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Potential Impact of Current Economic Conditions on Non-Profit Governance

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A review of current developments has led me to the following perspectives on how the governance of non-profit corporations may be affected by the evolving economic conditions, and related regulatory responses:

- 1. Premium on Business Judgment.** Although not a principal contributor to the current crisis, non-profit corporations—and their governing bodies—are unlikely to escape collateral damage from what appears to be an emerging climate of “finger pointing,” in which attempts to assess blame and to attribute responsibility to the board will be the order of the day. In this climate, charity regulators may be increasingly compelled to hold non-profit boards more directly accountable than before for “preventable” harm/loss to charitable assets. This will place a premium on the exercise and documentation of business judgment by the board.
- 2. Executive Compensation.** Adoption of the Emergency Economic Stabilization Act of 2008 (“EESA”) has opened a “Pandora’s Box” of executive compensation issues, all of which are likely to have a spillover effect on the non-profit sector. The EESA has introduced into mainstream discourse such previously “taboo” subjects as: (a) ceilings on total compensation; (b) “clawbacks” on incentive compensation based on metrics later proven to have been merely inaccurate (an expansion of Sarbanes-Oxley principles); (c) restrictions on “golden parachutes” and other severance or retirement benefits perceived as excessive; and (d) limitations on compensation incentives tied to “unnecessary and excessive risks” that threaten the value of the organization. The non-profit executive compensation committee will want to consider the policy implications of these provisions, together with other similar developments (e.g., the *Care First* and *Grasso* decisions).
- 3. Investment Management.** Experience suggests that any downturn in the securities markets will prompt focus on investment practices by individual non-profit organizations that result in investment losses, causing economic harm to the investing entity and, where applicable, to the operating charity that is to be supported. Extraordinary losses attributed in large part to investment strategies subsequently perceived as imprudent may be subject to scrutiny by state charity officials, notwithstanding the protections afforded by liberal state investment management laws (e.g., UPMIFA, the Uniform Prudent Management of Institutional Funds Act). The current volatility in the securities



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markets mandates greater attentiveness on the part of investment committees and governing boards of non-profit organizations with respect to their fiduciary duty to invest prudently. Moreover, it will become increasingly important for investment decision makers to properly memorialize the processes and considerations by which investment decisions are made.

4. **Tax-Exemption Pressures.** The likelihood of an increased individual income tax burden to finance the recent extraordinary government "bailout" measures may place additional pressures on non-profit organizations to justify their tax-exempt status. This comes as many in both the public and private sectors have begun questioning whether the public benefits that tax-exempt organizations are providing are commensurate with such organizations' resources and the tax subsidies they receive. This questioning is also consistent with an environment that is less willing than before to extend non-profits the benefit of the doubt. Non-profit boards must be sensitive to growing skepticism regarding whether they "deserve" tax exemption.
5. **Governance Practices.** Boards should expect additional scrutiny on the extent to which they have adopted the latest round of governance best practices (e.g., Panel on the Nonprofit Sector, IRS, Smithsonian). The current economic climate appears to be prompting a broad repudiation of the concept of self-regulation. This climate is being compounded by a perception that Sarbanes-Oxley may not have been the "magic elixir" of corporate responsibility it was intended to be. Practices relating to director qualifications and length of tenure (e.g., excessive), and frequency of board/committee meetings (e.g., too infrequent), may be areas of particular focus. Given this, more action may be expected from non-profit boards in terms of governance oversight and controls.

A likely byproduct of this emerging climate of accountability is the avoidance of risk by the board (e.g., the perception that aggressive risk-taking is primarily responsible for current conditions). Yet, fiduciary principles promote the taking of informed risk by the non-profit corporation. The challenge going forward is how to balance liability avoidance in an unforgiving environment with assuming prudent risks on behalf of the charitable mission.

The Governance Institute thanks Michael W. Peregrine, partner, McDermott Will & Emery, LLP and Governance Institute faculty, for contributing this article. He can be reached at mperegrine@mwe.com.



The Impact of Quality of Care on Financial Performance

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As healthcare spending pushes towards 20 percent of the gross domestic product (GDP), and quality of care in the U.S. consistently ranks below other developed nations, CMS (the nation's largest payer) will push hospitals to deliver higher-quality care and decrease reimbursement for adverse events.

To Err is Human: 10 Years After the Institute of Medicine Report

Nearly a decade ago, the Institute of Medicine released its groundbreaking report, *To Err is Human: Building a Safer Health System*, where it revealed the startling impact of preventable medication errors. Since then there have been numerous initiatives on a national level to improve the quality of the care that is delivered in the United States. The measures have ranged from corporate (e.g., The Leapfrog Group), to non-profit (e.g., National Quality Forum and the Joint Commission's Quality Measures), to the state level (e.g., The California Nursing Outcomes Coalition Database Project). Although the call for quality has been loud and clear, presenting a business case for quality has been more difficult. With labor costs increasing, rewards for performance minimal, and reimbursement failing to keep up with costs, finding the capital and resources to push quality initiatives has been slow to gain momentum. However, as private payers and CMS look for ways to not only improve care but also reduce costs, incentivizing providers to improve quality is the most obvious solution.

CMS Setting a Precedence: Building a Business Case for Quality

In November 2001, CMS began its first hospital-based pay-for-performance initiative with the Hospital Quality Initiative (HQI), which decreased reimbursement to hospitals that did not report certain quality measures for public disclosure. Effective October 1, 2008, CMS will take the next step by eliminating hospital payments for ten preventable hospital-acquired conditions. HealthPartners and employer coalitions such as The Leapfrog Group have adopted similar payment rules, and private insurers (WellPoint and Aetna) have announced plans to follow this practice.

Exhibit 1

Hospital-Acquired Condition	FY2007 Volume	Average Cost Per Case
Foreign Object Retained After Surgery	750	\$63,631
Air Embolism	57	\$71,636
Blood Incompatibility	24	\$50,455
Stage III & IV Pressure Ulcers	257,412	\$43,180
Falls, Traumas, and Other Injuries	193,566	\$33,984
Catheter Associated Urinary Tract Infections	12,185	\$44,043
Vascular Catheter Associated Infection	29,536	\$103,027
Surgical Site Infection:		
a) Mediastinitis after Coronary Artery Bypass Graft (CABG)	69	\$299,237
b) Certain Orthopedic Surgeries	269	\$148,172
c) Bariatric Surgery for Obesity	37	\$233,614
Glycemic Control:		
a) Diabetic Ketoacidosis	11,469	\$42,974
b) Nonketotic Hyperosmolar Coma	3,248	\$35,215
c) Hypoglycemic Coma	212	\$36,581
Deep Vein Thrombosis/Pulmonary Embolism Following Total Knee Replacement and Hip Replacement	4,250	\$58,625

Source: CMS-1390-F Centers for Medicare and Medicaid Services (CMS), HHS, Final Rules, August 18, 2008.

The Financial Impact of Preventable Hospital-Acquired Conditions

The change in reimbursement likely will only widen the gap that already exists between the costs of treating adverse events and additional reimbursement. Research has estimated that the extra payment received from adverse events cover less than a third of the costs of the event.¹ CMS has shown that patients who experience preventable hospital-acquired conditions cost the healthcare system billions of dollars in conditions that are reasonably preventable with better care. Of the preventable hospital-

¹ C. Zhan, B. Friedman, A. Mosso, & P. Pronovost, "Medicare Payment for Selected Adverse Events: Building the Business Case for Investing in Patient Safety," *Health Affairs*, Vol. 25, No. 5. 1386-1393.

acquired conditions identified by CMS for FY2009, the cost was over \$22 billion in FY2007 (see Exhibit 1), or approximately \$5.5 million for each non-federal hospital in the U.S. When compared to the most recently available data on Medicare spending, this represents approximately 5 percent of the total Medicare payment. CMS expects to save approximately \$50 million per year over the next three years from withheld reimbursement.²

The trend toward withholding payments for preventable hospital-acquired conditions will only continue to progress and gain momentum. The advent of Medicare severity diagnosis related groups (MS-DRGs) in FY2008 set the stage for CMS to be able to withhold higher acuity reimbursement for certain adverse events by separating diagnoses to those with and without complications. The first list of preventable hospital-acquired conditions included eight conditions, which expanded to ten by the time the FY2009 Medicare Final Rule was released, and Medicare continues to solicit comments and insight for additional conditions that may be added in the near future. The overall financial effect of quality initiatives will be compounded by private payers withholding reimbursement for poor quality and additions made to the preventable hospital-acquired conditions list from CMS.

Operational Excellence: Bringing Together Care Quality and Financial Performance

Nationally, almost two-thirds of hospital reimbursement is tied to CMS. Current initiatives like the Hospital Quality Initiative and withholding reimbursement for preventable hospital-acquired conditions will increasingly tie a hospital's financial performance to the quality of the care provided. Board members and administrators must emphasize that patient safety and outcomes are priorities for all employees in the organization. Operational tactics should be organized around several key operational initiatives that will improve quality of care:

- **Improve nurse staffing.** The National Quality Forum has indicated that nearly half of the preventable hospital-acquired conditions identified by CMS are associated directly with nursing care variables.³ Various studies have shown that adverse outcomes, such as nosocomial infections, sepsis, urinary tract infections, falls, and medication errors, result from sub-optimal nurse staffing. Appropriate staffing can reduce adverse events, decrease morbidity and mortality, decrease liability, and increase reputability. Improving other nurse staffing indicators, such as staff education level, hours of care provided, skill mix, and ratios can also play an important role in improving operations and care.
- **Stabilize staffing.** Recruitment and retention of professional staff continue to be top of mind in the healthcare industry. The aging population, better management of chronic illnesses, and the innovations in diagnostics and therapies will result in increased demands for healthcare providers such as pharmacists, therapists, and technicians. Nursing practice will be challenged by the increasing complexity of patient care, clinical specialization through technology and innovations, and the expansion of nursing roles, such as the clinical nurse leader and advanced practice nurses. Turnover is costly and certain positions may take months to fill, resulting in registry or traveler's fees. Consistent staffing provides for continuity of care and practice that is consistent with a hospital's mission and vision.
- **Implement a fair and just culture.** The principles of a fair and just culture are based on human behavior and management research. To create a fair and just culture, administrators must focus not only on patient safety, but on a culture of safety and transparency in all of the organization's clinical and non-clinical departments. Trust is a key factor in a culture where event reporting is encouraged and rewarded. When reporting occurs, a root-cause analysis will identify beneficial changes in systems, management processes, and human behavior. There may be situations when analysis confirms a reckless or willful violation of policies, and individuals must be held accountable. A fair and just culture defines the boundaries between blameless and blameworthy actions.

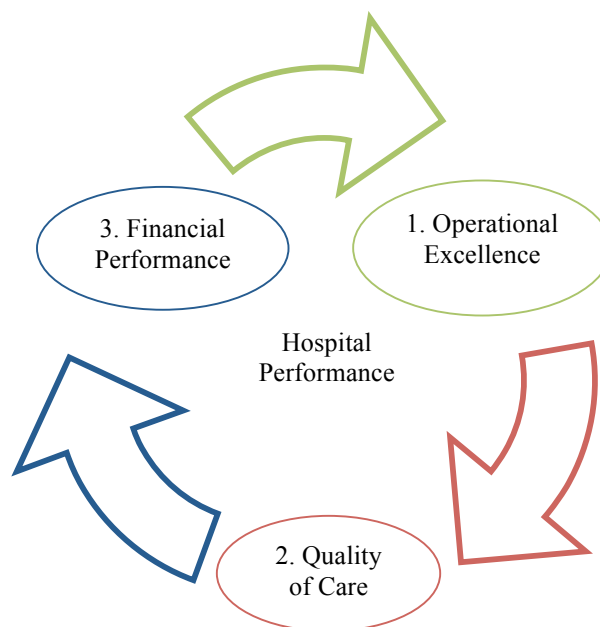
² R. Andrews, *The National Hospital Bill: The Most Expensive Conditions by Payer, 2006*. Statistical Brief No. 59. Healthcare Cost and Utilization Project, 2008.

³ E. Kurtzman, P. Buerhaus, "New Medicare Payment Rules: Danger or Opportunity for Nursing?" *American Journal of Nursing*, Vol. 108, No. 6 (2008), pp. 30–35.

- **Comprehensive case management.** Case managers have always been integral to patient care progression. Now, CMS is proposing an Acute Care Episode (ACE) payment, which would combine payment for hospital and physician services. The goal is to better align the incentives of both providers, which will result in better quality and greater efficiency of care delivery. The demonstration project will include 28 cardiac and nine orthopedic surgical procedures selected because: 1) profit margins and volumes have historically been high, 2) there is market place competition, and 3) quality metrics are available for measurement. The role of the nurse case manager will evolve to focus on clinical areas and directing multi-disciplinary teams to utilize care protocols that will focus on the appropriate level of care and intensity of diagnostic and clinical services. Care will be coordinated across the continuum to ensure that the clinical, quality, and financial indicators are achieved to the mutual benefit of the patients and the providers.
- **Reduce variation in clinical practice.** The benefits of evidence-based clinical practice have been well documented, but many healthcare providers have been reluctant to adopt this innovation into their practice. One of the benefits of order sets or care protocols is that internal processes within the organization may be standardized—thus all clinicians are aware of the cycle times for patient care, are able to expedite diagnostics and treatments, and physicians are able to be efficient in their medical decision making. Additional effects include clinical resource efficiencies, such as pharmacy and diagnostic test utilization, management of supplies, and staff productivity.

Operational excellence, care quality, and financial performance will become increasingly linked as key drivers of hospital performance (see Exhibit 2).

Exhibit 2



A Call for Action

Board members and hospital leadership must take a proactive role in setting the direction of their organization toward improving operations and the quality of care provided:

Improve nurse staffing

- Provide adequate nurse staffing by utilizing benchmarks and leading practice guidelines to properly distribute workload and prevent burnout.
- Continuously support nursing and staff education with a focus on patient safety and quality.
- Ensure nurses are properly equipped with the skills needed to succeed and provide quality care.

Stabilize staffing

- Continuously monitor staff satisfaction and have action plans in place to address concerns.
- Maintain positive relationships between staff and management.
- Implement recognition and reward programs.
- Provide staff with opportunity for professional growth and advancement within the system.

Implement a fair and just culture

- Leadership should commit to work directly with staff to integrate just and fair culture principles into practice.
- Adopt a just and fair culture at all levels of the organization, including at the board level.
- Create a non-threatening environment for staff to share problems, errors, and misunderstandings.

- Be understanding of complex issues, provide constructive feedback, and take a proactive approach to address issues.

Comprehensive case management

- Design case management roles that include development, implementation, and management toward clinical outcomes.
- Foster collaborative relationships between the medical staff and the case managers
- Build and maintain relationships with aftercare venues, with particular emphasis to those services not provided within the system.

Consistency in clinical practice

- Develop evidenced-based protocols for high-volume, high-risk diagnosis and procedures.
- Engage physician leaders to be the “champions” for implementation.
- Align operational processes to support the care protocols.
- Review operational, quality and financial outcomes at medical staff, executive council meetings, and board quality committee.

Successful hospitals will be the ones able to achieve operational excellence, advance care quality, and in turn, improve financial performance.

The Governance Institute thanks Patricia A. Hines, R.N., Ph.D. and Kevin Yu, R.N., BSN of The Camden Group, for contributing this article. Dr. Hines can be reached at phines@thecamdengroup.com, and Mr. Yu can be reached at kyu@thecamdengroup.com.



The Governance Institute to Introduce New Board Portal Tool

Increasingly, boards are struggling to make the most of their most precious resource: time. A board portal is a new tool that can increase board efficiency. Many of you might be familiar with board portals as a tool to create and distribute the board packets electronically, but an evolved board portal will do much more than that.

Well-developed board portals will also:

- Allow trustees to communicate with staff and other board members in a secure environment.
- Function as an organizational document repository, or institutional memory, that can be accessed from anywhere you can connect to the Internet.
- Support committees with online workrooms and discussion space.
- Enable trustees to respond to meeting requests and add events to personal calendars.
- Give insight into recommended practices and resources, which in turn increases confidence levels of trustees.

After an exhaustive examination of options in the market, The Governance Institute has chosen to collaborate with BoardEffect® on the next level of board communication and content delivery solutions. This board portal resource combines the superior framework and proven software of the BoardEffect® portal and is further enhanced with the governance education materials and customer service provided by The Governance Institute.

The week of November 10, we will be inviting Governance Institute members to a special VIP Web event to discuss how high-performing boards are implementing board portals and demonstrate this new offering.

If you are interested in learning more, please email Jessica McMullen, marketing manager, at jmcmullen@governanceinstitute.com.