospitals may not be on the cutting edge for robotic surgery or medicine, but rural hospitals will benefit from telehealth using the technology and medicine locally.

The sixth and final observation is **patient engagement**, which is the toughest issue for healthcare in general. A plus for rural hospitals is that they have an opportunity to lead by setting up local clinics to help residents improve their health status through programs such as congestive heart failure clinics, diabetes, medication management, weight management, and behavioral health issues, to name a few.

Telehealth can be used locally through the hospital practices and clinics to connect with local residents who are engaged and ready to improve their health. In addition, rural hospitals have the opportunity to partner with

local employers to offer self-help programs to help keep employees in the workplace and provide another revenue program for hospitals.

It is uncertain whether “Medicare for all” will come to fruition or if the government decides to write one check to your community to manage all the local healthcare. Healthcare will continue to be politically charged, and hospital board members will need to stay abreast of new policies and reimbursement programs.

There is even one state assembly considering passing legislation that requires board members to take a certification exam as a board member.

Regardless, hospital board members have to be engaged and aware of their fiduciary responsibility for the local hospital and understand its role in the dynamics and success of the local rural community.







# **Governing Board Manual Volume III**

**Illinois Critical Access Hospital Network**

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