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Welcome to The Governance Institute's E-Briefings!

This newsletter is designed to inform you about new research and expert opinions in the area of hospital and health system governance, as well as to update you on services and events at The Governance Institute. Please note that you are receiving this newsletter because you are a Governance Institute member or expressed interest at one of our conferences.

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Terms of Engagement: Board Oversight of Physician Alignment

This is the first article in a series examining governance tasks that may now require a heightened level of attentiveness.

By Michael W. Peregrine, McDermott Will & Emery, LLC

Recent developments serve to encourage greater board-level engagement in physician alignment initiatives of the hospital or health system. Clearly, these initiatives assume a prominent role in the board's post-Affordable Care Act (ACA) strategic planning. Yet, the substantial value often associated with such initiatives must increasingly be tempered by the notable realities of an aggressive regulatory enforcement climate. Depending upon the structure and implementation of particular initiatives, the risk/reward ratio for the organization may be significantly out of balance. The ability of a hospital or health system to effectively implement successful, compliant alignment arrangements will depend in large part on a thoughtfully prepared and thoroughly applied internal review process. The ultimate responsibility for ensuring the effectiveness of such a review process rests with the board.

Certainly, regulatory risks have always been inherent in any type of hospital–physician relationship. The very nature of the federal anti-kickback and Stark laws ensures that to be the case. And, of course, the board has always had the ultimate responsibility for ensuring compliance oversight over such arrangements. But in many respects, "it's a new day" with respect to the board's oversight of physician alignment proposals. The ACA has dramatically increased the benefits of alignment, to both health systems and physicians alike. At the same time, the regulatory risks have also increased. Much has changed in recent years.

Indeed, the ACA, and related healthcare reform initiatives, have sparked a notable increase in the compliance obligations and regulatory hurdles that must be satisfied in order to avoid liability under key federal anti-kickback and anti-self-referral statutes. The ACA itself contains numerous new anti-fraud provisions. The federal government's healthcare fraud prevention and enforcement activity for FY 2013 produced record-breaking levels of recovery ($4.3 billion) from enforcement actions against individuals and companies. The 2014 Work Plan for the Office of Inspector General includes a number of anti-fraud initiatives with implications for physician alignment relationships.[1] Significant government enforcement litigation with anti-fraud implications for physician alignment strategies continue to work their way through the courts. Most notably, an October 2013 decision of a federal district court in South Carolina upheld a jury verdict and directed Toumey Healthcare System, a non-profit organization, to pay damages

[1] Work Plan for Fiscal Year 2014, Office of Inspector General, U.S. Department of Health and Human Services.

in excess of $237 million for violation of the Stark law and the False Claims Act in connection with certain part-time physician employment arrangements entered into by the health system.

These developments materially increase the organizational risks associated with alignment arrangements the government might interpret as "aggressive." They also directly affect the standard of care to be applied by the governing board in connection with its oversight of the organization's physician alignment strategies.

Applicable Standard of Care

The duty of care, and its focus on "acting in good faith, like a reasonably prudent person under similar circumstances," is the primary fiduciary duty affecting governance obligations with respect to physician alignment matters.

Most state non-profit corporation laws will apply an objective standard in interpreting adherence with the duty of care. *What would a person in a like position under similar circumstances reasonably believe to be appropriate*? And the concept of "similar circumstances" is key. Things are changing here. It's not business as usual. We're talking about significantly more complex arrangements that may implicate increased business and regulatory risk. In that context, regulators (and other third parties) are likely to hold health system directors to a greater level of engagement. As the stakes to the health system increase, so—it may be argued—must the applicable standard of care. Directors called upon to consider physician alignment proposals must become more engaged and be prepared to work more efficiently and attentively than in the past. This may, in turn, require a substantial reorientation of the way in which the board approaches these matters. The "old ways" of board involvement may no longer be sufficient.

Elements of Greater Engagement

There is no established set of guidelines by which a board may manifest "greater engagement" with respect to physician alignment matters. However, experience suggests that an appropriate course of action might include the following:

- **Dedicated committee**: Form a committee with board-delegated powers to provide direct oversight over physician alignment. This committee could be populated by board members with the type of background and expertise (e.g., medicine, law, accounting, strategy, finance, or valuation) that would enhance the committee's ability to oversee and review alignment matters. It could provide a vehicle for more focused and prompt governance attention to alignment proposals, while maintaining proper transparency and coordination with the compliance and audit committees, and the full board.
- **Increased education**: Provide directors with a greater level of understanding of applicable laws, and of the policy implications supporting those laws. This is particularly important given that the principles behind the anti-fraud statutes can be difficult to comprehend by members who do not possess a background in regulated industries. It is critical that the board, or delegated committee, has a clear understanding of the legislative intention associated with these laws, of the policy goals of the enforcement agencies, and of the type of conduct and arrangements that the regulators may find problematic.
- **Internal procedures**: The board/committee can play an important role by working with outside advisors and management to help apply an alignment-focused internal review process. The focus of such a dedicated process would be to establish reasonable and legally compliant standards for the various elements of an alignment project in development (i.e., expectations on the mission benefits and other goals and objectives, business planning, financial projections, terms and conditions, management and advisor checks and balances, and related matters). The expectation is that such a process would generate proposals more likely than not to be legally compliant and financially prudent.
- **Involvement of experts**: The board/committee should become directly involved in the selection and work product of outside experts (e.g., valuation, accounting, and legal) necessary to provide appropriate comfort as to the reasonableness of particular arrangements. It is appropriate for governance to work closely with management to ensure that competent, disinterested experts at all appropriate levels are engaged and properly supervised. Board members do not require specific expertise in order to scrutinize the qualifications of a proposed advisor, or to determine whether they are disinterested (or have a conflict).
- **The opinions of experts**: Since the board expects to be able to rely on the opinions of experts, it is appropriate that governance play a more direct role in reviewing and accepting opinions and other advice and reports provided

by those experts. Areas appropriate for board/committee scrutiny include the scope of the opinion, the qualifications of the opinion, the extent to which it relies on the work product of others, whether it assumes a certain understanding of facts, and disclaimers or exceptions incorporated within the opinion. It is also appropriate for the board/committee to question statements or conclusions made by the experts that appear unclear or uncertain, or are contrary to the understandings of the board members.

- **Risk evaluation**: A critical element of enhanced engagement is a greater appreciation of the risk profile of the organization, the risks inherent in physician alignment arrangements under applicable law, and of the risks arising from particular arrangements presented to the board for review and approval. This includes an awareness of the risks that the proposal may violate the law, the penalties associated with violation, and the specific description of risks, as provided by counsel. These can be difficult concepts for the board to comprehend, but they are necessary to an effective review process. The board should work with qualified counsel to address matters of risk profile.

Internal Management Tensions

As part of increased engagement, the board should also be attentive to signs of tension amidst the management team with respect to physician alignment proposals. It is only natural that management may perceive particular alignment proposals as important to the financial success and long-term sustainability of the organization. In such circumstances, it would not be unexpected for senior management to place additional pressure on other members of the management team (e.g., the chief financial officer, the general counsel, and the chief compliance officer) to approve individual proposals, sometimes despite their objections or concerns. The engaged board will be alert to this potential and will closely monitor the interactions between participating members of the management team to protect against bias or pressure affecting the decisions, recommendations, and advice of key executives.

Conclusion

The ability of health systems to pursue legally compliant physician alignment arrangements in a post-ACA environment will be enhanced by greater board engagement in the review and approval process. That is not to suggest, however, that such increased engagement constitutes a recognized "best practice," a recommendation from regulators, or an applicable statute. Rather, it is an experience-based reflection that suggests that the degree of legal compliance associated with potentially high-risk ventures is directly associated with the extent of board scrutiny.

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How to Avoid Hiring a Guy Like Me

By Peter J. Betts, LFACHE, Peter J. Betts & Associates, Inc.

Save a catastrophic event, it generally takes years for a hospital to slide from doing well into being distressed and finally into crisis. Why does it take so long for some boards to take action to correct the situation before calamity strikes? More than once I have been engaged to help a hospital that has only one half-day cash on hand—with payroll on Friday. In one case, volume dropped 40 percent in the preceding few years and in another most of their capital equipment, including air conditioning chillers and wires in the walls, were sold and leased back at exorbitant rates in a desperate attempt to raise cash. It took the prospect of missing payroll to move these boards to take action and engage a turnaround specialist. Even though intervention occurred at the last minute, both organizations continue to serve their community today.

If a hospital hits the proverbial brick wall, engaging turnaround experts can be the best thing to do. However, given the intense nature of the work, its

expense, and potential for traumatizing the organization, especially if filing for bankruptcy protection is required, the best course of action is to have a culture and systems in place that prevents the crisis in the first place.

Why Does It Take Some Boards So Long to Take Action?

The boards I have worked with are well-meaning people trying to do good by leading an extremely complex organization whose structure, product, physician and patient customers, relationships, and reimbursement are unlike any other business with which they are familiar. Reasons boards do not take corrective action sooner include:

- They do not receive good information in a useable format. Instead of material tailored to the board's needs, they receive last month's recycled management reports. Many boards spend most of their time on finance to the detriment of planning for the future and paying close attention to quality; the market; employee, physician, and patient satisfaction; and other mission-critical indicators, which can denigrate financial results. Not understanding the root causes of poor financial performance leaves the board without knowing what action to take when margins drop.
- Many board members feel they do not know the right questions to ask so they rely solely on submitted reports. It is management's and the medical staff's responsibility to help the board identify and quantify key mission-critical indicators, and be knowledgeable about what performance level can and should be achieved for each, thereby enabling informed questions and decisions.
- Some boards assume the situation will correct itself or be solved through the next planned initiative. Boards that approve successive budgets projecting losses should have demanded a change of course instead. Building volume to resolve financial shortfalls is not a successful short-term tactic, and depleting cash reserves to support the "build it and they will come" attitude has been the Achilles' heel for some. I know of hospitals with negative cash flows purchasing another hospital in desperate condition in an attempt to build a flagship out of two losers. If a negative trend line is not improving, a new plan is required.
- The board must depend upon and have faith in management; however, faith cannot be blind. Management may be in denial, or aware of the declining situation but afraid to inform the board for fear of the consequences. There needs to be a collegial relationship between the board and the CEO, but board members should never forget the CEO is their employee—they are in charge and ultimately responsible. Unfortunately, I have seen situations in which the CEO manipulated board reports to provide a rosier outlook. One management team reported they made a profit in November only to learn in January from an auditor that they had lost $14.7 million. For years, the hospital's losses were moved into a subsidiary, whose financial results were not shared with the board. The auditor, who should have been selected by the board, was chosen (and intimidated) by management.

The Board Needs to Get a Grip

As the board is responsible and accountable for the organization, protecting its assets and ensuring it is fulfilling its mission, it must take control and provide leadership as well as ensure board, management, and medical staff accountability. Setting up the systems and creating a culture of accountability to achieve this is a large but manageable undertaking.

First, the board needs to "get a grip" on all aspects of the organization. An external auditor is engaged to ensure financial matters are properly managed and recorded, but a qualified "second opinion" is not sought for all of the other key operational elements. An assessment of the entire operation by a qualified external individual or firm reporting to the board will, hopefully, verify all divisions are functioning well. If not, specific areas needing intervention will be highlighted so they can be addressed. Problems cannot be fixed if they are not recognized and put on the table. An assessment is not an "I gotcha!" opportunity but an effort by the board to seek ways to improve performance. Among areas the assessment needs to examine are: finance, quality, satisfaction, information systems, market, medical staff, compliance, planning, and governance. The assessment should result in an action plan to build upon the identified strengths and mitigate weaknesses. Even well-performing organizations can improve.

Second, in conjunction with management and the medical staff, the board needs to agree upon a list of critical success factors that, at the very least, cover the assessment areas listed above. Metrics and goals for each factor need to be established (there are sources for obtaining benchmarking information), with responsibility and target dates

assigned for each and a timely reporting system tailored to board needs created. Software programs are available to assist with this, enabling the board, management, and medical staff to quickly determine where activity is on target and where intervention and a corrective action plan is needed.[2] These systems enable a daily update so intervention can be immediate and they do not have to wait for the next monthly report to discover the problem.

Third, depending upon the nature and scope of needed corrective action, the board may recognize that a turnaround is required. A turnaround needs to be led by an experienced individual or firm external to the organization for the following reasons:

- An external advisor is objective, not invested in programs or services, and will better identify missed opportunities that helped to create the need for a turnaround in the first place. Internal staff is "too close to the forest to see the trees."
- As external advisors are with the hospital temporarily, they are less influenced by political pressure, enabling them to do any heavy lifting needed. It is useful for them to wear the black hat and then leave.
- Results will be achieved more quickly by those with turnaround experience. Most hospital executives do not offer a track record of multiple turnarounds and more ground may be lost while they undergo trial and error on-the-job training.
- Experienced external resources provide tools and procedures specifically developed and proven for turnarounds, which are left behind at the end of the engagement.
- An external executive provides the intense focus needed to conduct a turnaround. Managing the day-to-day operations of the hospital is a full-time job and the management team cannot be expected to do both simultaneously.
- Experienced turnaround individuals or firms know how to secure emergency cash infusions, which may be needed to enable the corrective action to be achieved.
- The external executive is familiar with court proceedings and negotiations with creditors, which may be needed even if the hospital has not filed for bankruptcy protection.
- Bringing in expert external help improves the image of the board as it demonstrates they are taking difficult but needed action to forestall a crisis.

How Are Solutions Hardwired In?

Once the organization is stabilized and back on track, it is imperative to create a culture of accountability by installing a system to ensure the solutions achieved are built upon and not lost over time. This means the board cannot lose its focus on achieving agreed upon goals, with corrective action plans submitted for those that start to fall behind. Management and the medical staff need to drive accountability throughout the organization by delegating goals and tasks down through their organizations and holding staff accountable for achievement, just as the board holds them and itself accountable.

Consequences need to be established, and enforced, should targets not be achieved, and rewards granted for superior achievement. (Personally, I have a difficult time justifying bonuses for achieving targets, as that is what we are paid to do.) Exceeding targets can justify an award—with the understanding that all targets are "stretch" goals to begin with.

Recognizing the need and undertaking a turnaround is a governance responsibility—restructuring how the board functions is the place to start. A board that is inefficient cannot oversee a turnaround much less ensure gains achieved are not lost. Serving as a role model for change will not be lost on the hospital's stakeholders. Consider:

- Board members and the chair should have job descriptions specific to their roles. Structured turnover to bring in new ideas, talent, and perspectives needs to be built into the bylaws with recruitment targeted to needed skills. Physicians should be on the board, but elected medical staff officers have a conflict of interest if they are voting members, so this conflict needs to be recognized and handled appropriately, with these physician board members recusing their votes and/or not participating in discussions affecting the medical staff. I strongly believe that elected medical staff officers should not serve on the board at all, although this might not be practical for some organizations. Those that do serve on boards must remember that they represent the community and the best interests of the organization's stakeholders in their role as director.
- Committees need a detailed charter describing their duties, responsibilities, and authority. Ideally, committees are strong and submit their

[2] For more information on benchmarks and reporting system software, contact Peter Betts at peter@peterjbetts.com.

carefully written minutes (think "report") to the board. Committee deliberations should not be rehashed at board meetings; discussions should be limited only to matters requiring approval or direction. Consider a mechanism that will enable some members of the community and medical staff who are not board members to participate at the committee level.

- The board needs to have its own policy manual to provide structure and direction in critical areas like quality, compliance, conflict of interest, and delegation of approval authority. Rigid enforcement of policy will help to protect the board and the institution as well as foster a culture of accountability.
- The board must have its own set of goals, remembering that management and the medical staff cannot do their jobs unless the board does its job.
- The annual board self-evaluation must be taken seriously. Input from management and the medical staff should be solicited, ensuring that criticisms are offered and taken constructively and without reprisal.
- If something is important to the organization, it will be found in the budget. Likewise, the board's meeting agenda will reflect its priorities. Since the very reason the organization exists is the provision of quality care, this should be at the top of every agenda. If the committee structure and performance are excellent and a consent agenda is implemented, less time will be spent looking in the rearview mirror instead of through the windshield.
- Time and resources need to be found for focused, high-quality board education. Healthcare is going through dramatic change and board members cannot be expected to provide leadership, create a vision, and exercise oversight if they do not know what is going on around them.
- Medical staff physicians must be partners with the organization, with meaningful participation and involvement in decisions that affect them and patient care. This means the board, medical staff, and management must trust each other.
- Just as auditors evaluate financial operations, periodic operational assessments by a qualified external source validate present practices and identify opportunities for improvement. Even thriving organizations can always do better.
- Consider engaging a qualified firm or individual to provide support as an advisor/coach. An objective "second opinion" provides new perspectives and being able to bounce ideas and concerns off a knowledgeable and "safe" sounding board is invaluable.

Having to bring in a guy like me to lead a turnaround can be avoided if the board is committed to strengthening lines of communication, improving the clarity of expectations, and holding itself and the organization accountable. Building a culture of accountability is hard work, but once imbedded it becomes second nature. Culture must continually be nurtured as it is, after all, a defining attribute.

The Governance Institute thanks Peter J. Betts, LFACHE, president, Peter J. Betts & Associates, Inc., for contributing this article. He can be reached at peter@peterjbetts.com.

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New Publications and Resources

Balancing Mission & Margin in an Era of Accountable Care (System Invitational Proceedings, Fall 2013)

BoardRoom Press, Volume 25, No. 1 (*BoardRoom Press*, February 2014)

Considering the Customer: The Evolution of Customer-Centric Healthcare (Webinar, January 2014)

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Upcoming Events

Spring System Invitational
Center for Advanced Medical Learning & Simulation
Tampa, Florida
April 6–8, 2014

Leadership Conference
The Omni Grove Park Inn
Asheville, North Carolina
May 18–21, 2014

Chairperson, CEO, & Physician Leader Conference
Boca Raton Resort & Club
Boca Raton, Florida
June 8–10, 2014

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