BoardRoom Press

A Bimonthly Journal of News, Resources, and Events for Today's Healthcare Boards

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SPECIAL SECTION

A Quadruple Win through Data and Analytics

How Hospital Boards Can Advance Their Community's Healthcare

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If Everyone Innovates, Is It Still Innovation?

Healthcare organizations must learn how to rapidly adapt as markets evolve and uncertainty continues. Innovation seems to be the name of the game. Before jumping on the bandwagon, healthcare board members must remember that at the heart of the job, their responsibility is still to establish policies, set strategy and vision (aggressively yet appropriately!), and then actively oversee, monitor, and modify as needed.

In this issue, we learn that no news is bad news when it comes to compliance. Improving the clinician experience and providing physicians with reliable data regarding unwarranted variation can help achieve the "quadruple win." We can and should move forward with bundled payments, even if the federal government is sending mixed signals about that. We need to go beyond the minimum requirements for just about everything we do.

It seems the ideal healthcare board in 2018 is made up of a collection of detail-oriented, micro-perfectionists yet who are open-minded, collaborative, and know their boundaries between governance and management. We can be greater than the sum of our parts. We hope this issue of *BoardRoom Press* provides aid and focus as we tread forward into this new year.

Kathryn C. Peisert

Kathryn C. Peisert, *Managing Editor*

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Embracing Innovation: Utilizing a Prototyping Center at Your Health System

BY PHILIP A. NEWBOLD, FACHE, BEACON HEALTH SYSTEM

Innovation, defined as the implementation of a new product, service, or offering that brings value or leads to a competitive advantage, may be the most important competency for our future. In the healthcare field, many large, nontraditional corporate giants such as CVS, Amazon, and Google have established healthcare as a new top priority, and there is a growing mob of upstarts and niche players that are targeting the insured, ambulatory consumer with new technology and value propositions. Hospitals and health systems, however, have been slow to embrace innovation, and the warning signs of inaction and preserving the status quo seem to get louder every day. One way that healthcare organizations can more aggressively embrace innovation is to develop a prototyping center to rapidly test new consumer offerings, channels, brands, and consumer experiences.

Philip A. Newbold, FACHE
Former CEO
Beacon Health System

I first learned about rapid prototyping from IDEO, a company with expertise in design and new product ideas. At its core, prototyping is making ideas tangible or, as Tom Kelly, the past General Manager of IDEO, says, "It is dashing off sketches, cobbling together creations of duct tape and foam core, shooting quick videos to give personality and shape to a new service concept." Health systems sit on top of one of the most valuable assets and resources that can help jump-start this prototyping process—their thousands of employees and their families. Since health systems have full control of how employee benefits are designed and offered, it is invaluable to be able to create incentives and small experiments to rapidly test new services and offerings that can then be taken to the marketplace or directly sold to local and regional employers.

In this article, I will share a few examples of how Beacon's talented employees and their families have been critically important to the early prototyping process, and how governance can support other organizations in doing the same.

New Facilities

Memorial Hospital of South Bend, now part of Beacon Health System, opened the first two Convenience Care Clinics for Walmart in the United States. One of the keys to winning this opportunity in the early years of nurse-based clinics in retail settings was the experiences gained by rapidly prototyping this new urgent care center model with our staff and their families. We first constructed a full-scale model made entirely of cardboard, foam core boards, sheets, towels and old furniture, all held together with duct tape. More than two dozen staff and their family members volunteered to go through simulated urgent care visits to gain new insights and make rapid changes. After the second version of the Convenience Care Clinics was constructed out of drywall and wood, staff and their families again helped with improvements and suggestions.

This same rapid prototyping discipline was used when Beacon Health System constructed a new $40 million Heart and Vascular Center and the Beacon Children's Hospital. Both the hospital board and health system board are extremely supportive of these types of new capital projects because they appreciate how rapid prototyping minimizes the risk involved in large projects, such as these, and how any potential failures are made in early versions before final construction. Prototyping can be used whenever or wherever new spaces are created to minimize the level of risk in the planning process and to test your offerings with real consumers.

Key Board Takeaways

Health system boards should implement three policies to support their organizations' efforts to embrace innovation, perform rapid prototyping, and promote employee health and engagement:

- Implement an innovation policy to stress the importance of innovation as a core competency for the future.
- Ensure a health and well-being policy is in place to encourage better health among an organization's employees and to test-drive health innovation prototypes.
- Establish a tithing policy to provide critical funding to innovate in the community served by a healthcare organization.

New Services

Prototyping works with testing virtual services and digital offerings, too. Three years ago, Beacon Health System noticed the emerging opportunity of virtual visits or telehealth offerings for primary care and urgent care settings. After conducting a year's worth of market research, Beacon developed a virtual urgent care offering to supplement our other physician and nurse-based urgent care centers. For this project, we worked with a digital partner, American Well, to get this vital new product into the market quickly with Beacon's branded smartphone app. To help educate the region on this new offering and to access physician-based urgent care settings, Beacon began offering eight free virtual urgent care visits each year to its more than 7,000 employees and their covered families. This is a quick and easy prototyping method to test the system under actual working conditions, using staff and their family members, and work on problems encountered before its launch to the general public in the region. Governing boards also are often asked to "test drive" these new service offerings as a way to educate them and build support for new digital access points.

Beacon is currently testing a new, rapid outpatient experience app that measures the experiences and satisfaction of people in outpatient settings 10 minutes after a visit through a secure HIPAA-compliant text format. Once again, we partnered with a small start-up firm and we acted as an early test site organization to both gain valuable consumer experience and build appropriate databases. I was personally involved in this prototype testing. After I finished some outpatient tests, I was walking to my car and received a text about seven to eight minutes after my visit. I quickly answered seven questions about my outpatient experience and had

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Measuring the Compliance Program's Effectiveness: Suggestions for the Board

BY FLETCHER BROWN, WALLER LANSDEN DORTCH & DAVIS, LLP

The Department of Health and Human Services' Office of Inspector General (OIG) has long encouraged healthcare organizations to establish compliance programs. Not only does a compliance program serve to guide the organization through the maze of regulations, it also serves as a best practice and a firewall against regulatory sanctions, legal actions, and negative publicity. Further, should there be criminal action, a compliance plan offers favorable sentencing credit under the United States Sentencing Guidelines—and last year the U.S. Department of Justice released guidance for compliance programs related to the sentencing review.

Given the importance placed on compliance programs by federal agencies, including the OIG, the United States Attorney's Office, and the Centers for Medicare and Medicaid Services (CMS), how can a healthcare board measure the effectiveness of its compliance plan in dealing with an ever-expanding regulatory environment?

Maintaining and Measuring a High-Functioning Compliance Program

While historically providers were encouraged to maintain effective compliance programs, there were few resources of published guidance or objective criteria to consider when determining whether their compliance programs were effective. Then, in 1998, the OIG published a document commonly called the "Seven Elements of an Effective Compliance Plan."[1] This outlined seven elements that providers could use to establish and maintain compliance programs:

1. Implementing written policies, procedures, and standards of conduct
2. Designating a compliance officer and compliance committee
3. Conducting effective training and education
4. Developing effective communication lines to receive complaints and protect anonymity
5. Conducting internal monitoring and auditing
6. Enforcing standards though well-publicized disciplinary guidelines
7. Responding promptly to detected offenses and undertaking corrective action

Essentially this guidance establishes a framework for a compliance program that, through the compliance officer, develops policies, receives complaints, monitors and audits conduct, and responds to compliance concerns. However, the seven elements do not address or provide guidance on measuring the effectiveness of a compliance program.

In fact, shortly after publishing the seven elements, the OIG stated that "[s]uperficial programs that simply purport to comply with the elements discussed and described in this guidance or programs that are hastily constructed and implemented without appropriate ongoing monitoring will likely be ineffective and could expose [providers] to greater liability than no program at all."[2]

This statement clearly indicates that going forward the OIG will focus more on what providers are actually doing to ensure that their compliance programs are functioning effectively and less on how the compliance program is structured. This shift in focus is also the reasoning behind the March 2017 release of the publication *Measuring Compliance Program Effectiveness: A Resource Guide*.[3]

About the same time, the Department of Justice subsequently released a guidance publication titled "Evaluation of Corporate Compliance Programs."[4] This publication provides an extensive list of more than 100 questions that federal investigators use to inquire across a range of compliance program operating functions and that were found to be useful in evaluating provider fraud, waste, or abuse. Many of these questions target the provider's actions before and after the alleged conduct occurred—all of which emphasize the existence of an effective compliance program.

Evidence of the critical importance of effective compliance programs is easy to find. It's been splashed across media for the past few years. In 2016, South Carolina-based Tuomey Healthcare System paid $72.4 million to resolve a $237 million judgment for illegally billing the Medicare program for services referred by physicians with whom the hospital had improper financial relationships. Tuomey's former CEO also paid a $1 million settlement and was excluded from participation in federal healthcare programs for four years. Additionally, the health system's board of directors and management were replaced, and ultimately Tuomey merged with Palmetto Health.

Key Board Takeaways

In light of aggressive government enforcement and the dramatic rise in whistleblower cases, simply having a compliance program in place is not enough. Hospitals and health systems should actively manage, monitor, measure, and modify compliance efforts. The board should consider the following:

- A compliance "dashboard" is an effective tool for boards to monitor ongoing compliance efforts.
- When staff members feel comfortable raising concerns they are less likely to become whistleblowers.
- To be effective, a compliance program must adapt as healthcare regulations and markets evolve; the board is responsible for knowing when it's time to update the compliance program.

Fostering a Culture of Compliance

Simply having a compliance program in place is not enough. An organization must work actively to manage, monitor, and modify its compliance efforts. A compliance program is not inherently effective if no reports have been received. In reality, no news is probably bad news. When few or no compliance issues are being reported

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1 Office of Inspector General, Publication of the OIG Compliance Program Guidance for Hospitals, Federal Register, Vol. 63, February 23, 1998; pp. 8987, 8989.
2 Office of Inspector General, Publication of the OIG Compliance Program Guidance for Home Health Agencies, Federal Register, Vol. 63, August 7, 1998; pp. 42410–42411.
3 *Measuring Compliance Program Effectiveness,* HCCA-OIG Compliance Effectiveness Roundtable, March 27, 2017.
4 U.S. Department of Justice, "Evaluation of Corporate Compliance Programs" (available at www.justice.gov/criminal-fraud/page/file/937501/download).

A Quadruple Win through Data and Analytics: Achieving Rapid Results in Lowering Unwarranted Variation in Clinical Care

BY WALTER W. MORRISSEY, M.D., SUSAN CAMPBELL, RN, AND JENNIE DULAC, RN, KAUFMAN, HALL & ASSOCIATES, LLC

Is your board focused on a Triple Aim and/or the "Quadruple Win?" The latter recognizes that an engaged clinician workforce is essential to achieving the three national health goals of higher quality, more affordable care, and better health for the populations served. It adds the fourth dimension of improved clinician experience.

Parallel Goals and Challenges

The current environment presents significant challenges for healthcare clinicians and organizations. With expectations of an increasingly constrained payment environment and lower utilization trends, healthcare directors and executive teams of hospitals and health systems nationwide are experiencing a "big squeeze" to transform care delivery in order to achieve Triple Aim goals. But at the heart of what both clinicians and hospitals seek is to do what's best for the patient, as desired by the patient, through high-quality care that achieves best-possible outcomes.

Boards increasingly are aware that, for most hospitals and health systems, unwarranted variation in care is a significant source of suboptimal patient outcomes and unnecessarily high costs.[1] Tracked by the Dartmouth Institute for Health Policy and Clinical Practice for more than a decade, such variation is present in clinical practice in all types of healthcare organizations when there is a gap between the desired "best practice" and current practice.

Nationwide, the gap is large. The Dartmouth Atlas estimates that 30 percent of total U.S. healthcare spending is unnecessary.[2] Causes of inappropriate spending typically include:

- Suboptimal clinical practices
- Overuse and inappropriate use of specialists
- Misuse of preference-sensitive care (such as high-cost orthopedic prosthesis, when a lower-cost one would provide equal clinical benefit)
- Underuse of proven effective care
- Provision of services or procedures that are not clinically indicated (e.g., unnecessary diagnostic testing)

Significant improvement in healthcare delivery to reduce unwarranted care variation can be achieved through hospital–clinician collaboration now and into the future. Partnerships create a quadruple-win situation for physicians and other clinicians, hospital leadership teams, payers, and most importantly, patients and their families.

Board oversight of the development and use of a multipronged approach that uses the three strategies described here is critical to clinical improvement going forward.

Key Board Takeaways

Unwarranted variation in care is a significant source of suboptimal patient outcomes and unnecessarily high costs. Significant improvement to reduce such variation can be achieved through hospital–clinician collaboration. Partnerships create a "quadruple win" for physicians and other clinicians, hospital leadership teams, payers, and most importantly, patients and their families. Three strategies can help to reduce unwarranted care variation:

1. Use an interdisciplinary team of key stakeholders with leadership skills, expertise that spans patient care processes (e.g., pre-admission, admission, diagnostics, treatment, discharge, and post-discharge), and credibility.
2. Establish a trustworthy data foundation and use it to engage physicians.
3. Build a sustainable program by using evidence-based, standardized practices that are clinically appropriate.

Use an Interdisciplinary Team

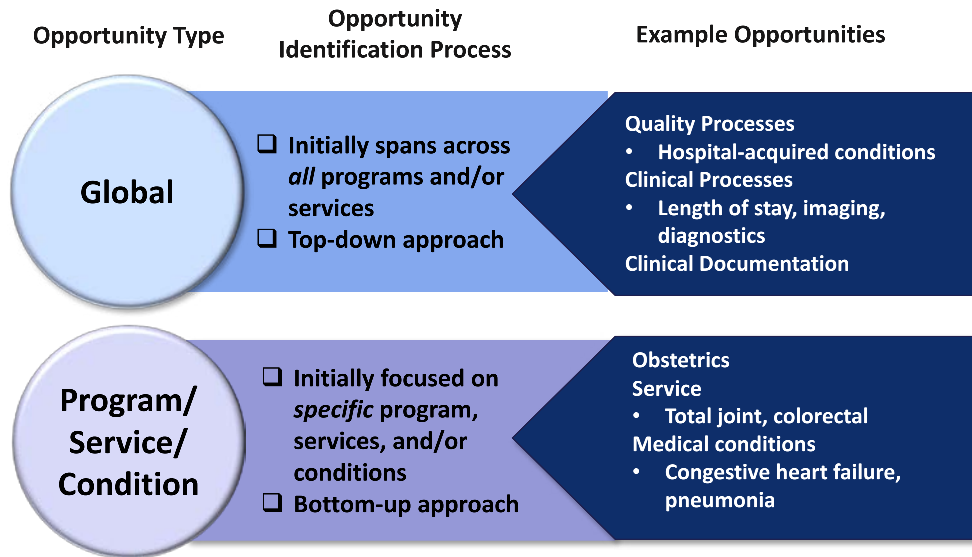
Clinical variation reduction starts with commitment to a team structure. An interdisciplinary team, with representation of key stakeholders, can accomplish the following:

- Identify, assess, and synthesize performance-improvement opportunities into a coordinated and coherent program
- Identify elements of clinical redesign needed to yield improvement
- Ensure that solutions are applicable to the local environment
- Increase buy-in for implementation and ongoing success in areas such as adherence to protocols and utilization reduction

Team members will vary by organization based on whether the organization is tackling the clinical variation problem at a global level across all

1 W.W. Morrissey, R.W. Pryor, and A. Krishnaswamy, "Using Data and Analytics to Improve Clinical and Financial Performance," *Leadership,* November 17, 2016.
2 The Dartmouth Atlas of Health Care, "Reflections on Variations" (available at www.dartmouthatlas.org/keyissues/issue.aspx?con=1338).

Exhibit 1: Approach to Identifying Unwarranted Clinical Variation



Source: Kaufman, Hall & Associates, LLC

programs and services, or at a specific program, service, or condition level (see **Exhibit 1**). Either means is appropriate; both are recommended.

For example, at the *global* level, an organization might be targeting improvement in:

- *Quality processes* through reduction in hospital-acquired conditions and readmissions
- *Clinical processes* through reduction in length of stay, imaging, and diagnostics to levels appropriate to the patient's clinical needs
- *Clinical documentation* through improved systems and processes

At the *program or condition* level, an organization might be targeting reduced clinical variation in:

- Specific procedures, such as total joint replacement or coronary artery bypass grafting
- Specific programs, such as cardiac surgery or obstetrics
- Specific conditions, such as sepsis, heart failure, or pneumonia

Healthcare directors should ask their medical and executive leadership about the composition of clinical improvement teams. An effective team focused on reducing length of stay organization-wide might include the chief medical and nursing officers as executive sponsors, quality management leaders, hospitalist medical directors, care management directors, finance staff, and IT staff. Or a team targeting improvement in a specific program or service (for example, obstetrics) might be led by the medical and nursing directors of obstetrics, and include key obstetricians employed by or affiliated with the hospital, nurses, anesthesiologists, quality management staff, and medical coders.

The key point is that success with performance improvement is a team sport. Teams must include members with leadership skills, expertise spanning patient care processes (e.g., pre-admission, admission, diagnostics, treatment, discharge, and post-discharge), and credibility. Team member selection should be thoughtfully considered by senior executives and clinician leaders to ensure a combined effort that will result in optimized patient care along every step in the process. Then leaders must empower teams to make decisions. When they do so, the synergy created by the whole will be "greater than the sum of its parts."

Establish a Credible Data Foundation and Use It to Engage Physicians

A data-grounded approach to improvement will successfully engage physicians in reducing care variation.[3] Physicians are trained in the principles of science and evidence-based medicine. The credibility of data is essential to driving their behavioral change. Physicians who receive reliable data with evidence of unwarranted variation in their own care—whether related to quality, outcomes, or cost—typically need no further inducement to bring their practices in line with their colleagues.

Organization-wide, the alignment of quality and finance data better provides "one source of truth." It ensures that the finance staff is looking at more than cost data and analytics, while the quality and clinical staffs are looking at more than quality data and analytics. Boards can and should ask questions if the data reported to them lack one or the other.

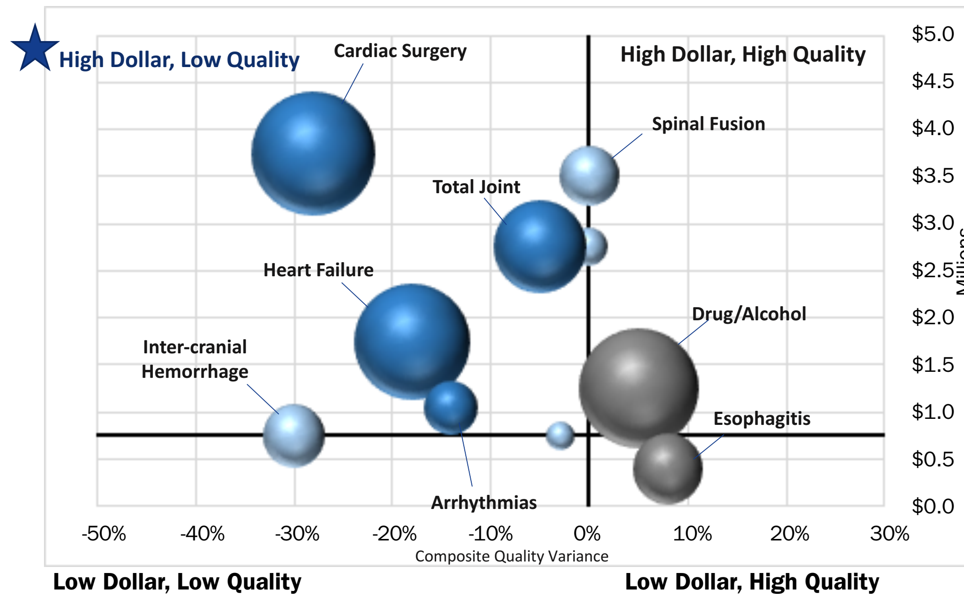
For example, if a team wants to identify best- and lowest-performing physicians for an overall condition, such as heart failure, quality/outcomes data would include: patient cohort demographics, inpatient average length of stay (LOS), severity-adjusted clinical outcomes of complications, mortality rate, and 30-day readmission rate. Finance data would include overall adjusted direct cost, which could be comprised of the following:

1. Medical/surgical supplies: physician preference items often have high cost differentials
2. Pharmacy: brand versus generic drugs and drugs for certain therapies have

3 R.W. Pryor, "Data Can Engage Physicians in Value," *Trustee*, April 10, 2017.

Exhibit 2: Identifying High-Opportunity Areas through Use of a Quality, Volume, and Cost Matrix

Detailed Example: Opportunity v. Quality



Source: Kaufman, Hall & Associates, LLC.
Note: Size of the bubbles represent number of cases.

high cost differentials, at times without effectiveness differentials

3. Laboratory and pathology: standing orders for daily tests, for example, may or may not be needed/appropriate
4. Imaging: the physician's choice of imaging options, including MRI, CT, ultrasound, and X-ray, has a large impact on cost

> Physicians who receive reliable data with evidence of unwarranted variation in their own care—whether related to quality, outcomes, or cost—typically need no further inducement to bring their practices in line with their colleagues.

As an example, one performance improvement team at a 14-hospital system in the Midwest looked closely at the risk-adjusted data by physician, excluding physicians with low volume, for the treatment of patients with heart failure as identified by DRG codes. The team found some dramatic variances:

- The best performers had a 0.0 percent mortality rate for heart failure patients, compared to 5.5 percent among the lowest performers.
- For average LOS, there was a two-day difference between best performers and lowest performers (3.1 days compared to 5.1 days).
- The 30-day readmission rates of the best performers was 42 percent lower than lowest performers (17.8 percent compared to 30.5 percent).
- Overall average adjusted direct costs were 26 percent lower for the best performers ($3,725 compared to $4,957).

To learn more about the cost variation, staff drilled further into specific physician orders through an analysis that compared best-physician performance against the average for all physicians. When costs of three items were considered across all 4,996 patient cases for two years, the best-performing physician spent $654,609 less than average-performing physicians on care of patients with heart failure.

Such analyses make data accessible to decision makers at all levels, and translate data into meaningful information for improvement. Data should prompt team discussion that results in a collective rather than prescriptive solution to reducing inappropriate variation.

In all organizations, high-volume, high-cost, and low-quality cases make the best candidates for clinical improvement initiatives. **Exhibit 2** illustrates how hospitals can use quality, cost, and volume indicators to identify the conditions or services with greatest potential, namely those in the upper left quadrant.

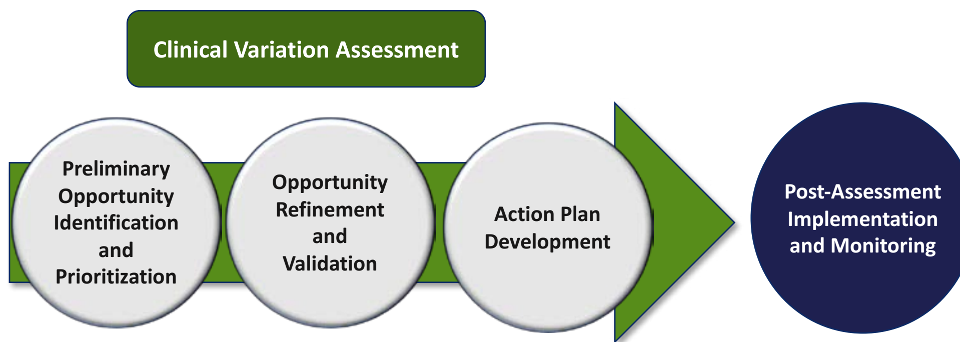
A recent study in *Health Affairs*[4] proposes another way for providers to identify areas of focus for reducing unnecessary spending without "disappointing patients, disrupting practice norms, or reducing the quality of or access to care." The approach involves looking at low-cost, high-volume services associated with low-value care.

Using 44 clinical services determined to be of low value by the ABIM Foundation's Choosing Wisely Campaign, Medicare's Healthcare Effectiveness Data and Information Set criteria, and other expert sources, the authors created a "waste calculator" to identify particularly low-value, high-volume services that organizations could reduce or eliminate.

The top low-value-ranked service by use/volume is baseline lab tests for low-risk patients having low-risk surgery, with a waste index (WI) of 78.6 percent. Other services on the 10 most costly low-value list include: EKGs, chest X-rays, or pulmonary function tests in low-risk patients having low-risk surgery (WI 97.5 percent); routine head CT scans for ED visits for severe dizziness (WI 52.7 percent); and imaging for low-back pain within the first six weeks of

4 J.N. Mafi et al., "Low-Cost, High-Volume Health Services Contribute the Most to Unnecessary Health Spending," *Health Affairs,* Vol. 36, No. 10, October 2017.

Exhibit 3: Clinical Variation Assessment



Source: Kaufman, Hall & Associates, LLC

symptom onset, in absence of red flags (WI 86.2 percent).

The authors conclude that this approach might be "a more strategic way to catalyze the movement to tackle the problem of low-value care," and that "aggregate, minor actions by all clinicians can have a sizable impact on reducing unnecessary healthcare spending." Discussions in boardrooms can focus on whether this could be a reality in their organizations.

Build a Sustainable Program

A program to reduce inappropriate clinical variation should have as its fundamental goal the increased use of evidence-based, standardized practices that are clinically appropriate and within the organization's current infrastructure and capabilities. The program should target untoward outcomes that occur as a result of failure to follow established protocols and guidelines.

Optimizing care through reduction of care variation *does not* remove "the art of medicine," but instead ensures that all patients with a similar clinical condition have their care rooted in evidence-based principles. Use of external benchmarks and internal comparisons will enable teams to identify best practices, and drive change to improve quality and outcomes while reducing costs.

The essential steps of program development involve building a credible data foundation, as described earlier, identifying treatment or diagnostic areas of variation that have the most significant impact on cost and quality, and pinpointing and addressing significant drivers or levers of variation.

Identification and pursuit of the most promising areas of opportunity for a variation-reduction program can occur through an assessment process illustrated in **Exhibit 3**. The assessment includes:

- Preliminary identification of opportunities across the organization, with detailed identification of opportunities specific to a team's unique clinical environment
- In-depth review of performance related to key clinical conditions (for example, total joint replacement and sepsis)
- Comparative performance review by physician for select clinical conditions
- Prioritization of opportunities

The interdisciplinary team develops a "future state vision" for the improvement opportunity and the plan to move from current to desired state. The plan should guide decisions related to people, process, technology, and resources required to sustain change.

IT changes related to the electronic health record (EHR) and development or acquisition of data and analytic tools should be considered. Care redesign based on evidence-based medicine requires use of EHR-enabled order sets, clinical pathways, protocols, practice guidelines, and point-of-care alerts. Operational issues may need to be addressed before clinical processes can be changed—for example, gaining department or organizational approval for changes to formal protocols and/or order sets prior to implementation.

A phased approach to plan development and implementation is recommended. An assessment/data analysis stage can be accomplished in about two months, program design in about four months, and program infrastructure implementation (occurring concurrently) in about four months.

Benefits Going Forward

An interdisciplinary approach to the identification and design of initiatives to reduce inappropriate care variation based on a credible data and analytic framework provides winning results for all stakeholders. This collaborative approach, as approved and monitored by the board and executive team, strengthens physician relationships within all types of organizations. While the primary focus of the improvement programs is quality, its successful implementation reduces unnecessary spending and care variation, resulting in improved quality, outcomes, and cost-optimization—all to the benefit of patients (first and foremost), clinicians, payers, and hospitals.

The Governance Institute thanks Walter W. Morrissey, M.D., Managing Director and a member of the Strategic and Financial Planning practice, Susan Campbell, RN, Vice President and a member of the Strategic and Financial Planning practice, and Jennie D. Dulac, RN, Vice President, Clinical Solutions, Kaufman, Hall & Associates, LLC, for contributing this article. They can be reached at wmorrissey@kaufmanhall.com, scampbell@kaufmanhall.com, and jdulac@kaufmanhall.com, or at (847) 441-8780.

How Hospital Boards Can Advance Their Community's Healthcare

BY WILLIAM C. MOHLENBROCK, M.D., FACS, VERRAS HEALTHCARE INTERNATIONAL

Sir Winston Churchill stated, "Americans can always be counted on to do the right thing…after they have exhausted all other possibilities." His prescient observation fits the current state of American healthcare because we have now exhausted virtually all other possibilities and finally arrived at the "right thing"—bundled payments. The preeminent healthcare business strategist, Michael Porter of Harvard, has embraced this patient-centered care delivery model by concluding in a recent article, "Bundled payments are the only true value-based payment model for healthcare. The time [to implement them] is now."[1]

Unlike other care delivery models, bundled payments align any type of hospital and physician incentives to maximize quality and conserve resources. Heretofore, the sharing of net savings between the two entities was prohibited, even if clinical quality was improved. Now hospital personnel and physicians can collaborate to improve quality outcomes, which invariably saves dollars. These net savings can then be legally shared among the participants. Moreover, opportunities for bundled payment collaborations and sharing are now in place in the private sector and will proliferate independent of federal alterations. What is critical for board members to recognize are their unique roles as community business leaders who can also encourage hospital leadership and medical staffs to deliver healthcare value for patients and purchasers using bundled payments.

Key Board Takeaways

Many healthcare organizations are implementing bundled payments as they move to provide value-based care. Board members should consider the following:

- Hospital boards are positioned to encourage bundle payment implementation as influential community healthcare leaders and purchasers.
- Hospitals and physicians can now legally share net savings by collaborating to improve quality and efficiencies.
- Now is the time to implement bundled payments to promote effective and efficient hospital care irrespective of institution size or type of organization.

Value Is the Combination of Quality over Costs

Professor Porter's definition of medical value mirrors that of American shoppers who buy consumer products based on their knowledge of each item's quality features and costs. The definitions are the same, but there are two distinct differences in shoppers' ability to purchase consumer products versus medical services. The first distinction is Professor Porter's example of buying automobiles as a unit, instead of purchasing an engine here and wheels there. Physician and hospital services are generally unbundled and invariably confusing.

The second, and more important, distinction involves the objective and detailed quality measures that car and other manufacturers furnish their customers for assessing the value of the purchase prices. Hospitals provide no such quality outcomes that purchasers and patients can comprehend to differentiate the value of comparable medical services. This is the reason there are such large variations in clinical outcomes and prices among provider groups for the same clinical conditions.

Incentives for Physician Participation

Post WWII medical costs have risen unabated. As a consequence, Medicare (CMS) has progressively decreased hospital and physician reimbursements as a cost-containment measure with insurance companies doing likewise. As their major revenue sources diminished, providers compensated by shifting their costs to private purchasers and patients. CMS also expanded its cost controls by instituting a mandatory bundled payment model for selected hospitals that must accept inpatient and post-discharge financial risks for total hips and knees. Emboldened by CMS' bundled payment model, some physicians are partnering with their hospitals to pursue risk-bearing, commercial contracts with employers to share savings and cover their rising costs. These contracts are most often with self-insured employers.

Incentives for Hospital Participation

Meaningful clinical improvements and therefore hospital net savings must begin at the physician level. This places pressure on doctors to conserve the hospital's finite resources. Efficiencies are achieved primarily at the physician level and secondarily at the hospital operations level. Physician efficiencies are critical because every X-ray, medication, and hospital admission begins

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1 Michael Porter and Robert Kaplan, "How to Pay for Healthcare," *Harvard Business Review*, July–August 2016.

Embracing Innovation…

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an opportunity to request a personal call back if I was dissatisfied or if I wanted to praise someone who made the experience memorable.

Governance Implications

Governing boards and executive leadership teams would benefit from the adoption of three policies that can help support, fund, and hold accountable these innovations efforts. First, an innovation policy is necessary to highlight the importance of innovation as a core competency for the future, and to ensure there is ongoing education and training around this crucial discipline. It also is critical to ensure the executive team include a senior leader who has experience with prototyping innovation. Without board commitment to innovation, an organization is defenseless against aggressive, for-profit niche players that target well-insured patients with new technologies and convenient settings at rock-bottom prices.

Second, a thoughtful health and well-being policy will help to ensure that the organization does not place all of its resources and interests in a medical model that focuses only on sick and injured patients. Although the newly emerging health models do not have the same lucrative reimbursement incentives as the traditional medical model, far more people consider themselves to be consumers of health than traditional sick patients. This policy should offer healthy food options throughout the system; incentivize employees to exercise, reduce stress, and lead healthier lifestyles; and design benefits that use preventive and early detection screenings. Board members would do well to have regular educational sessions on the new digital consumer and the impact of social media in today's fast-paced world.

Finally, healthcare boards should establish a tithing policy that sets aside a fixed percentage—around 10 percent—of the bottom line to provide critical funding to innovate in the community with a focus on prevention and education about healthy choices in life. Beacon has been a tithing organization for more than 25 years, and this important community work is among my proudest accomplishments and has positioned Beacon as the guardian of the health and well-being of the communities we serve.

Governing boards and executive leadership have so many new pressures and forces to deal with today, but nothing is as important as beginning to develop a pipeline of new services and offerings in a digital world powered by a robust innovation competency. Together with our talented staff and the backing of the community, we can embrace the many changes we face through innovation, rapid prototyping, and employee engagement.

The Governance Institute thanks Philip A. Newbold, FACHE, former CEO of Beacon Health System in South Bend, Indiana, for contributing this article. He can be reached at pnewbold@beaconhealthsystem.org.

Measuring the Compliance Program's Effectiveness…

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it is most likely because staff members are unaware of the procedures for communicating concerns or they are afraid to raise an issue for fear of a negative response or even the loss of their job. To truly foster a culture of compliance, individuals should feel comfortable asking questions and raising concerns. Whistleblower cases filed under the False Claims Act's *qui tam* provisions have risen dramatically since the 1980s. Ensuring that staff members can confidently and comfortably voice their concerns on compliance issues can be a critical tool in reducing the number of employees who turn into whistleblowers.

Boards increasingly rely on performance dashboards for quick and easy access to high-level information on clinical care, finances, and other indicators of facility or system performance. A *compliance* dashboard is equally valuable for communicating information on how many compliance reports have been received, how many investigations have been conducted, and the amount and type of compliance training that has been provided to staff members and employees. A compliance dashboard is a powerful tool for board members to monitor ongoing compliance efforts, and the use of a dashboard reflects positively on the board's commitment to its compliance program.

To truly be effective, a compliance program must be viewed as a living document that adapts as healthcare regulations and markets evolve. It should not be placed on a shelf and only dusted off periodically. We recommend that boards place equal effort and emphasis on their compliance programs as they commit to their Joint Commission accreditation. It is up to the board to recognize when an outside assessment of its compliance program is needed. The board is also responsible for knowing when the compliance plan needs updating.

In conclusion, boards that regularly ask insightful and thoughtful questions designed to inquire across a range of compliance program functions will have a better chance of developing and maintaining an engaged, adaptive, and focused compliance program. Additionally, by pursuing a multi-level inquiry across the range of compliance functions, the organization will be better positioned to not only demonstrate a program utilizing the "seven elements" but will also demonstrate an active and engaged level of compliance program monitoring.

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How Hospital Boards Can Advance…

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with the stroke of a doctor's ordering pen, whether for inpatients or outpatients. The ordering pen is the most expensive medical device in healthcare. Moreover, hospitals are the venue where most resources are expended and where clinical data is most readily available for facilitating outcome improvements.

The most effective way for physicians to create net savings is to improve clinical quality because one complication doubles or quadruples the costs of care. As quality improves and net savings are accrued, the manner of their distribution becomes extremely important. If the sharing is objective and transparent, it will virtually guarantee physicians' endorsement and the success of any bundled payment model.

Three Information Imperatives for the Success of Bundled Payments

Though bundled payments are the ideal competitive model for delivering medical value, information is the critical component for success. Physicians are most effectively empowered and patients are best educated utilizing three specific types of information:

- First, each physician must be provided with at least one year of his/her own risk-adjusted, best-demonstrated resource utilization information. Identifying only those resources that were appropriate to produce his/her best-demonstrated outcomes for each patient group will immediately begin the process of practice improvements. The unwitting squandering of resources tolerated in fee-for-service practice must be eliminated.
- Second, the hospital must provide information to ensure the net savings created by doctors will be objectively and transparently distributed among the facility and physician groups on the basis of established quality metrics—not just dollars. Physicians want to be financially rewarded for practicing high-quality, cost-efficient medicine.
- Finally, the same information physicians use to improve quality must be formatted to be easily understood by patients, self-insured employers, and other purchasers motivated to buy healthcare on the basis of value, not just price.

Board members are uniquely positioned to institute value-based care delivery by encouraging their hospital executives and medical staff members to implement bundled payments. Board members often assist hospital executives with such strategic decisions, but they may also be front-line healthcare purchasers for community businesses who assiduously seek value for employees, their families, and themselves.

When Professor Porter wrote his article, he referred to new technologies being developed for specialized information that meet the critical demands of bundled payments. Fortunately, these technologies are now established and ready for deployment. Patient and physician-level assessment technologies plus collaboration with medical staff members will ensure a hospital's ongoing success as they fulfill employers' and patients' impassioned pleas for medical value. As Michael Porter said, "the time to implement bundled payments is now" and hospital board members can positively influence American healthcare by encouraging their hospitals to comply and deliver the healthcare value their patients and communities deserve.

The Governance Institute thanks William C. Mohlenbrock, M.D., FACS, Founder and Chief Medical Officer, Verras Healthcare International, for contributing this article. He can be reached at bmohlenbrock@verras.com.

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is not fully concluded, at this point the doctor has been awarded over a million dollars in damages because she clearly was not treated with the requisite due process and objectivity required. While it is important for board members to ensure that medical staff leaders are adhering to proper process and objectivity when carrying out peer review and making credentialing recommendations, this case illustrates that the board itself can be guilty of such breaches.

Going Beyond Peer Review and Credentialing

Board oversight of the medical staff goes beyond ensuring the delegated activities of peer review and credentialing are sound. In today's healthcare environment, strong working relationships with the professional community are essential. The board should be interested in how well the medical staff develops a culture of collegiality and excellence, and how collaborative and respectful the interactions are between doctors, management, and the board. Success in these areas reduces staff turnover, improves recruitment, and helps set the stage for success in quality improvement efforts and moves to create a high-reliability care environment. Numerous engagement tools are available to assess the attitudes of medical staff members and boards can get firsthand knowledge by inviting key physicians to board retreats or to participate in strategic planning activities.

The epidemic of physician burnout in hospitals and health systems across the country is a matter that should be of concern to every board. Physician burnout has been linked to increased rates of medical errors, turnover, and higher mortality ratios in hospitalized patients. The actions of management and physician leaders have been shown to have a significant impact on the magnitude of practitioner burnout. Boards should stay informed of the efforts being made by both hospital and medical staff leaders to gauge the extent of staff burnout and to ameliorate factors known to contribute to its rise.

In 2018, despite the tumultuous state of the healthcare industry, hospital boards cannot afford to neglect their core responsibility to bring diligence to medical staff oversight.

The Governance Institute thanks Todd Sagin, M.D., J.D., President and National Medical Director of Sagin Healthcare Consulting and Governance Institute Advisor, for contributing this article. He can be reached at tsagin@saginhealthcare.com.

Board Oversight of the Medical Staff: A Critical Responsibility

BY TODD SAGIN, M.D., J.D., SAGIN HEALTHCARE CONSULTING

Hospital board members must grapple with enormous governance challenges in these tumultuous times. In healthcare, we see volatile market forces, rapid technological change, reimbursement uncertainties, and political incoherence on the national stage consuming the attention of boards trying to chart a viable path forward for their institutions. In such an environment, it is easy to overlook the critical responsibility the board has to oversee the hospital's organized medical staff. Indeed, the governing board truly has only two direct reports: the hospital (or health system) CEO and the organized medical staff.

The major tasks delegated to the medical staff may seem routine and "old hat" to long-standing board members. However, the truth is that medical staffs (and therefore the boards that oversee them) are being faced with new and growing challenges that go to the heart of whether a hospital delivers safe, high-quality care. For example, the area of practitioner credentialing (possibly the most valuable patient safety activity a hospital undertakes) continues to see significant new developments. Most hospitals and health systems are dealing with rapid growth in non-physician practitioners, telemedicine physicians, locum tenens doctors, part-time and low-volume practitioners, aging healthcare providers, and applicants with some element of concern in their backgrounds. These concerns can range from malpractice history to episodes of impairment, and from incidents of unprofessional conduct to requests for privileges for which the applicant has minimal experience.

Too many boards rely exclusively on their medical staffs to vet credentialing concerns without really knowing how well physician leaders are performing this work. Most hospitals and health systems underinvest in physician leadership training and therefore the quality of medical staff review for any particular practitioner application may vary widely. How is a board to know whether reliance on medical staff input is justified? Indeed, most boards do little to educate directors on best practices in credentialing and medical staff oversight. This results in a great deal of "rubber stamping" of medical staff membership and privileging applications at the board level.

Key Board Takeaways

Medical staff oversight is a critical board responsibility that can easily be overlooked in today's busy healthcare environment. Hospital and health system boards should:

- Insist that both physician leaders and directors are adequately educated to address the latest challenges in medical staff credentialing and peer review.
- Consider periodically requiring an audit of medical staff credentialing functions to ensure they are rigorous and contemporary.
- Utilize a checklist to identify credentials applications, which will require discussion at the board level and prevent "red flags" from flying under the radar.
- Ask hospital and physician leaders to keep the board abreast of efforts to address practitioner morale and burnout.

The Consequences of Poor Oversight

The adverse consequences of poor governance oversight of the medical staff can be significant. Lawsuits are on the rise from coast to coast that allege corporate negligence on the part of hospitals and health systems for inadequate or improper credentialing of staff members. These can be large financial judgments and can do serious harm to the reputation of a community hospital. Doctors who claim they were kept off staff or lost privileges for improper reasons or without reasonable due process can win even larger judgments that include punitive damages.

Boards can get their institutions in trouble by being either too passive in their medical staff oversight or by being improperly intrusive. Passive boards usually lack sophistication regarding good credentialing or peer review practices, fail to question medical staff leaders appropriately about their recommendations regarding applicants, rarely (if ever) carry out audits of the credentialing process to ensure that it is functioning properly, and overlook "red flags" in order to fill understaffed clinical specialties.

An example of such board passivity can be seen in the 2013 lawsuit, *Guinn v. Mount Carmel Health*. Dr. Guinn, a private cardiologist on the medical staff, sued after he was suspended and subsequently had non-renewal of his electrophysiology privileges. He won a judgment of over a million dollars against both the hospital and the doctor who initiated the investigation of his privileges. The peer review and credentialing processes in this case were blatantly corrupted, yet the board failed to notice any deficiencies in the events that took place.

The opposite situation occurs when one or more board members advocates aggressive steps against a medical staff member without the concurrence of medical staff leaders. While the governing board has final say over medical staff membership and privileges, overriding medical staff recommendations can be a treacherous road to travel. Such a move can rupture good working relationships with physician leaders and can lead to harmful litigation.

An example of this is seen in a recent case, *Miller v. Huron Regional Medical Center*. In that situation, at least one board member reportedly became concerned about the quality of a medical staff surgeon because of complaints from his neighbor suggesting poor care. The board demanded aggressive peer review and pressured medical staff leaders to curtail the surgeon's practice. Medical staff leaders could not substantiate the concerns expressed at the board level, but communicated to the surgeon that she had incurred the displeasure of the governing body. The surgeon cut back her surgical activities in response and the hospital reported this action to the National Practitioner Data Bank. Dr. Miller, in turn, filed a lawsuit. While the litigation

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