E-Briefings

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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.

In this issue:

How Do Boards Fail Community Health System CEOs and What Should Be Done About It? A Top 10 Primer for Boards

By Daniel K. Zismer, Ph.D., Castling Partners and University of Minnesota

Today, a sizable proportion of healthcare delivery in the U.S. remains in the hands of independent hospitals and health systems governed by community-based boards—i.e. community-based systems of care not owned or controlled by large, multi-state conglomerates (public or private).

Community boards rely upon their CEO as the principal link between governance decisions and execution of those decisions. CEO hiring and performance oversight is the responsibility of the board, along with other roles and accountabilities that necessarily come with the responsibilities of a "fiduciary."[1]

The balance of this article asserts and defends the position that boards too often fail their CEOs—an unintentional occurrence that is avoidable. This is framed as 10 observations to use as a guide for discussions between a community health system board and its CEO.

1. Understanding the Work of the Board

Governing boards of "hospitals" (licensed components of community health systems) are, by state statute, tax code, and accreditation criteria, the last stop in the accountability chain.

Boards hold accountability for all requirements of a licensed, accredited hospital. It is often the case that "the hospital" is at the center of the community health system. This hospital carries the license for the care system. By most state statutes, the board is responsible and accountable for the entirety of the performance of the healthcare organization and all it does.

The principal work of the board is upholding the healthcare organization's fidelity to its mission responsibilities. This is accomplished through what the board observes, evaluates, and directs management to attend to. The work of the board is evidenced in its balanced scorecard,[2] which

[1] The term "fiduciary" derives from the Latin "fiducia" meaning trust; a person (or institution) who has the power to act on behalf of another. A fiduciary carries responsibility beyond the "casual person"—the responsibility of carrying greater knowledge and expertise. The beneficiary (here a healthcare organization) is in a position to rely upon the fiduciary to act in good faith without conflict of interest or self-dealing.

[2] The "balanced scorecard" is a tool often used by boards to gauge ongoing performance against approved performance goals and objectives developed in collaboration with management (see R. Kaplan and D. Norton, *The Balanced Scorecard*, 1996). Performance measures include financial and non-financial. The work of the board and management is the translation of the vision and strategy of the organization to metrics that are used for board decision making.

shows what the board measures and helps determine where the CEO should focus his/her attention.

The work of the CEO is the support of the board's work. Boards must make this work clear to the CEO. The CEO's job is about the execution and performance on the board's vision and plan to serve its mission. Community boards too often defer to the CEO for the definition of their collective job. It should be the other way around.

2. Are We a Competency-Based Board?

Community health system boards are often composed of successful, well-intended community leaders who willingly serve their local healthcare organization to fulfill a sense of civic responsibility.

The probability that the board possesses the fullness of competencies to govern the complexity of community healthcare delivery is remote. To have a competency-based board, the composition of the board must be intentional. Many (if not most) community health systems require some level of reconstruction, including the re-examination of the definition of "community."

"Communities" can and should be defined variously; definitions can be encompassed by geographies, healthcare needs of populations, demographics, socioeconomic strata, etc. Boards require an accepted definition of "communities" as they go about their work.

An ongoing question of a CEO and board leadership is "what competencies are we missing?"

CEOs necessarily must also rise to the level of a board's lack of competency. It is important to know when and to what level that is occurring so plans can be made for ongoing board competency development.

3. The Lack of a "Belief System"

The guideposts of any organization's strategy is its belief system—what it believes about its position in the dynamic world and markets in which it exists.

Stated beliefs are different from the organization's values.[3] Beliefs guide behaviors, including the behaviors of strategy for a health system. Values guide how an organization carries out the actions of its mission. CEOs operate with more conviction and confidence when they know where a board stands on its collective beliefs and values.

4. Defining Priorities for the CEO

Clarity regarding what the board believes the CEO is responsible for is paramount. The answer to related questions is obvious, right? "It's everything!" Not so fast. Experience shows that boards and CEOs thoughts around this can differ, or at least emphasis of time and effort allocations. CEOs will, necessarily, be self-directed in the allocations of their time and efforts according to their judgements of "need," which is typically not an issue until the "big problem" arises and the board asks, "Where were you?"

Board leadership will often shy away from checking in periodically on this issue for fear of micromanaging the CEO. However, health system board members typically hold opinions on what the CEO should be doing. CEOs can be caught unaware, finding themselves adrift in a sea of perspectives on "what you should have been doing." Periodic check-ins on priorities management should not be viewed as a board micromanaging the CEO. Board chairs need to put this high on their list of "things to do."

5. Watching for Excessive Centralization of Decision Making (Especially with Physician Strategies)

Smaller organizations, in particular, can fall prey to excessive (and at times pathological) centralization of decision making; specifically, "the CEO makes all the decisions" especially those related to key physician strategies, contracts and terms and conditions of employment agreements, and the like. The latter can become very problematic. Community hospitals and health systems are and will continue to employ an increasing proportion of physicians required to fulfill mission responsibilities and strategies. Success with employed physician strategies

[3] Values of an organization define the principles and ethics by which it conducts its business. The values guide the behaviors of the organization, including those of the board. Beliefs of an organization describe what leaders believe to be true about the environments and markets in which a business or industry operates. Values remain constant (immutable), while beliefs are subject to the changing nature of business environments and related dynamics.

requires the development of a physician services organization, a dedicated leadership model, and a healthy culture. A healthy culture encourages a sense of equity, fairness, and transparency, including how physicians are treated and compensated. When the CEO of the organization "holds all the cards" (i.e., controls all terms and conditions of employment agreements) and arrangements are to be held "in confidence," the ability to develop a healthy and productive physician services culture is constrained.

Boards should be concerned with ensuring that the CEO establishes and encourages the framework for a productive physician services strategy, ensuring that related decision making is appropriately delegated to a qualified leadership team with appropriate legal, regulatory, and financial guidance as it relates to agreements between the health system and employed (and otherwise contracted) physicians.[4]

6. The Role of Physicians on the Community Health System Board

Community health system boards will, necessarily, require increasing representation from physicians, including physicians employed by the health system.

Boards need to understand the purpose and roles and responsibilities of physicians on the boards. While qualified as "insiders" by the Internal Revenue Code,[5] they are there for the same fundamental reasons as all other board members—to act as fiduciaries on behalf of the organization. They are not there to represent constituencies (special groups of physicians, employed or independent) nor are they there to "report" on the performance of management.

Boards (especially board leadership) set the tone for the roles (and behaviors) of physicians on the board. Physicians will, typically, appreciate clear guidance on their responsibilities as members of the board; the role is often a new experience for physicians. CEOs need to know that physicians aren't a special class of board member, with the understanding that specific board seats may be assigned to ex-officio members (the chair of the executive committee of the medical staff, for example). Here, a board member may hold a special duty to the board. Such duties should be made clear, in writing.

7. The Insufficiency of Peer Group Comparisons

A common practice of the management team's evaluations of performance is comparisons with peer groups—"how we're doing compared with organizations like ours." While a useful point of view, related observations are limited and insufficient for the ongoing evaluation of organizational performance. For example, with financial performance indicators a healthcare organization may see that, as compared with its peer group, it ranks above the 60th percentile in operating margin performance. On the surface, it's doing better than most in its class. The reality is its financial performance may be absolutely insufficient to build the debt capacity required to fund the future capital asset investment requirements for its mission in the community.

Governing boards should provide CEOs permission to expand the board's perspectives on the performance of the organization to answer the important questions regarding "how we are performing as compared with how we need to perform to succeed with our mission and our strategy."

8. Board Edicts and Related Constraints

Community health system boards will take stands that constrain the CEO's thinking, attitudes, and behaviors; stands proclaimed as edicts such as "our strategy is to remain independent." Well, for starters, "staying independent" is a cause not a strategy, and such proclamations shape and direct the thinking and leadership behaviors of CEOs.

More than one CEO has taken such edicts to heart forsaking all other learned and available rational strategies, including what may be best for a community-based health system.

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[4] Boards should be mindful of the methods and processes applied to create legal arrangements with physicians. Board involvement should extend beyond understandings of legal and regulatory oversight to business practices that implicate internal and external fairness and equity and protections of organizational reputation and brand value. Excessive concentration of control of these relationships and arrangements with the CEO exposes the organization to risks related to "due care of a board."

[5] An "insider" is defined by the Internal Revenue Code as a person having a financial interest in the activities of an organization.

Resolve by a board is not the issue here. It is the forethought required to know if such resolve will cause a CEO to labor against his or her experience, common sense, instincts, and ethics.

9. Interference of Personal Relationships

By definition, community boards are composed of members of defined communities and are oftentimes high-profile members of these communities. Consequently, stakeholders in the mission, strategy, and business affairs of the health system will have access to board members. Historic relationships facilitate ease of access.

The bane of many CEOs is this ease of access, which frequently gives way to unfettered discussions at social and neighborhood events, and worse, the unsanctioned "secret meetings." When left uncontrolled, boards can and should expect the paranoia of the CEO to spike and ultimately reach dangerous levels if everyone but the CEO knows about this.

Management of this issue is done by board leadership, a written code of board conduct with informal and formal sanctions if violated. While it is impossible to unring a bell, once heard, board members should bring such potentially destructive commentary to the board chair for management with the CEO in the loop, unless such knowledge rises to a level of importance that puts the organization at risk by premature and unmanaged disclosure.

CEOs must trust their board to conduct itself professionally and by standards and best practices that provide them reasonable and practical levels of protection from inappropriate and back-channel communications.

10. Going to the Outside for Responsible Performance Metrics and Related Methods of Performance and Risk Evaluations

A major risk for boards is being overly reliant upon the CEO (or other officers) for what they should know about their organizations. The major risk is almost never "what you know," it's "what you *don't* know." Boards will believe that permitting the CEO to establish the depth and breadth of required performance metrics, standards of performance, and related indicators of organizational risk constitutes a show of good faith and confidence in their CEO. To a certain extent it does, but it, in turn, exposes the board to the risk of not knowing what they don't know, which has translated to the legal risk of what is reasonable and prudent for a qualified board to know.[6]

A case example is useful here:

> The community health system has grown its employed physician base to 100. The CFO reports that this group of employed physicians "is producing at the median for similarly structured groups." The board doesn't know what to make of this—"Is this good or not?" With a little education the board could know that with such analyses median productivity can be significantly less than the mean (due to the typical shape of the sample distribution curve) meaning if collective productivity was moved to the mean (the average), upwards of several million dollars of incremental revenue would be produced for the health system generating a sizable contribution to operating margin.

Here a modicum of board education goes a long way to decision making related to system strategy and financial risk management.

Boards should encourage the CEO and senior leadership to go outside the organization for best practice examples of balanced scorecards and strategy maps, especially samples from larger, more structurally and strategically complex organizations.

Conclusions

While CEOs do fail in their jobs, boards often contribute to that failure—boards do fail their CEOs. Boards fail CEOs for a number of reasons and, often, at several levels. The 10-point framework provided is intended to encourage healthy conversations between a board and its CEO (and ultimately the senior leadership team).

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[6] One of the two principal duties of fiduciaries is the "duty of care" (the other is the duty of loyalty)—to act in good faith and in a prudent manner in decision making. To the extent that a board relies solely upon the counsel and judgement of the CEO for important decisions, a board may reasonably be accused of not exercising "due care" in the execution of it responsibilities.

Board chairs carry the principal responsibility for the board's obligations to support the CEO. The board chair/CEO relationship, with roles clarification, is important.

Boards should routinely undertake not only rigorous self-evaluations of how they are doing in fulfillment of their responsibilities and accountabilities to the organization and the communities served, but also how the board is doing in its responsibility to the CEO. The CEO's opinion matters in the process. The framework provided here can be a good conversation starter for such efforts.

The Governance Institute thanks Daniel K. Zismer, Ph.D., Managing Director and Co-Founder, Castling Partners, and Professor Emeritus, School of Public Health, University of Minnesota, for contributing this article. He can be reached at daniel.zismer@castlingpartners.com.

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The Best Directors Ask the Hardest Questions

By James L. Reinertsen, M.D., The Reinertsen Group

Jim Conway, former Executive Vice President and COO of the Dana-Farber Cancer Institute, remembers when his colleagues would congratulate him after a board or committee meeting saying, "Great presentation, Jim! The board didn't ask a single question!" This view of a "good board meeting"—elegant presentations by staff that consume 90 percent of the allotted time, leaving no opportunity for real questions, dialog, and productive disagreement—still seems to prevail in all too many boardrooms, especially for those portions of the board agenda that deal with topics on which many lay board members are not experts (i.e., clinical care, quality, and safety). When discussions on these topics come up, lay board members tend to stay silent, and defer to the doctors and nurses in the room.

But the board is responsible for *everything* in an organization, including the quality of clinical care. How does your board spend its time on oversight of quality and safety? Listening to PowerPoint presentations or having real conversations about the important issues? To improve discussions around quality and safety board members, either at the committee or full board level, should start by asking harder questions—even if they aren't doctors. This article provides some basic clinical quality questions that anyone on the board can ask.

Smart Questions Around Quality and Safety

Has everyone read the quality report in the packet? Yes? So could we dispense with the PowerPoint presentation of what's in the packet and spend our time talking about some of the hard issues raised by this report? The first thing most boards need to do is free up time for real conversation. The best way to do this is to put good information into the board packet, expect the board to prepare in advance, and never to "re-present" that same information at the meeting itself. Note that this idea works for the *whole* board agenda, not just clinical quality and safety.

Can you translate that into the number of patients who were affected last year? Board quality reports are often expressed as a confusing table of rates and percentages, displayed as red, yellow, or green, depending on whether the various measures are meeting targets. But what does "1.9 infections per 1,000 device days" mean? Directors tend to engage much more strongly about safety performance when they understand that it means "24 people got a preventable infection in our hospital last year—an infection that doubled their risk of dying."

What does "green" mean? For this measure, if we were "green," how many patients would still be having this problem? Boards set goals, which are often linked to management incentive compensation systems. For quality and safety, if performance is on track to achieve the goal, it's displayed as "green." But how high are your goals? Could your hospital or health system be "in the green" and still be harming a lot of patients? If so, are you okay with that? This question might provoke an interesting conversation at your next board meeting.

Does every doctor on this list for reappointment to staff faithfully follow all of our safety protocols and procedures? The medical staff recommends, and the board decides, which doctors will be allowed to practice at the hospital or health system. Medical staffs

generally do an excellent job of making sure that candidates presented to boards are properly credentialed and technically capable. But in the era of accountable care, with its emphasis on safety, technical competence is not enough. Boards must also be assured that the doctors being approved for staff membership are *culturally competent*—particularly in their leadership of a culture of teamwork, and in their adherence to important safety rules and standards. If you were to ask the above question the next time you are asked to approve a list of 40 doctors' names for reappointment, you probably wouldn't get a very clear answer at the meeting. But the board could, and should, then ask the medical staff leadership to return with a plan to assure the board that each doctor being recommended for reappointment is in fact leading, rather than impairing, the organization's safety culture.

There appears to be a solid business case for purchasing this new, expensive technology. Can someone tell me that the "safety case" is equally strong? Can we do this new procedure safely? How do you know? Boards usually insist on a solid return-on-investment analysis before approving major capital expenditures such as new surgical robots. But many new procedures have a fairly significant learning curve, and require substantial experience (and sufficient volumes) to be done safely. For this reason, some hospital and health system boards insist on very strict safety standards for new procedures and technologies, and require doctors to perform many of them under expert supervision before they're allowed to do them on their own. Other boards pay little or no attention to the "safety case" for these potentially very dangerous new activities. These boards need to change the conversation, so that the board prospectively weighs the safety risks of new technologies as closely as it does the business case.

Am I the only director who doesn't understand what you just said? Healthcare is an enormously complex enterprise, with a bewildering vocabulary, and an even more bewildering set of acronyms. As a board member, you cannot meaningfully participate in important conversations and decisions if you don't understand what's being said. I have watched the faces of the board members around the table when one of their colleagues has asked the above question, and the vast majority light up with relief! Don't hesitate to ask for clarification, especially on clinical quality and safety matters. You'll be speaking for many others in the room.

The best directors know that they are responsible for everything in the organization, especially what might go wrong in quality and safety. They don't passively listen to reports, and then vote on complex issues they don't really understand. Rather, they insist on real, meaningful conversations that air out concerns, and surface controversy. *The best directors do this by asking the hardest questions.*

The Governance Institute thanks James L. Reinertsen, M.D., President, The Reinertsen Group, for contributing this article. He can be reached at jim@reinertsengroup.com.

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The Clinical Documentation Improvement Program: An Essential Element in a High-Performing Hospital

By Ellis "Mac" Knight, M.D., M.B.A., Coker Group

Language and terminology are funny things in healthcare. Clinicians tend to use one lexicon and coders, who must translate these clinical terms into billing codes, often use another. This disparity can lead to misunderstandings and communications to payers, purveyors of quality, and others regarding the reality of clinical conditions or services rendered in the hospital setting.

Consider, for example, when a patient is septic due to an underlying urinary tract infection. Sepsis implies a life-threatening situation where the body's immune response to the infection is so overwhelming that damage to the tissues and underlying organs of the infected patient may occur. Clinicians often refer to the condition where a patient is septic from an infection in the urinary tract as "urosepsis." Professional coders, however, translate the term "urosepsis" as an infection of the bladder (i.e., simple cystitis). But cystitis is not a serious condition nor is it treated in the hospital and certainly not the intensive care unit (ICU) where hospitals and health systems

commonly place septic patients. Therefore, if this discrepancy in terminology and coding remains uncorrected, the healthcare organization may end up not being paid for the expensive treatment of a very ill patient.

There are countless situations similar to the urosepsis example, and the solution for fixing these translational errors is one with which many hospitals and health systems struggle. To help in these efforts, healthcare organizations often develop clinical documentation programs where clinical documentation specialists (CDSs) review the medical records on a real-time basis to encourage physicians and other providers to document the clinical condition in a way that results in an accurate representation. These programs can be quite successful, but they are also fraught with complications. Physicians often balk when being told how to document in the medical record. Further, coders must abide by strict regulations that prohibit them from interpreting the information in the health record on their own.

Accurate Documentation for Quality Reporting and Improved Patient Care

Many hospitals and health systems are now rated, ranked, and compensated based on their quality performance, which adds further complexity and urgency to this situation. This quality performance, in turn, is risk stratified (i.e., outcomes are adjusted based on the clinical risk inherent in the patient population cared for in the hospital). All of this rating depends on accurate clinical documentation and translation of this information into accurate diagnostic codes, which are used to gauge a hospital's quality performance.

Take, for example, a tertiary referral hospital that manages many extremely ill, complex cases referred to them from smaller facilities, which may not have the equipment, staff, or expertise to care for these high-risk patients. If the hospital does not accurately document the high-risk nature of its patient population, their outcomes (e.g., mortality, complications, or readmissions) may appear as reflecting substandard care delivery rather than the fact that the patients under care are at extremely high risk of adverse outcomes. Furthermore, with more and more reimbursements now dependent on quality outcomes, these quality ratings could cost the hospital considerable dollars along with an undeserved reputation for providing poor quality care.

Finally, and something that is often lost in the conversation around clinical documentation, the primary purpose of promoting good clinical documentation is so that communication between and among clinicians can occur in a manner that provides for good patient care. Most patients in a hospital or health system receive care from more than one physician. Physicians, increasingly, work with teams of caregivers who must communicate with each other in a way that ensures that every member of the team is up to speed on the patient's history, current condition, and treatment plan. Good clinical documentation is, therefore, a cornerstone of high-quality medical practice and not just a mechanism to drive higher reimbursements or quality scores.

Evidence of this trend for team-based patient care is that hospitalists (i.e., physicians who solely care for patients in the inpatient setting) primarily care for most patients in hospitals and health systems today. These specialists work in teams alongside nurses, pharmacists, rehab specialists, and care managers. They usually work in shifts, and they hand off the care of patients to each other at the end of each shift. This all-important hand-off process is critical to ensure continuity of care, and it is a very high-risk period, during which clinicians must make sure that nothing "falls through the cracks." The key to this transfer of responsibility is good documentation that accurately reflects what has happened with the patient during the previous shift and what the plan is for the patient during the next shift.

Developing Clinical Documentation Improvement Programs

So, what are ways in which hospitals and health systems can develop clinical documentation improvement (CDI) programs that meet the demands outlined above?

First, a high-quality CDI program must focus on the translational challenges in the clinical documentation process. Translating clinical parlance into coding terms is not difficult, but what is often difficult is convincing clinicians, particularly physicians, that it is worth their time to engage in this process and make sure that everyone is reading off the same page. Many providers are extremely busy and look at this effort as a waste of their time. However, once better informed about both the financial and non-financial impact good documentation habits can have, many providers are more willing to work with the CDSs or even directly with coding staff to make sure the translation is accurate.

Next, an excellent CDI program must staff the right kind of individuals—i.e., those who possess both the technical knowledge (clinical terminology, coding requirements, etc.) and the interpersonal skills to bring the clinical and coding worlds together in a way that overcomes the parochialism that can often derail the best of efforts. These individuals are not easy to find, but they are nevertheless essential for a CDI program to be successful.

Like all good quality improvement efforts, a CDI program needs to be data-driven. Key performance indicators, such as the case mix index, the percentage of physician responses to CDS queries, the risk or mortality, and others, should be tracked and used to drive continuous process improvement in the CDI program.

Structured interdisciplinary bedside rounding (SIBR) is an innovative approach to rounding, wherein the multi-disciplinary hospitalist teams, mentioned above, round together on patients and communicate essential information about each patient verbally before documenting the information into the medical record. In fact, the SIBR is incorporating clinical documentation specialists into its process to ensure that appropriate information is documented in the record, once the entire team is in agreement as to what that documentation should convey.

In brief, CDI is an important element in any high-performing hospital or health system. Many aspects of CDI can be automated via software solutions, but knowledgeable CDI managers and staff still are necessary to have a top-notch program. The highest quality CDI activities also address the way that CDI professionals interact since this is an important element to the program's success. Hospitals or health systems that try to shortchange their commitment to excellence in this area will do so at their peril and could suffer negative consequences, both financial and non-financial.

Takeaways for Board Members

As board members exercise their fiduciary responsibilities and attempt to ensure high-quality care delivery in hospitals and health systems, it is imperative that they understand the importance a strong clinical documentation improvement program can play in both of these areas. Financial performance, quality ranking, and most importantly, effective communication among providers is dependent upon a successful CDI program. Therefore, board members are well advised to query their senior managers about their organization's CDI activities and insist that this foundational element of a successful healthcare enterprise is firmly in place.

The Governance Institute thanks Ellis "Mac" Knight, M.D., M.B.A., Senior Vice President and Chief Medical Officer at Coker Group, for contributing this article. He can be reached at mknight@cokergroup.com.

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Upcoming Events

[Leadership Conference](#)
Omni Nashville Hotel
Nashville, Tennessee
October 30–November 2, 2016

[Forum on Consumerism & Transparency](#)
The Ritz-Carlton, Amelia Island
Amelia Island, Florida
November 13–15, 2016

[Leadership Conference](#)
The Ritz-Carlton, Naples
Naples, Florida
January 15–18, 2017

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Upcoming Webinar

The New Payer: Why Consumers Will Save Healthcare—Or Destroy It

September 22, 2016
2:00–3:00 p.m. Eastern Time/11:00 a.m.–12:00 p.m. Pacific Time

Consumers are now the fastest growing payers of healthcare services and they place increasingly tough expectations upon healthcare organizations to deliver. This Webinar will share deep insight into the resources and programs necessary to create and sustain value among discerning consumers—an audience that increasingly carries healthcare's future within its grasp.

[Click here to register.](#)

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[Board Culture: An Intentional Governance Guide: Trends, Tips, and Tools](#) (Intentional Governance Guide, August 2016)

[Building a Board Education Program](#) (*Elements of Governance*, August 2016)

[The Carilion Clinic Model](#) (Video, August 2016)

[*BoardRoom Press*, Volume 27, No. 4](#) (*BoardRoom Press*, August 2016)

[Governance Notes](#) (Governance Support Newsletter, July 2016)

[Board Brief: Considering the Consumer](#) (System Focus Article, July 2016)

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