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## Compliance or Leadership: The Governance Role in Community Benefit

By Elaine Zablocki

For some hospitals, Schedule H of the new Form 990, which virtually all not-for-profit hospitals must file annually with the Internal Revenue Service, will present major challenges. That’s because they haven’t routinely assembled much of the detailed information the form requires about charity care and other forms of community benefit and community development activities. For other hospitals that have already incorporated community benefit reporting into their operations and governance work, the Schedule H will be just the next step on a well-paved path.

Great Boards looked at eight such hospitals and health systems. Representing a range of religious and secular, academic and community-based institutions, these organizations and boards don’t just collect community benefit data — they use the information to both plan and oversee community outreach efforts. They’ve made a strategic choice that others must now make as well: whether to approach community benefit as a matter of compliance or as one of mission-based leadership.

The hospitals we examined are, on the whole, viewing community benefit through a leadership lens. They are challenging themselves to meet community needs with programs that extend outside hospital walls and expand the definition of healthcare. They are gathering data on the effectiveness of community benefit programs, and making community benefit an integral aspect of all major governance decisions.

From 2002 to 2006, the Advancing the State of the Art in Community Benefit (ASACB) demonstration project worked to develop and implement reforms to enhance hospitals’ investments in community benefit. Kevin Barnett, DrPH, MCP, was the principal investigator. A key lesson was that top-level leadership truly powers the work of dedicated staff working at the community level.

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“We learned through years of work on community benefit that we could give middle managers all the skills in the world, but if they didn’t have sufficient understanding and support from the hospital’s senior leadership and board, they were dead in the water,” he says. “Unfortunately, this happens in many hospitals. The community benefit function tends to become a marginal enterprise focused on reporting, rather than planning and strategic leveraging of the hospital’s limited charitable resources.”

How does a board organize itself to oversee community benefit? ASACB’s standards call for a board-level subcommittee that includes trustees, senior management, and in most cases, a majority of external community stakeholders. “It’s a skills-based committee that includes people who have lived for many years in communities with disproportionate unmet needs, and are in a position to make informed decisions,” Barnett says. “While the board of trustees makes final decisions, the subcommittee focuses on oversight and monitoring of all the hospital’s charitable resources. Typically, the full board has too much on its plate to deal effectively with these issues.”

## WHAT’S INSIDE SCHEDULE H?

**What is Schedule H?** It’s one of the schedules that accompany IRS Form 990 released by the IRS December 20, 2007. Schedule H will be phased in.

**What is included?** Part I, “Charity Care and Certain Other Community Benefits at Cost,” includes questions on a hospital’s charity policy and eligibility criteria. It is based on the Catholic Health Association’s community benefit reporting model and gathers data on charity care, unreimbursed Medicaid, community health improvement services, research, and contributions to community groups.

Part II, “Community Building Activities,” enables hospitals to report services such as coalition building, community health improvement advocacy, leadership development and training, housing, and economic development.

Part III, “Bad Debt, Medicare & Collection Practices,” requires hospitals to report bad debt and Medicare shortfalls, including their own estimates of how much should be treated as community benefit.

Part IV requires hospitals to list management companies and joint ventures in which they participate, including a description of each entity’s primary activity, the percentage of ownership the hospital has, and the percentages owned, if any, by officers, directors, and physicians.

Part V requires the organization to list all of its facilities.

The IRS notes that many hospitals “may need to establish or modify record-keeping systems to compile or report information for [some] parts of the schedule. The additional burden could be substantial for many hospitals, particularly for the first year of reporting.”

**Is filing mandatory?** Only identifying information (Part V) will be required for the 2008 tax year; other sections are optional. The entire schedule must be completed for the 2009 tax year, to be filed in 2010.

**Are disclosure rules clear?** Not yet. Even though the IRS made extensive changes in response to concerns expressed by hospitals about an earlier draft (released June 2007), hospital financial managers will have to wait until the IRS issues instructions (expected this spring) on how to answer many questions accurately.

Several boards we studied, including Saint Francis Memorial Hospital and St. Bernardine Medical Center, discussed below, have community benefit committees, but not all do.

At Hospital Sisters Health System (HSBS), a 13-hospital system based in Springfield, Ill., the whole board (not a committee) deals with community benefit. It is one of the

system’s six strategic initiatives, discussed regularly at every board meeting.

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John R. Combes, MD, serves on the HSHS board and is also president and CEO of the American Hospital Association's Center for Healthcare Governance. "The system has a Franciscan heritage, and we look at community benefit as part of our rigorous mission integration strategy," he says. "Over the past several years,

hospitals have learned that quality shouldn't be a matter of isolated reports or a single committee within the board structure; instead it should be an aspect of our mindset as we approach almost any issue. In the same way, community benefit should be an integral part of all the board's work."

Beth Israel Deaconess Medical Center (BIDMC), in Boston, has had a board-level community benefits committee for many years, on a par with finance, patient care, and other standing board committees. It has two subcommittees, one for maintaining relations with seven affiliated health centers and one on equitable care. BIDMC has three layers of governance, with boards of directors, trustees, and overseers. All of them are represented on the 14-member board committee:

Eight hospitals have made a strategic choice that others must now make as well: whether to approach community benefit as a matter of compliance or as one of mission-based leadership.

two directors, five trustees, and seven overseers.

That means that unlike most community benefit committees, everyone on the committee is a board member; no one is a nonboard community representative. "We made a conscious decision to have a diverse board, including community representatives," says Ediss Gandelman, director of community benefits. "If someone is good enough to sit on the committee, they are good enough to be an overseer, trustee, or director."

Presbyterian Intercommunity Hospital (PIH), in Whittier, Calif., has a Community Benefits

Oversight Committee (CBOC) that includes two board members, five hospital managers, and eight community representatives. The committee is empowered to make programmatic and budgetary decisions on community benefit, without referring the matter to the full board. "The hospital board of directors has granted CBOC this authority," says Dawn Marie Kotsonis, director of community benefit development. "At present there are no budgetary limitations. The hospital has been willing to say, 'Let's work with the situation and see how it goes; we won't set any restrictions until the need arises.'"

Saint Francis Memorial Hospital (SFMH), a Catholic Healthcare West hospital that participated in ASACB, serves the homeless population of San Francisco's Tenderloin district. It values broad community representation and includes a majority of nontrustees on its 24-member Community Advisory Committee (CAC), says Abbie Yant, senior director of ambulatory and community benefit. The committee oversees the community benefit plan and includes four board members as well as medical staff, management, foundation representatives, and ten community leaders. It is an expertise-based committee, with a charter that defines criteria for committee membership, committee responsibilities, and priorities used to assess community benefit projects (see charter, next page).

## MEASURING RESULTS

Community benefits reports are by definition "after the fact." They report what's been accomplished to meet community needs, but they don't try to assess community needs to design future efforts. That's why some boards ask for detailed information on community needs and healthcare disparities in order to set

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priorities, make rational decisions about community benefit programs, and evaluate the results against community needs.

For example, Lucile Packard Children's Hospital at Stanford (LPCH), an ASACB participant and the pediatric division of Stanford University Medical Center, makes grants to other organizations that share LPCH's community service mission. LPCH includes specific outcome measures in its community-benefit investment plan.

reasonably able to achieve. In August, when our new funding cycle began, we got progress reports on those outcomes, and then in most cases set new ones for this year."

For instance, LPCH provides pediatric and obstetrics staff for the Ravenswood Family Health Center in East Palo Alto, a federally qualified health center. One goal which was achieved was to maintain a 90 percent childhood immunization rate for all children in the local school district, relying on a mobile van LPCH supplied. A

A key lesson from the ASACB Initiative was that top-level leadership truly powers the work of dedicated staff working at the community level.

"We negotiated the measures with the organizations receiving our funding," says Candace Roney, executive director for community partnerships. "We selected outcomes that were important to the hospital and that the grant recipients also wanted to work on and felt

second goal was to streamline processes and increase clinic visits by an average of 18 per day. Ravenswood achieved an increase of 12 per day, but was hampered by a high no-show rate for

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## SAINT FRANCIS MEMORIAL HOSPITAL COMMUNITY ADVISORY COMMITTEE CHARTER

### Membership Recruitment Criteria

Members will reflect a breadth of knowledge, experience, and expertise in the following areas:

- ◆ Characteristics, dynamics, and history of communities with disproportionate unmet health-related needs in SFMH's catchment areas
- ◆ Education
- ◆ Social services
- ◆ Analysis of service utilization and population health data
- ◆ Finance and accounting
- ◆ Housing
- ◆ Youth and family services
- ◆ Physical infrastructure (concern for public and private space)
- ◆ Community-based organizations in SFMH's catchment areas
- ◆ Public sector agencies and policy issues in San Francisco
- ◆ Clinical service delivery
- ◆ Primary prevention
- ◆ Legal issues (health law expertise a plus)
- ◆ Immigration
- ◆ Addiction
- ◆ Faith community

### Committee Responsibilities

- ◆ Community benefit plan
- ◆ Program content/design
- ◆ Program monitoring
- ◆ Program continuation/termination
- ◆ SFMH Community Hero Award
- ◆ Budgeting decisions
- ◆ Geographic/population targeting
- ◆ Advocacy
- ◆ Secure outside funding
- ◆ Oversee Catholic Healthcare West community grants

### Criteria for Priority Setting

- ◆ Size of problem (i.e., number of people per 1,000, 10,000, or 100,000)
- ◆ Seriousness of problem (i.e., health impact at individual, family, and community level)
- ◆ Economic feasibility (i.e., program cost, internal and potential external resources)
- ◆ Available expertise (i.e., can we make an important contribution?)
- ◆ Time commitment (i.e., overall planning, implementation, and evaluation)
- ◆ External salience (i.e., evidence that it is important to community stakeholders)

Source: Saint Francis Memorial Hospital

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well-child visits as well as by limited exam space. This year, the clinic is converting to an open access scheduling system and expects to reduce cycle time and improve patient flow.

The Dana-Farber Cancer Institute, in Boston, benefits from its Center for Community-Based Research, which rigorously evaluates community-based interventions. For example, a recent NCI-funded study focused on a program using peer leaders in low-income housing sites to educate residents about the benefits of colorectal screening. The center evaluated its effectiveness over a three-year period. “Colorectal screening rates went way up,” says Anne L. Levine, vice president for external affairs. “Now we’re working together with the center to ensure that the program is sustained at the existing sites and expanded to other Boston locations.”

At PIH, the hospital board has embraced a philosophy it calls “right care, right time, right place.” That means focusing not on what’s best for the hospital, but on what the community needs,” explains Kotsonis. “That’s why we’ve built additional community clinics. We now have a team of enrollment coordinators

“Hospitals have learned that quality should be an aspect of our mindset as we approach almost any issue. In the same way, community benefit should be an integral part of all the board’s work.”

— John R. Combes, MD, Board Member, Hospital Sisters Health System

who proactively seek out uninsured and underinsured people in the community and help them connect with an appropriate medical home so they receive care before it becomes an emergency.” ER usage is declining, and Kotsonis is in the process of compiling formal statistics.

### INFLUENCING STRATEGIC AND POLICY DECISIONS

When community benefit becomes a board priority, it can drive strategy and policy decisions. For example, Baptist Health South Florida, a six-hospital system, serves some affluent areas of Miami as well as Homestead, which lost substantial population after being devastated by hurricane Andrew. The system is doing well overall financially, says president and CEO Brian E. Keeley, and has been deeply involved

in community benefit. An eight-member community benefit committee (of the 23-member system board) oversees community benefit policy, and the committee chair presents recommendations to the full board.

In Homestead, community benefit helped drive the board to make a strategic decision to replace the existing, outdated hospital, recalls Keeley. “It was losing about \$11 million a year. We replaced it with a brand-new, \$135-million facility. Now we lose \$30 million a year.” He adds, “We expect that over the next five to 10 years, as the area recovers, the hospital’s financial performance will improve. However, no for-profit corporation would ever have considered building a hospital there.” The system board carefully considered this decision, Keeley says. “While a couple of board members

were concerned about the financial implications, most felt that we’re a community-driven, faith-based organization, and our mission is to serve the community.” Keeley cites a number of other board-driven decisions on community benefit. Although Florida sets the threshold for charity care at two times the federal poverty level, the board approved offering 100-percent financial assistance to those at three times the federal poverty level. Community benefit is a key element in the management incentive program; all executives must meet or exceed community benefit targets each fiscal year. The system also provides funding and services for five free clinics.

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St. Bernardine Medical Center (SBMC), a Catholic Healthcare West hospital in San Bernardino, California, was one of the ASACB pilot sites, and as part of that process it formed a board committee on community benefit. “We’ve always been very mission oriented, but in the past our planning process was informal,” says Linda S. McDonald, vice president for mission integration. “Today, it is much more rigorous and accountable.”

For example, when SBMC started a parenting skills course for pregnant and parenting teens, called Teen Choices, it first brought the program to the board committee for input. The program offers eight weekly sessions at a local high school, with topics including nutrition, baby care, job search skills, family relationships, and how to deal with emergencies.

“Five years ago, I’d have talked it over with my project coordinator, and if it seemed like a good idea, we’d go ahead and do it,” recalls McDonald. Instead, the community benefits committee reviewed the proposal and made a number of recommendations that reshaped the program. “Because we gathered data

beforehand, involved all the relevant people, and strategically considered various options, we have increased the sustainability of this program,” says McDonald.

## IMPLICATIONS FOR OTHER BOARDS

So, what will be the impact of the new community benefit reporting requirements to the IRS and to state government agencies? “I think it’s inevitable that an increased focus on community benefit will occur nationwide, whether

it’s legislated or regulated or through voluntary compliance,” says Levine. “For hospital boards that aren’t familiar with these issues, the best first step would be to familiarize themselves with community benefit guidelines, such as those developed by the Catholic Hospital Association.”

In the end, though, the decision on whether community benefit is a matter of compliance or helps drive strategic and policy decisions at a governance level is up to the board.

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“We negotiated specific outcome measures with the organizations receiving our funding. We selected outcomes that were important to the hospital and that the grant recipients also wanted to work on and felt reasonably able to achieve.”

— Candace Roney, Executive Director for Community Partnerships, Lucile Packard Children’s Hospital

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For community benefit resources for boards and examples of hospitals’ community benefit reports, please go to <http://www.greatboards.org/resources/cbr.asp>

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## Looking Ahead: IS THE HEALTHCARE WORLD FLAT?

By Don Seymour and  
Barry S. Bader

Thomas L. Friedman, in his book *The World Is Flat*, writes that “lightning-swift advances in technology and communications put people all over the globe in touch as never before.”

American companies outsource high-tech and low-tech jobs to India, Chinese goods find worldwide buyers, and consumer information is a mouse click away. In the dramatic transformation to a global economy, the traditional barriers separating suppliers, employees, and customers vanish. The world is increasingly a level playing field in economic terms, where all competitors have an equal opportunity, and employees can be anywhere. Companies must fundamentally alter their business models to succeed. “We are about to see creative destruction on steroids,” writes Friedman.

Can the Friedman analogy and lessons be applied to the transformations occurring in the U.S. healthcare system?

Arguably, they can, but healthcare’s flattening isn’t so much about globalization overseas – fewer than one percent of 35 million hospitalizations of American citizens occur in other countries. Similarly, although radiologists in Bangalore, Switzerland, Australia, and Israel read x-rays during the wee hours for more than 500 U.S. hospitals, most Americans’ radiologic images are still made and read on this continent.

What is happening in American healthcare is that technology is a major force driving a fundamental change in the economic model for healthcare delivery. Healthcare used to be driven by the supply side, i.e., physicians, hospitals and new medical technology dictating utilization, patient referrals to providers, and prices. Now healthcare is evolving rapidly toward a demand-driven system in which individual consumers, health plans, employers, and government – aided by distance-shrinking information technology – are taking more control. This transformation will require shifts in perception and strategy if hospitals intend to remain competi-

tive and responsive to their communities in the new environment. Is your board ready for the transformation?

### Demand-Side Changes

America’s insatiable demand for healthcare is outstripping society’s willingness and ability to pay for it. In an attempt to regain some control, society (acting through payers and government) is changing the rules of the game (i.e., its social contract with healthcare providers). With healthcare at 16 percent of the gross domestic product and climbing, society is increasingly unwilling to write blank checks to reimburse the costs of facilities, physicians and nurses, and technology to meet the growing demand.

As a result, hospital trustees will be forced to make increasingly difficult decisions throughout the next decade regarding, for example, what services to provide and for whom. Hospitals in competitive markets won’t be able to fall back on pat responses such as “we are a full-service community hospital; therefore we do everything for everybody.” Solo community providers will face tough triage challenges on what to keep and what to refer to more specialized facilities.

On the demand side of the equation, transformation is driven by three principal factors:

- 1.** Growing utilization. Utilization will continue to increase on both the ambulatory and (a surprise to many) the inpatient side. This growth will be driven by an increase in total U.S. population, from roughly 300 million today to 320 million in 2020, and by the aging of the baby boom generation. Because older patients consume more hospital resources, the aging population by itself will increase healthcare utilization by 1.6 percent annually, according to a study in *Health Affairs*. Clinical technology will shift some volume from inpatient to outpatient settings, but this effect will be limited since approximately 80 percent of surgery is already done on an outpatient basis.
- 2.** Insurance coverage and the uninsured. Changes in the payment sector continue to remove providers’ ability to set prices that recoup a reasonable margin. Public payers Medicare and Medicaid dictate rather than negotiate prices, and they chronically pay at or

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below cost. The bargaining power of private health plans is growing. Anthem Inc.'s purchase of WellPoint Health Networks for \$16.4 billion makes it the nation's largest health insurer, with 26 million health plan members in 13 states, while UnitedHealth Group, which has agreed to buy Mid Atlantic Medical Services for \$2.95 billion, will give UnitedHealth more than 20 million members.

What about the uninsured? The universal coverage aspect of the healthcare policy debate will continue well beyond November 2008. If the Republicans retain the White House and control Congress, we can expect promotion of "market-based solutions" such as pay-for-performance and consumer-directed health plans, which will benefit primarily those who already have insurance, or could buy it if premiums were more affordable. Under this scenario, the ranks of the 47 million currently uninsured will probably increase, highlighting the need for more extensive changes in policy.

If the Democrats are in charge, we can expect the debate to focus on some form of universal coverage. However, any such program could take six to 10 years to fine-tune and implement. The biggest stumbling block: determining who will pick up the estimated \$50 to \$145 billion tab. Healthcare doesn't exist in a vacuum; several other major issues are competing for votes and funding in this election year, including the economy, education, energy, Iraq, and homeland security. So don't expect your hospital's financial burden for treating the uninsured to decline much very soon.

**3.** Transparent information. The increasing availability of comparative hospital and physician information on clinical outcomes, patient safety, patient satisfaction and cost, combined with the education, affluence, and demanding nature of baby boomers, are major factors that will contribute to consumer-driven health care. But consumer-driven purchasing will be a long time coming, impeded by significant factors such as the lack of reliable information and a constrained supply of providers (see sidebar, "What's Flattening Healthcare?" on the next page). Ten years from now health-

care delivery will be much more driven by knowledgeable consumers, but over the near term, consumer-driven products will generate more heat than light.

## Supply-Side Changes

Supply-side changes will be dominated by four key trends:

**1.** Increasing clinical technology demands. From pill-cams transmitting images of the gastrointestinal tract to minimally invasive neurosurgery via the nasal cavity, improvements in clinical technology will continue to amaze us as they improve patient care. Not too long ago the single-slice CAT scanner was considered the latest and greatest. Today patients and clinicians want 256-slice devices. Shelf lives are shorter and the capital cost to acquire this technology is substantial, but hospitals have little choice if they wish to maintain market share. Baby boomers want a 52-inch HDTV, an SUV in the garage, and the most advanced diagnostic and treatment technology when they're ill – especially when somebody else pays the bill. New technology generates an arms race among competing providers who must invest in centers of excellence just to keep pace.

**2.** Physician shortage. Unless something changes, we will face a growing and severe shortage that by 2020 may range as high as 200,000 physicians. But the problem hospitals face goes beyond a headcount. Most physicians emerging from training today don't want to be tireless entrepreneurs, hanging out an independent shingle. Instead, they expect to be good clinicians who collect a regular paycheck from their employer, and "have a life" outside the office. In addition, many physicians of all generations feel they no longer really need the hospital. Even those who do want to support their local hospital find the notion of "volunteer time" unrealistic. They are simply out of discretionary time as they cope with economic stresses in their practices and want more time for personal pursuits. Many physicians are opting for early retirement.

**3.** Nursing shortage. If forecasts of the physician shortage give hospitals a headache, the nursing shortage will deliver a migraine. The current predicted shortfall in 2020 is approximately 400,000 nurses. At the same time,

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part of the solution to the physician shortage could be using more advanced practice nurses as primary caregivers (Have you been to your nurse-staffed neighborhood clinic at Wal-Mart or Walgreen's lately?), which would make the hospital's nursing shortage even worse. The problem is not limited to nurses; shortages are forecast in virtually every aspect of hospital employment.

**4.** Growing competition. In the early 1980's futurist Jeff Goldsmith wrote that healthcare was a "neighborhood business." That's no longer true. Notwithstanding the 200,000 U.S. citizens who went to places such as Bumrungrad Hospital in Thailand in 2005, most hospitals and doctors aren't subject to overseas competition. The real action will be right here at home because the old neighborhood has changed. Today, mobile patients empowered with information on where the best care is available readily travel to hospitals, outpatient facilities, and physician specialists doing sophisticated work in their offices in the next town, county, or state. Hospitals today face a range of old and new competitors, including other hospitals, physicians, and investor-owned enterprises.

Constrained facilities and capital access are often considered to be important supply-side trends. While they clearly affect a hospital's ability to provide services, hospitals that transform themselves and align with physicians to operate efficient and high-quality enterprises will be able to generate solid margins and obtain the capital needed to build facilities and acquire new technology, thus creating a self-fulfilling cycle of success. Investment capital will be available to those whose performance merits it.

## Social Contract

When the "greatest generation" returned home from the war, employer-based health insurance was already embedded in U.S. culture. The next two decades were a heady time, and the healthcare system participated in that prosperity. Hospitals were built with Hill-Burton funds, subsidies were provided to train physicians, and (some) insurance was provided for the elderly and poor through Medicare and Medicaid. At the risk of oversimplification, we can

say that society contracted with healthcare providers, saying "care for us, and we'll give you our trust and respect, and we'll pay you well."

Why are so many middle-aged physicians angry today? Because that contract is being rewritten – without negotiation. The new contract from society reads more like this:

- ✦ Take care of more people, who have more complicated conditions, and increased expectations.
- ✦ Provide more complex care with fewer resources and face increased regulatory costs.
- ✦ In return, we'll keep a wary eye on you and let you know how much we're going to pay you when we get around to it.
- ✦ Are we clear on this?

Many physicians feel they have about as much control of their destiny as American manufacturers facing global competition from low-cost producers. Their business no longer sustains their profession.

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## What's FLATTENING Healthcare?

### MORE POWER ON DEMAND SIDE

- ✓ Increasing utilization
- ✓ Government and health plans dictate prices and quality/regulatory requirements
- ✓ More transparent information on quality, safety, and price
- ✓ More informed consumers
- ✓ More choice of outpatient facilities and nontraditional providers

### LESS POWER ON SUPPLY SIDE

- ✓ Costs of technological arms race
- ✓ More competition
- ✓ Workforce shortages
- ✓ Traditional hospital-physician separatism inhibits efficiency
- ✓ Little ability to limit demand from insured/poor payers

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## Implications for Boards

The trends reshaping healthcare call on boards to question traditional beliefs and practices and to change to address new economic realities. Trustees should rethink their approach in several areas, including:

**1.** Mission and clinical priorities. A full-service mission may no longer be what the community is asking for, AND it may not be sustainable economically. If your hospital has a lagging market share in a given service, the service area may be sending you an important message. No hospital can be the best in everything. Harvard strategist Michael Porter advises that “... strategy is choice and trade-offs ...” meaning that strategy is about deciding what you will not do, just as much as setting priorities for what you will do. This suggests that a clear assessment of your clinical service portfolio may be in order.

**2.** Quality and patient safety. The current model employed by many hospitals relies on volunteer physicians for credentialing, peer review, and quality improvement. Research from the RAND Corporation and

## The Case for Building a Hospital-Based MULTI-SPECIALTY GROUP

- ✓ Newly trained physicians prefer to be employed. We will face a seller’s market for the next decade, and hospitals without a multi-specialty group (MSG) will be at a disadvantage.
- ✓ MSGs foster collegiality and a spirit of inquiry, which in turn lead to improved patient safety and quality.
- ✓ Within MSGs average family practice physician incomes are about seven percent higher (an obvious aid in recruitment) as a result of benefits of scale and cross-subsidization from specialists (who are rewarded with referrals).
- ✓ Electronic medical record development is enabled when a hospital and a MSG are sister corporations (i.e., subsidiaries of the same parent). Interoperability is in the parent company’s interest, even when it means the hospital and/or MSG have to give up some aspects of their preferred, individual modality.
- ✓ When the MSG coexists as a sister corporation to the hospital, the parent company can also negotiate with “single signature” authority, focusing on the overall value to the health system, without regard to whether the medical group loses money on its piece.

Dartmouth Atlas suggests this is a flawed model, and anecdotal field experience consistently backs up the research. Other than the smallest institutions, hospitals may need full-time, paid clinical leaders with a mix of administrative/clinical responsibilities, especially to chair large departments such as surgery and medicine.

**3.** Physician employment. Most physicians are currently in practices that range from one to three physicians; however, single specialty and multi-specialty groups (MSGs) are likely to be the dominant organizational structures of the future. This means trustees need to think now about the role of the hospital in building

or acquiring such groups. There are a number of compelling reasons for hospitals to form their own MSG (see “The Case for Building a Hospital-Based Multi-Specialty Group”).

True, the late 1990s’ experiment in physician employment was for many hospitals an abysmal failure. Times have changed. Hospitals acquiring practices needn’t overpay for inflated “goodwill.” A commonsense approach to practice management, such as basing physician compensation on productivity and net revenues, combined with noncompete clauses, can make hospital-owned groups viable and enable hospitals to overcome past problems.

**4.** Information technology. Information technology (IT) can be the “steroid” of organizational transformation when appropriately prescribed to support an organization’s strategic plan. By enhancing communications among providers and with patients,

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IT enables providers to improve quality while simultaneously cutting costs. Paper-bound providers with legacy systems that don't talk to each other can't meet the markets' demands for efficiency and demonstrable quality. Current estimates suggest healthcare costs could be cut by a third if IT were fully implemented. However, the capital costs of implementing IT networks are enormous, and the near-term cultural hurdles of physician adoption are daunting. While it is theoretically possible for all the bits and bytes to talk with one another, it turns out to be quite difficult to implement interfaces among such a wide variety of legacy systems. Boards need to stay focused on IT as a core strategy and not be deterred by the operational challenges.

IT will tear down barriers to consumers' access to information. In the future "best practice" hospitals

## Factors Inhibiting the Move to CONSUMERISM

- ✓ Comparative information on provider quality is:
  - ✗ Limited to few conditions
  - ✗ Inconsistent and contradictory among sources
  - ✗ Not understandable to less literate segments of population
- ✓ Little useful information is available on providers' relative prices, and few consumers are incented to choose lower-cost providers
- ✓ Constrained supply: no real choice when few/no alternatives exist for a local hospital or specialist
- ✓ 70/10 Rule: 70 percent of healthcare costs are associated with 10 percent of the population
- ✓ Policy concerns: only the affluent will have access to "the best" providers
- ✓ Litigation: physicians taking legal action to prevent panel exclusion

will do much more than post information on their Web sites. They will educate consumers on how to acquire, interpret, and compare reliable information. Information technology will also expand the possible locations for diagnosis and treatment. A hospital campus will be one among many venues where patient care can be provided. Other options include physician

offices, ambulatory care centers, patient homes, retail stores, and even the Internet. Hospital campuses will be redesigned to improve access to ambulatory care and also offer patients single rooms, thereby reducing infections and improving quality, productivity, and patient satisfaction.

## Conclusion

As the economic model for healthcare delivery evolves over the next decade, hospital trustees will face increasingly difficult decisions. U.S. healthcare won't be flat in the global sense, but it will trend towards a buyer's market. Understanding this will be critical for both mission and margin.

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# Rising Expectations Require Not-for-Profit Boards to Demonstrate Their “Institutional Integrity”

by Barry S. Bader

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**When the Internal Revenue Service released a dramatically expanded version of the Form 990 tax return in December 2007, it marked the culmination of a year of increasing criticism and rising expectations for not-for-profit organizations generally, and hospitals and health systems specifically.**

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Federal agencies, congressional leaders, state attorneys general, labor unions, and local revenue authorities all stepped up their attacks on tax-exempt hospitals. Meanwhile, a variety of organizations and associations, including the IRS, the American Hospital Association, Independent Sector, and The Governance Institute all published guidelines recommending practices that would enable not-for-profits to demonstrate their community benefit, corporate integrity, prudent financial stewardship, and ethical conduct (see sidebar describing Form 990 on the next page and the timeline of events on page 15).

As the external demands on not-for-profits escalate, the reaction from many boards and executives has followed the familiar five stages of grief – and organizational change: denial, bargaining, anger, depression, and finally, acceptance.

**DENIAL.** Many hospital leaders believe that the only organizations at risk are those whose executives and boards are guilty of serious ethical misconduct or dereliction of their community-benefit responsibilities. The leaders of Provena Covenant Medical Center in Illinois would argue otherwise: Provena lost its local tax exemption despite a commendable community benefit record.

**BARGAINING.** Some hospital leaders believe that if government agencies would only set clear and consistent standards for reporting on community benefit, executive compensation, clinical quality, and so forth, not-for-profit hospitals will make the required disclosures and their compliance will be apparent. In reality, disclosure is likely to be just one step toward more stringent regulation. The IRS already uses its “compliance checks” to target organizations to audit, and several legislators have proposed minimum standards for charity care to qualify for tax-exempt status.

**ANGER.** Many healthcare leaders are outraged that the same political leaders who approve costly, unfunded mandates and low Medicare and Medicaid reimbursements would criticize an industry that provides millions of dollars in charity care and other community benefits to the most vulnerable members of the community. Similarly, many trustees are distraught because the same standards for governance independence that the Sarbanes-Oxley Act requires for investor-owned corporations are being applied to not-for-profits, where similar abuses haven’t occurred. Some are concerned about the loss of valuable directors due to stiffer standards for conflict of interest. However, the fact is that Sarbanes-Oxley has become a de facto benchmark for assessing the practices of all types of boards.

**DEPRESSION.** Depression may be too strong a word to describe the reaction to the pressures facing tax-exempt hospitals – healthcare has too many “Type A”

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personalities in executive suites and boardrooms to admit depression. Nonetheless, it's a lot easier to generate enthusiasm about strategic initiatives to expand clinical services and improve quality than to get leaders excited about investing time and money to meet complex government reporting requirements, such as the vastly expanded Form 990.

**ACCEPTANCE.** Finally, there are organizations that accept rising expectations for institutional integrity as an opportunity to strengthen governance practices, reconnect with their communities, and reassure their stakeholders that their not-for-profit hospital has not forgotten what makes it different: its mission and community commitment.

### Getting Out in Front

A number of hospitals and health systems have reached the "acceptance" stage and are taking a proactive approach to one or more aspects of institutional integrity. Some hospitals have been motivated by a strong sense of mission; others are motivated by external pressures such as existing or anticipated

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## Institutional Integrity 2007-2008: A Timeline of Rising Expectations

**February 2007** — AHA's Blue-Ribbon Panel recommends that boards promote transparent performance reporting and oversee programs to meet stakeholders' needs.

**March** — Head of the Smithsonian Institution resigns following press reports and Congressional allegations of irregularities in executive compensation, travel expenses, ethical conduct, and board oversight.

- IRS compliance checks of executive compensation document "significant reporting errors and omissions" and result in \$21 million in excise taxes.
- Illinois Department of Revenue revokes tax-exempt status of two more hospitals.
- California state agency conditions approval of \$910 million in tax-exempt bonds on Sutter Health's contribution of \$8.5 million to support community health clinics and electronic health information systems for rural hospitals.

**April** — Report finds that 32 state legislatures now require hospitals to report pricing information, and six more have voluntary price reporting systems.

**July** — Senator Charles Grassley proposes two tiers of tax-exempt hospitals and minimum of five percent of annual revenues to be spent on charity care.

- IRS Commissioner Miller says the line between tax-exempt and commercial sectors is blurring.

**August** — HFMA releases latest recommendations to develop more rational, patient-friendly pricing systems.

**September** — Centers for Medicare and Medicaid Services announce results of patient experience surveys to be published quarterly beginning in March 2008 and added to clinical quality indicators on its Hospital Compare Web site.

**October** — Independent Sector Panel report recommends 33 principles for good governance and ethical practice covering legal compliance and public disclosure, effective governance, strong financial oversight, and responsible fundraising.

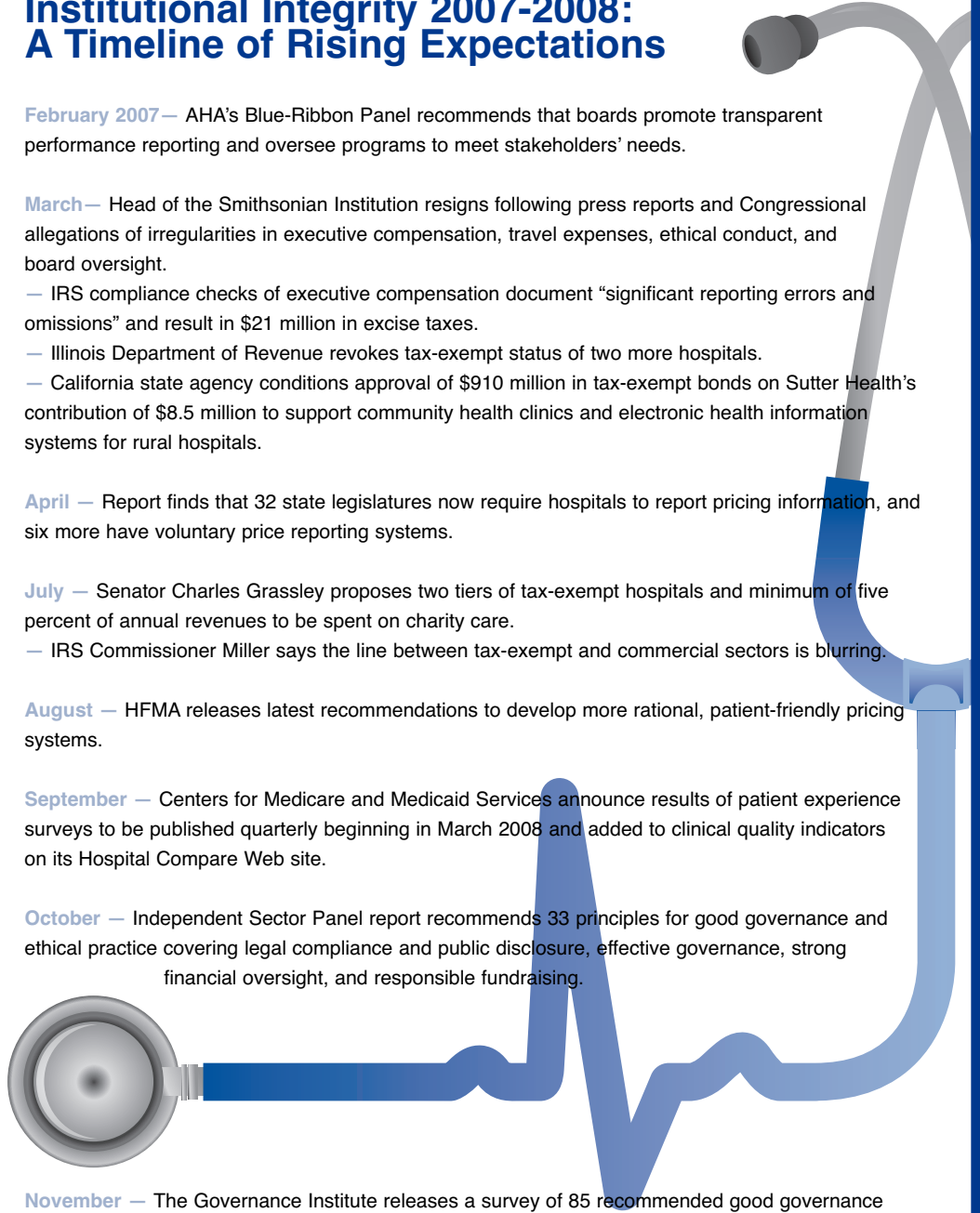
**November** — The Governance Institute releases a survey of 85 recommended good governance practices and finds a mixed record in meeting new institutional integrity requirements.

**December** — IRS releases the new Form 990.

- IRS announces its focus for 2008 will include executive compensation, community benefit requirements for tax-exempt hospitals, and Form 990 compliance.

**January 2008** — Ohio's attorney general announces plan to impose community benefit requirements on not-for-profit hospitals by the end of the year.

- The American Hospital Association files amicus brief urging restoration of Illinois hospital's local tax exemption.
- Moody's Investor Service says bond ratings are affected by documentation that a "hospital's quality effort is translating into tangible results in improved financial performance."



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state law. For example, in Vermont, a law called “Act 53 Hospital Report Card” requires hospitals to report on their quality of care measures, patient safety initiatives, quality improvement initiatives, community needs assessment, financial reports, governance, and complaint filing procedures.

Web sites provide a useful way to examine hospitals’ and health systems’ efforts to demonstrate institutional integrity. Although a Web site alone can’t take a full measure of a hospital’s initiatives, Web sites demonstrate transparency. They give journalists, legislative staff, and local residents an easy way to learn about the organization’s good works and governance practices. For example:

#### COMMUNITY BENEFIT.

As Elaine Zablocki’s article in this issue points out, more and more hospitals are communicating their community benefit activities and financial assistance policies. Lucile Packard Children’s Hospital at Stanford in Palo, Alto, Calif., publishes a community benefit report on its Web site, including descriptions of programs to improve access to care, address childhood obesity, and improve child safety. Advocate Health in

Chicago describes on its Web site \$296 million in community benefits it provided in 2006 and relates personal stories about the individuals it helped. St. Vincent Health System in Erie, Pa., has an easy-to-read community benefit

report on its Web site, with six pages quantifying and explaining the system’s charity care, health professions education and research, community health services and education, Medicaid shortfall, and contributions to com-

munity organizations, all totaling more than \$12 million a year. The report also describes an economic benefit for the region of more than \$625 million.

#### FINANCIAL STEWARDSHIP.

Spectrum Health in Grand Rapids, Mich., publishes extensive financial information on its Web site, including its community benefit expenses, audited financial statements, and its budget for the forthcoming year.

#### QUALITY TRANSPARENCY.

Alegent Health, which serves Nebraska and southwestern Iowa, reports its performance for the 21 Medicare-required quality indicators for treatment of heart attack, heart failure, and pneumonia, as well as for nine indicators that are part of the nationwide Surgical Care Improvement Project. The site also includes patient satisfaction scores for the system’s six hospitals. Other systems and hospitals prominently displaying and explaining their clinical quality or patient satisfaction results include Sharp Healthcare in San Diego; Baystate Health in Springfield, Mass.; Southwestern Vermont Health Care; and Baylor Health Care System in Texas.

### What’s Required by the New Form 990

The new Form 990 includes a section on “governance, management, and disclosure” that inquires about such items as:

- ◆ The number of voting directors and how many are “independent” (discussed later).
- ◆ Whether directors and key employees have any family or business relationships.
- ◆ Whether the full board received the Form 990 before it was filed and the process the organization uses to review the 990.
- ◆ Whether the organization has a conflict of interest policy, whether annual disclosures are filed, and how the organization regularly and consistently monitors and enforces compliance with the policy.
- ◆ Whether the organization has a written whistle-blower policy and document retention policy.
- ◆ Whether the process for determining executive compensation includes a review and approval by “independent persons,” comparability data, and contemporaneous substantiation of the deliberation and decision.
- ◆ Whether the organization participated in a joint venture or similar arrangement and, if so, whether the organization has adopted a written policy or procedure requiring an evaluation of compliance with applicable laws.

The IRS also announced new schedules for reporting by hospitals and for tax-exempt bond activities. Hospitals must report the specific amounts expended for charity care, community benefit, and other community building activities; information on the organization’s bad debt expenses, Medicare revenues, and collection practices; and the names of management companies, facilities, and joint ventures.

Hospitals must also provide information on their charity care policy, including the formula, based on Federal Poverty Guidelines, for determining whether patients are eligible for receiving free and discounted care, respectively.

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**GOVERNANCE EFFECTIVENESS.** Baptist Health South Florida in Miami has published its board policies on all the hot buttons of external scrutiny, including its policies governing loans to officers, directors, and trustees (it bans them); board member travel and reimbursement; executive air travel; meals and business entertainment expenses; conflict of interest; charity care; and community benefit reporting.

Alegent Health also has published its conflict of interest statement and disclosure form. Although the Web site does not disclose any conflicts that directors have reported, it does display the members of the board with their photographs, the charters for each board committee, and answers to such questions as: What does Alegent Health need to do to maintain its tax-exempt status? Does Alegent Health meet its obligations to provide charitable care in exchange for its tax exempt status? What is the difference between internal and external audit? How is the external auditor chosen? How are members of the finance and audit committee chosen?

## PRICING TRANSPARENCY AND BILLING PRACTICES.

Spectrum Health has been described as “passionate about building a better pricing system.” It posts average prices for common inpatient and outpatient services on its Web site, along with a complete explanation of what’s included and the typical charges paid by insurance companies. Geisinger Health System in Danville, Pa., has developed what it calls ProvenCare practices in cardiac surgery that enable it to quote a fixed price in advance and to guarantee that it will treat complications that occur up to 90 days after the procedure without additional charges.

Healthcare Partners Medical Group, a 400-physician practice based in Torrance, Calif., publishes its fee schedule for basic medical services on its Web site. Alegent Health has a tool on its Web site to enable members of various health plans to get a good-faith estimate of the costs of various procedures prior to admission. University Medical Center in Tucson has guaranteed that patients without insurance will be charged no more than what Medicare pays for a given service.

## What Boards Can Do

Not-for-profit organizations once enjoyed a presumption they were doing good works for unselfish motives. Today they must demonstrate that they deserve their tax exemption and the public’s trust. Four steps are critical:

1. Conduct an institutional integrity self-assessment. Assess the board’s current readiness to address rising expectations for institutional integrity. The Governance Institute has published an “institutional integrity self-assessment instrument” that examines 72 recommended practices in six areas: financial integrity and transparency, corporate compliance, executive compensation, conflict of interest/director independence, public transparency, and community benefit practices. The self-assessment enables senior management and the board to make an objective and comprehensive examination of the organization’s institutional integrity readiness, identify areas of risk and opportunities for improvement, and develop an action plan to address the highest priorities.

2. Review the board’s conflict of interest policy, disclosure requirements, and most importantly, how the policy is actually being enforced. Neither the IRS nor anyone else has banned individuals with a conflict of interest from serving on the board of a not-for-profit organization; however, the new environment demands that boards take a more stringent look at traditional practices. Boards should clearly define a conflict of interest to include any actual or potential economic transaction or other relationship that a director or officer (or business associates or members of their immediate family) has with the organization. All conflicts of interest should be disclosed annually, and immediately when they occur. Directors with a conflict of interest should not participate in discussion or voting on matters in which they have an interest, and the board should document in the minutes that such directors were not present during the board’s deliberations.

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The most common shortcomings in current board practices include:

— Vague definitions of conflict of interest that leave it up to individual trustees to determine if an economic relationship with the hospital could jeopardize their objectivity.

— The failure to define a relationship with a direct competitor as a conflict of interest that must be disclosed, and potentially as a reason to disqualify someone from serving on or remaining on the board.

— The failure to define who is an “independent director” (i.e., a director with no or minimal economic or other relationships with the organization) and to require that only independent directors may serve on the board committees that oversee executive compensation, audit, and corporate compliance.

— The failure to set a minimum percentage of the board that must be composed of independent directors.

— The failure to establish “disabling guidelines” which define conflicts so material that an individual should not be permitted to serve on or remain on the board when they occur. Examples are directors who are the spouse of a member of senior management, who hold a senior position with a direct competitor, or who have willfully violated the organization’s policies on conflict of interest or confidentiality.

— The failure to have all conflicts of interest routinely reviewed by a committee composed of independent directors who determine whether the conflict is acceptable and if any special action (e.g., periodic competitive bidding) is required.

— The failure to make a summary report of all conflict of interest disclosures and the decisions of the independent review committee to all board members, so there is full transparency and no hidden agendas.

3. Review the requirements for the new Form 990. The new form asks whether the board has reviewed the form before it was submitted. Answering this question “no” is like saying, “please conduct an audit of our organization.” The form also asks for a description of how the Form 990 was compiled. The IRS appears to be looking to see whether the organization has made a serious attempt to collect accurate information. The entire board, and particularly its audit and corporate compliance committee, should carefully review all the items required on the new form (see “What’s Required by the New Form 990” on page 14), and should ask management to describe its processes for preparing the information to ensure they are thorough and reliable.

4. Educate the board and decide how to take a proactive approach to institute good governance practices and increased transparency with key stakeholders. Just discussing institutional integrity is not enough. With healthcare reform looming as a major issue in Congress and state legislatures, ensuring that the public and policy-makers understand the tremendous work hospitals do for their communities and the ethical conduct of the vast majority of hospital boards and executives has never been more imperative. The public trust has to be earned every day if hospitals and health systems, along with their physician partners, are going to be heard as legitimate voices for patient care.

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