2010 Issue 1

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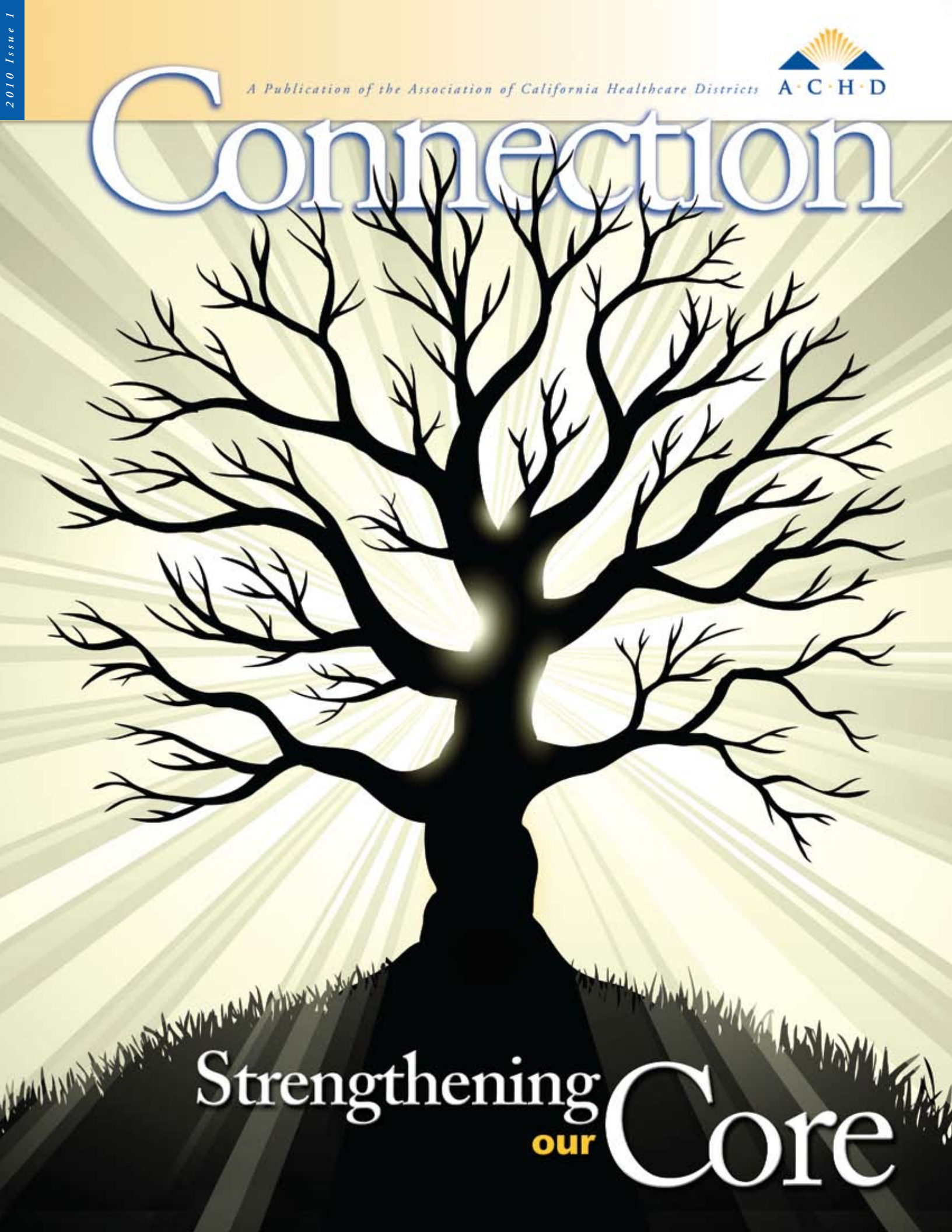
A·C·H·D

Connection



Strengthening our Core

CEO Commentary

We believe that the Leadership Development Program held in Sacramento in November 2009 will be viewed as the genesis of a statewide effort to implement a new and stronger culture of fiduciary duty and director professionalism in the governance of Health Care Districts.

These three (3) intensely productive days fostered a strong recognition that the fiduciary duty of all board members – particularly elected District directors – requires placing the interests of their organizations before their own personal agendas. Moreover, the new consensus on innovative board improvement strategies that arose from our discussions will shape the work of ACHD in 2010 and for years to come. Within the realm of things that could be accomplished in a few business days, the emotional engagement, shared insights and the anticipated cultural impact of this leadership program are rarely achieved.

The personal invitations to the Leadership Development Program sent to the chief executive officers and the board chairs of our Districts requested their participation "…in the most important examination of the leadership and governance issues within the District Model in twenty (20) years." The good news: from every comment we received from the participants, the program more than fulfilled its ambitious mission. The entire spectrum of Districts was represented at the program: Districts operating large tertiary care hospitals, Districts operating rural and critical access hospitals, and community-based Districts operating extensive wellness programs. Despite the press of work deadlines and preexisting commitments, chief executive officers, board chairs and first term directors from sixteen (16) Health Care Districts participated in refining a new paradigm for board functionality – this study of leadership became a real exercise in leadership.

Creating A New Board Culture For Health Care Districts

A number of our most skilled chief executive officers and board chairs became fully engaged in this markedly interactive process. The discussion panel of chief executives contributed numerous insights on board relationships with senior management and addressed the increasing time and information demands placed on District directors. The complexity of modern healthcare, the sophistication of District operations and the real time need to understand governmental healthcare reform were viewed as continuously raising the necessary level of director preparation and commitment.

The board panelists recognized the real harm to Districts that can result from a single director's refusal to place the interests of the District before his or her own agenda. Among the panelists and the attendees, the need for a stronger board culture emphasizing fiduciary duty and professional expectation was broadly recognized. With the support of the board chairs, the Leadership Program participants fashioned an interrelated set of initiatives to create and implement a new and stronger culture:

(1) The adoption by every interested District of a voluntary code of public responsibility that emphasizes fiduciary duty and professional expectation. This annually adopted code of public responsibility can serve as the center of a new cultural paradigm of fiduciary responsibility

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ACHD Staff

ACHD provides a variety of services to our Member Districts, and we welcome the opportunity to be of assistance to you. Please contact us with questions, comments, or concerns, as well as with news items and suggestions for articles in the *Connection*.

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Comments from the Chair

A Trustee's Commitment

Strengthening our core. Getting back to the basics. Sustaining viability. This pretty much sums up the commitments I made to my community many years ago when I first ran for the Health Care District Trustee office. You too may have made similar commitments. We may have all thought at one time or another—before running for office—that our District's viability was in trouble, or was going to be in trouble if some of the same people remained in office and power. That's why we ran for office, isn't it? Just to "fix" it?

If you're like most, however, you may have found that "fixing it" wasn't so easy. Unfortunately for many, the first thing new Trustees find that need "fixing" is the culture—the (*very public*) board culture—before being able to address the issues that, from their view, is threatening the District's sustainable viability. To be fair, however, there are also boards where the culture was "just fine until the new Trustee showed up!"

In any event, the fact is, board culture plays an immeasurable role in the success, or non-success, for each, and the whole of all California Health Care Districts. Because board dysfunction disrupts the flow and deters effective decision-making, dysfunctional boards oftentimes find themselves in the news and, eventually, their District in grave circumstance. It is those boards that work together that bring success. But it is those who do not that become the "Poster Board" for failure. The failure of Districts (and their boards) over the years has prompted public denouncement recently of the legislatively enacted District Model—that which allows a District to form and function.

ACHD's Leadership Development Program this past November —which, by the way was one of the best educational programs for District leaders that I've attended—was about just that…*how to avoid or eliminate board dysfunction.* Imagine (if you weren't there), executive officers and board members getting "down and dirty" together. In an attempt to address one of the biggest underlying threats that if continues will dismantle the District Model—board dysfunction—ACHD brought together senior executives and board chairs to talk openly about their issues and what they believe needs to change at the board level to address dysfunction.

We learned that to address board dysfunction we need to start by designing voluntary rules of conduct. After much discussion, we found that Districts were indeed very interested in implementing rules of conduct that emphasize fiduciary duties and professional expectation. District Board members recognized the real permanent harm to Districts that can result from a single director's refusal to place the interest of the board before their own agenda. All in all, we recognized that there is a dire need for boards to become more professional in *all* aspects of their district responsibilities. And if only just one board member were to suggest that rules of conduct be crafted and implemented, others would likely go along.

It is time to ask ourselves, "What can *I* do to avoid or eliminate dysfunction on my board?" With this New Year, let's each resolve to work for the best interest of our District—not ourselves—and commit to professional behaviors and responsibilities. If just one board member makes this their New Year's Resolution, and speaks it aloud to the others, maybe we all can instead be a "Poster Board" for Health Care Districts success. That's what being a District Board Trustee should be all about. ▲

Bob Wikoff
Chair, ACHD Board of Directors

CEO Commentary

Continued from page 2

and professional expectation. Although compliance with a code of public responsibility is ultimately voluntary for elected directors, the experiences of other governmental organizations clearly demonstrate that the cultural pressure to abide by these self-adopted rules strongly promotes individual professionalism and board functionality.

(2) The developing of advisory panels comprised of invited community leaders to strengthen affiliation with the District and identify future director candidates. In all of the communities served by our Districts, there are business and professional leaders with the skills and knowledge to contribute to District success. A number of our Districts are already utilizing advisory panels to develop greater affiliation with community leaders. These carefully selected individuals – who otherwise would likely never seek public office – can provide a continuing source of future board candidates. With the passage of years, the talented members of our advisory panels could likely comprise the large majority of our District directors. In fact, the board chairs of two of the Districts participating in the Leadership Program were former members of District advisory panels on finance and on community needs assessment.

(3) The recognition that the increasing demand for director preparation and commitment mandates modest compensation for directors. The time of the volunteer director should be coming to an end – regardless of whether the District is financially successful or sustaining annual losses. The net revenues of virtually every District would easily support modest but important compensation of their directors. The public work of the prepared and informed director is simply too demanding to be consistently and effectively performed without some compensation. Of the six separate study groups at the Leadership Program that considered this issue, all six supported modest and appropriate compensation of directors.

Going Forward Into 2010

In December 2009, the ACHD Board of Directors reviewed and discussed the governance insights and recommendations arising out of the Leadership Development Program. ACHD senior managers presented the interrelated set of initiatives that are the work product of ACHD and the Leadership Program participants. The **ACHD Board approved going forward with developing a model code of public responsibility for District Boards** – a code that strongly promotes individual fiduciary duty and board functionality.

The **ACHD Board also approved going forward with developing a template for District advisory counsels that would increase the number of community leaders involved in the District's mission.** In light of the importance of the role of director in the success of Districts, a planned effort to attract talented candidates appears appropriate and wise. On a closely related issue, to support the increasing level of director commitment and professionalism that Health Care Districts require, **the ACHD Board supported legislative efforts in the current session to amend the Health & Safety Code to allow Districts to increase the compensation of their directors.**

We believe that the dawning of 2010 marks the beginning of a several year effort to address the leadership and governance challenges inherent in the District Model. While preserving the strong community focus that is the fundamental strength of Health Care Districts, the boards of Districts that struggle with functionality (and District boards that are one election away from such issues) can evolve into boards recognized for their professionalism in public matters and their respect for fiduciary duty. ACHD has already begun the work of fashioning initiatives to support the stronger District board cultures that preserve and advance effective governance.

ACHD will consult with numerous Districts over the next several months on the initiatives addressed in this letter. It is already clear that the **fashioning of stronger District board cultures will be a primary focus of the 2010 ACHD Annual Meeting at Lake Tahoe on May 12 - 14, 2010.** In the interim months, ACHD will provide Members with updates on these initiatives as our work moves forward. ▲

Ralph Ferguson
Chief Executive Officer

The Editor's Notes

Strengthening Our Core

I've been working on strengthening my core now for several years…going to the gym, doing abs, spinning, yoga, you name it, I think I've tried it. And every year, at about this same time, I'm feeling, well, still a bit flabby. (*It must be the holidays…or am I getting older?*) It bothers me because I work so hard throughout the year to get fit, and find myself at the end of the year disappointed because I didn't stick to the regimen and essentially end up back where I started.

So, every new year I find myself resolving (once again) to stick to the basics: watch my diet…no more "pigging-out," exercise at least three times a week…strive for five, and get plenty of rest…no more late night Guitar Hero. (*Yes, it is really a lot of fun and a great stress reducer. You should try it! Just don't let it keep you up too late.*) If I commit, I can reach my goal. If I only partially commit, at best I'll maintain.

Sometimes it seems that all we can do is maintain, especially in our increasingly challenging world. But is that enough? Personal commitment to lifestyle changes are extremely difficult to achieve. It takes a great deal of investment—time, willpower, money, support—but the return can make a significant difference.

To make a difference, we've got to commit to strengthening our core.

ACHD has recently recognized a need to strengthen its core, and has committed much of its energy and resources to addressing a core issue that has recently drawn much public attention: Dysfunctional Boards. They're the leading cause for media dignitaries to begin questioning the validity and need for the District Model.

To address this issue, ACHD will be helping District boards build stronger board cultures, as we believe that it is the culture that most influences the decision-making process among board members. If the board culture is not strong, the strength of the District, and its value to its community, become compromised.

Read the CEO Commentary on page 2 to learn more specifically about what ACHD is planning in this regard, and feel free to contact me at 800.424.224, lindaf@achd.org if you have any comments or questions regarding this issue.

ALPHA Fund Does It Again!

How about those distribution checks ALPHA Fund sent out the end of last year?! This makes the third straight year that ALPHA Fund has returned excess reserves to its Participants through dividends. In November 2009, ALPHA

Fund returned $1.2 million, or approximately 6.4% of the prior fiscal year contributions to its Participants, bringing the three year total to $2.8 million!

For those not familiar with ALPHA Fund, the Fund was established in 1976 to address the rapidly increasing costs of Workers' Compensation for Health Care Districts. ALPHA Fund has since expanded to include services to not-for-profit health care organizations.

As noted by David McGhee, ALPHA Fund's Chief Operating Officer, "ALPHA Fund's business model is unique in that it's not a profit-oriented model, but rather a service-oriented model. An integral part of our model is the coordination of Educational and Loss Prevention Services to support our Participants. By working with our Participants to integrate safety practices as a core value in their respective facilities, frequency of injury is reduced, ultimately contributing to lower expenses for the Participant."

I personally have been on site visits with Brenda McGuire, Director of Participants Services, to see how she operates, and she is *crazy* about loss prevention! I know that sounds a bit much, but believe me…she lives and breathes prevention. She steps into a facility and almost instantly spots an accident waiting to happen. I was amazed at what she saw. With more than 30 years in healthcare—21 years in health and safety—Brenda's ability to help ALPHA Fund Participants keep employees safe and frequency of claims down has played a big role in the success of ALPHA Fund.

You can learn more about loss prevention by calling Brenda McGuire or Rob Ross at 916.266.6100, or emailing brendam@alphafund.org. By the way, are you planning on attending ALPHA Fund's Participants' Meeting? Fill out those registration forms now before it's too late. This will be unlike any prior Participant Meeting…you'll not want to miss it!

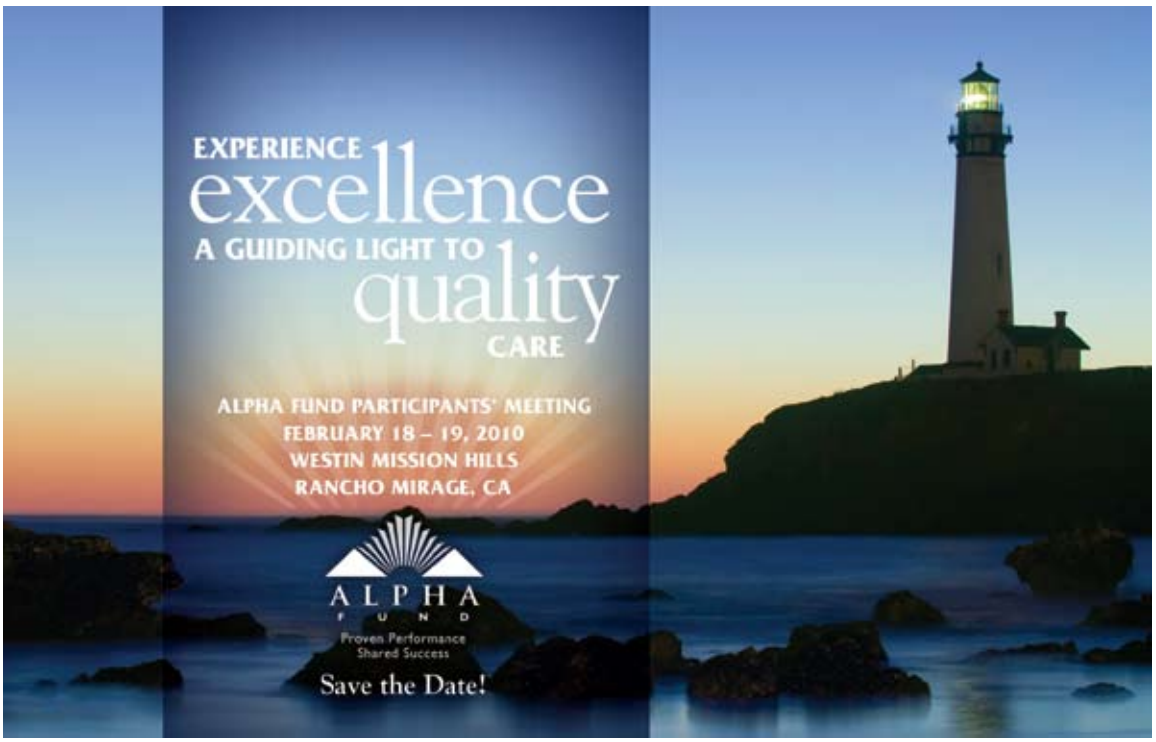
What else is news?

Look for your ACHD Annual Meeting registration material coming to you via mail and email in early March. The Annual Meeting is scheduled for May 12-14, 2010, and will be held at the Hyatt Regency Lake Tahoe. We're planning some new things for this year's event, so don't miss any of it—plan on being there all three days. If you can't wait until March to get more information, you can call me or Christine Chapman at 800-424-2243 or email lindaf@achd.org.

Got an opinion?

Please let me hear from you! I welcome *all* comments and suggestions on any matter, except on how to solve the world's problems. (*I don't believe that's possible…)* Email me, lindaf@achd.org. Call me, 800-424-2243. Write me, see address on inside cover of this magazine. Until next time…make a difference…commit to strengthening your core, stay connected, and look for the *eConnection* newsletter in your email monthly for more up-to-date information. ▲

Linda Faircloth
Editor | Marketing & Communications Director



The Sho(u)t

This past November, ACHD held its bi-yearly Leadership Development Program. Attendance for the program was the highest in recent history with 22 Districts being represented by 42 individuals.

Have you ever thought about the similarities between world history and poetry? What role might poetry play in a society's understanding of its history and vice versa? One might say they are both based on factual *or* fictional events.

History, while factually based for the most part, is somewhat based on the perception of those observing and recording the historical occurrence. One person's perception of an event can (and many times is) be different from another person who witnesses exactly the same event, at the same time, in the same place.

To illustrate my point I like to use the "Shot Heard 'Round the World" which is a phrase representing several historical incidents throughout world history. The line is originally from the opening stanza of Ralph Waldo Emerson's "Concord Hymn" and referred to the beginning of the American Revolutionary War. Later, in Europe and the Commonwealth of Nations, the phrase became synonymous with the shot that killed Archduke Franz Ferdinand and plunged Europe into World War I, both very different but similar events.

Of late, this phrase has been modified slightly to read, "The *Shout* Heard 'Round the World" and has become attached to several politically charged events that have occurred over the last year and a half, including Barack Obama's presidential campaign, the infamous Joe Wilson "shout out" during President Obama's speech on health care to a joint session of Congress, the charge of the "Chicago Tea Party" revolt led by CNBC's Rick Santelli during the whole mortgage bailout debacle and, quite interestingly enough, to Daniel Hannan, MEP, a conservative member of the European Parliament, who encouraged Americans to stand up and be Americans.

Heard 'Round the World

By Christine Chapman, Member Services Director, ACHD

Aside from the politico related lexicon, in either form, this phrase has also been tagged to more positive or some would even say several "feel good" phenomena including the song, "The Shout Heard 'Round The World" by the group, Boys Like Girls, the group named, The Shot Heard Round the World, out of Brooklyn, and the term given to the walk-off home run hit by New York Giants outfielder, Bobby Thomson in 1951.

So at this point, how many of you are scratching your head and thinking, "What the he** does this have to do with anything?" Hopefully I can answer that here. If you have gotten this far, you are at least interested in finding out what one person's perception is, which brings me to my point.

This past November, ACHD held its bi-yearly Leadership Development Program. Attendance for the program was the highest in recent history with 22 Districts being represented by 42 individuals. Prior year programs held that the core issue for Health Care District board members was "Board Roles and Responsibilities," and issues beyond the scope of this topic were better left to management and consultants. The perception that board members should not "worry themselves" or become involved in the day-to-day operations of the business was the norm. Fortunately, much has changed in the business world today

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The Sho(u)t Heard 'Round the World

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Boards are under increasing public scrutiny for how they discharge their responsibilities, including adequacy of public financial disclosure and oversight, excessive executive compensation, hospital policies and quality of care.

due in part to the impact of the Enron scandal, the banking industry meltdown and, most recently, the controversy of healthcare reform. Boards are under increasing public scrutiny for how they discharge their responsibilities, including adequacy of public financial disclosure and oversight, excessive executive compensation, hospital policies and quality of care. While some boards have made a successful transition from their previous philanthropic role to one focused on strategic, clinical, charitable and financial oversight, many are still struggling. They must set aside outdated perceptions of what a health care district trustee does and broaden their knowledge and be comfortable with all areas of the operation, but at the same time have the confidence in their management teams to leave the day-to-day operational issues to them.

Much of what was discussed during this program dealt with the fact that old perceptions are sometimes hard to change but in order for an organization to grow and prosper, change must occur. Trustees and CEOs spoke frankly about recognizing the amount of time and energy required on the part of the trustee and how compensation levels affect the amount and quality of time the trustee invests. Executives are employees of the district and therefore are monetarily compensated. Trustees typically receive a small stipend (legislatively mandated at no more than $100) and some elect to reject this stipend based on the financial health of the district. Others feel that that they give significant time to governing the district and they should be appropriately compensated. Many hold the view that even though they are not direct employees of the district, it

would be an incentive to offer benefits such as healthcare coverage to trustees as a way of recruiting more business savvy trustees. All of these issues, while important, are also somewhat controversial in many people's views, but are all necessary topics for discussion as districts grow and change and morph into vital organizations that are stepping up to meet the challenge of providing healthcare to their communities in today's complex world.

Maybe it's time to revisit the basic 80/20 principle (80 percent of the board's time is spent on active discussion and decision-making and 20 percent is spent on reports and consent agendas), and acknowledge that a shift in focus must occur in order for the board to be effective. And as controversial as these subjects are, we know that they are important to trustees and executives because many of you went back to your own districts and had these very topics placed on your board agendas for discussion.

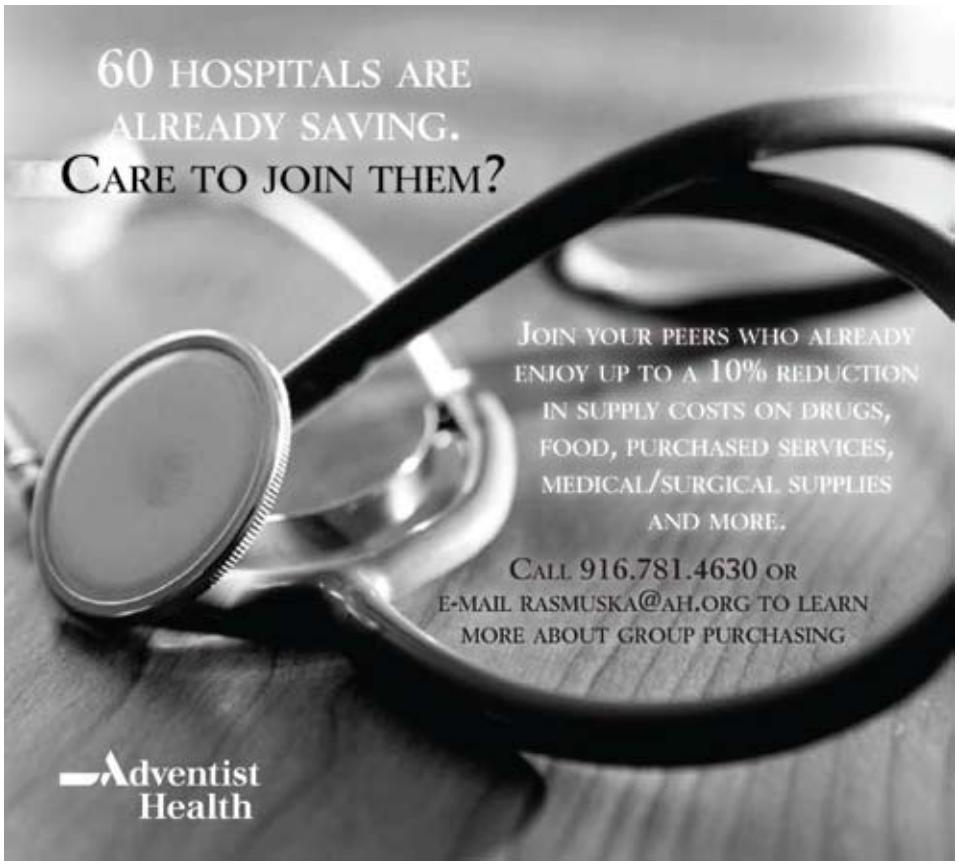
All of these topics were voiced loud and clear by those in attendance. In some cases, a few voices were louder than others but the clear message was a united voice, a SHOUT, if you please, that was "Heard 'Round the World" (or at least across the street), that change is necessary on many levels to help develop better, more effective boards. We were and still are excited about being the catalyst for these discussions and look forward to the impact that they will have on district boards in the future.

To all those who took part in this program, for those who "SHOUTED" for better communication, appropriate compensation, for recognition of the value of the contribution of time and energy and the need for benefits for trustees, thank you for making this the most successful Leadership Development Program. Without your participation, without your willingness to have these frank discussions and taking this message back to your districts, without YOU, this program would not have had the impact that it has had, and will have on our Districts now and in the near future. Continue to use your voice so that others experience the "SHOUT HEARD 'ROUND THE WORLD."

Using the Buddy System to Save Big on

By Doris Dobkins, Customer Support Specialist, Adventist Health

Pop quiz: What is the single largest expense category for hospitals? You probably got that answer right: Labor costs. Now, what is the second-highest expense?



The answer is *supplies*—food, drugs, lab items, maintenance, medical/surgical expenses and so forth—and it is an expense category that has become even more complicated and worrisome during the recent economic downturn. In today's challenging economy, many districts are looking for ways to cut expenses, and supply costs are an obvious place to start.

But that quest can quickly hit serious complications. After all, supply costs can be cut back only so far; at some point, there will be no other way to reduce—at least on your own.

For many smaller hospitals, the solution has been to find strength in numbers through an aggregated purchasing program. In California, for instance, 45 hospitals—including 10 district hospitals—are part of the Adventist Health Affiliate Program (AHAP). The program is administered by Adventist Health, a not-for-profit health care delivery system that operates 17 hospitals, primarily in California.

"We all face challenges related to supply costs," said Adventist Health President & CEO Robert G. Carmen. "Adventist Health hospitals clearly

Expenses

benefit from the strength of affiliation, as do all the other participating affiliated hospitals."

AHAP partners with Premier, Inc., headquartered in Charlotte, North Carolina, to offer group purchasing discount volumes on services, supplies and equipment. The program runs on a tier plan; the deeper a system commits to the program, the higher the savings are. If a member hospital doesn't want to use a particular Adventist Health contract, it may opt to access other Premier contracts.

By aligning with other hospitals, AHAP affiliates are reporting savings of five percent to 10 percent or more across a wide range of supplies.

"Our small, rural hospital has saved approximately 20 percent in pharmacy, med/surg, food service and capital equipment expenses," said John Ayers, director of material management at Tahoe Forest Hospital District. "I really appreciate what the program has done for us."

An added, and often overlooked, benefit of joining an aggregated purchasing program is the back-office support component, which uses data to continue to define new savings opportunities, at no cost to program affiliates.

"The monthly conference calls, annual face-to-face meetings and networking opportunities really help us bring additional value to our facility," said Coby La Blue, director of financial and logistical planning at AHAP affiliate Kaweah Delta Health Care District.

Lowell Church, Adventist Health's assistant vice president for material management, offered tips on what to look for in an aggregated purchasing program.

"The best programs do not charge a membership fee or require an investment in the program in order to join, nor do they dictate a particular length of commitment," he said. "In addition, those who save the most get engaged in the process and use the free tools and data that are available."

For more information about the Adventist Health Affiliate Program, call Kaul Rasmusson, corporate affiliate director, at 916-781-4630. ▲

In today's challenging economy, many districts are looking for ways to cut expenses, and supply costs are an obvious place to start.

Selecting the Right C

The Most Important Respon

You've just learned that your District's CEO seat is going to be empty. Yikes! Ensuring that your organization has the best possible leader is one of the MOST IMPORTANT jobs of a Board member. And Board members should ALWAYS be prepared if and when the time comes to fill that seat. The most important goal is to maintain stability and prepare for what lies ahead.

Should you find your organization without a CEO, the Board should carefully and promptly name an interim CEO to make sure the operations don't falter, and strategic initiatives stay on track. Are there executives in the organization that can fill the interim role? Or, is it better to bring in an outside temporary CEO? CEOs must be able to lead effectively, deal with diverse stakeholders, plan for the future, and ensure high-quality patient (and customer) care. Keep your options open and be clear about expectations and whether the interim CEO is a candidate for the permanent role.

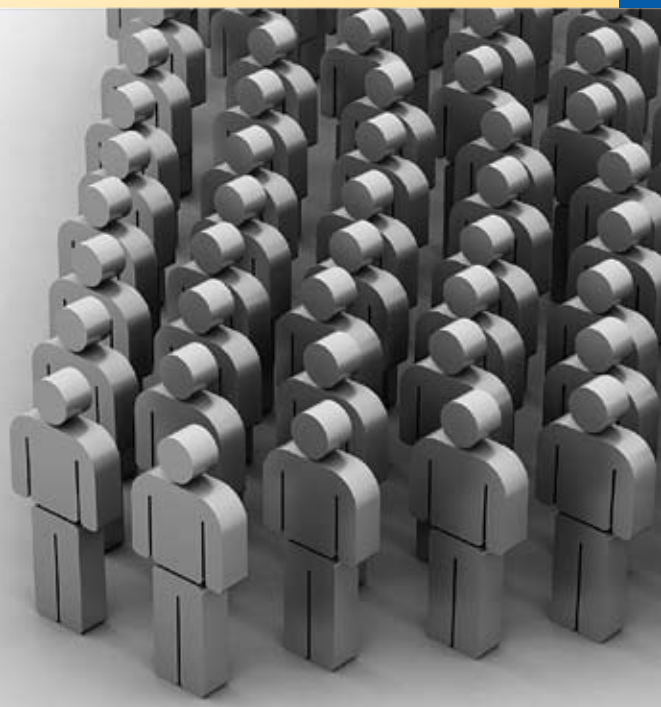
This time also presents an excellent opportunity to "clean up old messes." Consider a facilitated Board retreat to settle any differences, stabilize the Board dynamics, and come to a clear understanding about the characteristics and goals for the next CEO. This is also an excellent venue to decide on the composition of the Search Committee.

Ultimately, the decision to hire the CEO will be made by the full Board. It is helpful to name a Search Committee to expedite the process. Having no more than two District Board members on the Search Committee makes meeting scheduling easier, and will speed the process. There may also be an "Advisory Committee" that would include community members, medical staff, hospital managers, or others. This Committee would provide input to the Board or Search Committee on what the members think the organization and community needs. Make clear, however, that they are in an advisory

EO—

sibility of the Board

By Don Whiteside
Managing Director of Executive Search
HFS Consultants



capacity, and not a voting role, and it will be the District Board that makes the final decision.

Should you hire a search firm? While seemingly expensive, it might be the best investment you can make. ***Not finding the right leader will be the most expensive proposition.*** Search firms have the expertise and experience to keep the Board on task during a difficult time. They will objectively evaluate the organization and help determine the CEO job specification. There are always the "good, bad, and ugly" to every job, and search consultants can explain all of this to candidates in an objective and believable manner. A search firm will "search" rather than "accept applications" resulting in a higher caliber of candidate. A good search firm will help you avoid illegal questions and procedures, and manage the complex process. They also should help with the negotiations that should result in a fair, attractive, and long lasting employment agreement.

Other important considerations? Early on, get appropriate advice on CEO compensation, severance, and benefits. You don't want this to be a deal killer at the end. Determine the most important CEO skills needed—now, and for the future. Community "fit" may be the most important factor for a new CEO. If you haven't engaged a search consultant, do a brutally honest self assessment and make your own list of the "good, bad, and ugly"- your candidates will certainly be considering those same things. And lastly, be particularly sensitive to internal candidates. Create a confidential and respectful process that will allow these individuals to continue to serve the organization should they not be chosen.

Please call or write with any suggestions or questions. Don Whiteside, Managing Director of Executive Search, HFS Consultants. 510-768-0066 or whiteside@hfsconsultants.com. ▲

Hardwiring Excellen

in Your Next Strategic Plann

Building a strategic plan on a solid foundation at your annual board retreat is not a new concept, but doing so with a twist gave new meaning to strategic planning at Hazel Hawkins Memorial Hospital (HHMH) of San Benito Health Care District.

HHMH worked with Steve Rousso and Randy Grossman from HFS Consultants to incorporate the principles articulated by Quint Studer in his book *Hardwiring Excellence*. Retreat attendees left energized, challenged, and ready to address the issues ahead of them—those that were discovered during this unique retreat experience.

Studer reasons quite convincingly in his book that hospitals of excellence set operational goals and objectives for each of five operational pillars: People, Service, Quality, Finance, and Growth. Each pillar uses a number of guiding principles, such as:

- commitment to excellence,
- build a culture around high standards of customer service,
- continually measure progress in achieving goals,
- develop leaders,
- focus on employee satisfaction, and recognize and reward success,
- promote individual accountability and align behavior with goals values, organizational mission, and vision.

The more these principles become routine behavior or "hardwired" into a hospital's culture, the more the hospital will achieve sustained excellent performance.

At the strategic session for HHMH, approximately 35 District Board Members, key management, line staff, and key physicians practicing at HHMH participated in the planning session. To provide the foundation, Ken Underwood, CEO first presented an operational summary, followed by a financial performance review, a review of clinical operations, and Steve Rousso's review of the Hospital's strategic planning information.

Attendees considered the Hospital's service area from a geographic perspective as well as key demographic variables such as population, and key population cohorts (e.g. the elderly, women of childbearing age, ethnicity, etc.). Furthermore, a review of key industries and employers in the service area, as well as an economic profile of the service area was examined, as these are all factors impacting healthcare utilization and the ability of a hospital to meet community health care needs.

HFS then drilled down from the market data and presented historic and projected utilization data for the Hospital so participants could get a picture of how it is performing relative to their market. As Mr. Rousso explained, "It's important to separate the forest from the trees. The value of these data is that they allow you to 'peel the onion' and know how your hospital is performing relative to the market and what opportunities for growth you have. You need to rigorously examine your market share trends by service and ask, 'Why is our hospital performing this way,' or 'What can we do to correct a problem indicated from these data?'"

A unique SWOT (Strengths, Weaknesses, Opportunities, and Threats) exercise was then facilitated by Dr. Grossman where the participants were divided into the five operational Pillars of Excellence (PE) as described by Quint Studer (People, Service, Quality, Finance, and Growth.) Each PE group was charged with identifying the key SWOT characteristics of their pillar. To challenge the groups even more, they were asked to show how, if given the opportunity, they would invest up to a million dollars by either capitalizing on a strength or

ce

By Randolph Grossman, MPH, Ph.D.
and Steven Rousso, MPA, MBA
HFS Consultants

ing Retreat – A New Twist

opportunity, or confronting a weakness or threat. As Dr. Grossman explained, "By giving the groups this scenario, the groups were forced to prioritize their issues and quantify how the money would be spent." They then were asked to share their findings and justify their prioritization of issues and spending decisions to the group.

Sharing their findings with the entire group allowed an opportunity for improving and refining the issues of each pillar. Once refined, each group was then charged with formulating *measurable* goals and objectives that they thought were attainable in a specific timeline. In each case the groups were asked to clearly state a goal in a manner which could be tracked and measured and to state who does what, and by when. Each group then presented their goals to all the attendees and discussed their next steps.

The issues derived from this planning session then go to HHMH's Planning Committee. As strategic planning is an ongoing and dynamic process, the Committee will meet regularly to study the issues and determine which ones to concentrate on and prioritize for the coming year. Once a specific direction is agreed upon, the Committee assigns responsibilities and deadlines, and tracks and measures the outcome of each issue.

Ken Underwood commented, "The strategic planning session conducted by HFS was a good process. We were all energized and challenged to really think about where we want to be and what we have to do to get there." Re-emphasizing the value of an effective planning session such as that at HHMH, Steve Rousso added, "Since change is constant, you want to create a culture that can adjust and respond to change. No matter what shape health care reform legislation takes, the key question is, 'Will you be prepared to rapidly respond to it?'"

For more information about HFS' strategic planning or Board retreat services, contact Steve Rousso at 510-768-0066 (ext. 224) or Randy Grossman (ext. 310). ▲

Lessons Learned from Construction

Hospital capital expansion projects pose significant risks to unsuspecting project owners. As a Trustee or hospital executive, you need to feel confidant that capital dollars are wisely invested. Unfortunately, in the case of most construction project owners, their business and core competencies typically differ from the construction expertise needed to manage the project.

Yet, the future of the hospital may ride on completing the capital expansion project on time, with sufficient quality and within budget.

Unfortunately, relying on outside architects, engineers, contractors, and a project management firm all hired to manage your multimillion and sometimes billion-dollar-plus construction project may lead to significant problems in key areas where no control structure is in place, such as budgetary management, financial reporting, staffing, cost management, and policies and procedures. In our line of work, we have witnessed several surprises on district hospital construction projects:

- Project completion delayed 12 months costing $150 million of potential revenue.
- Excessive change order charges costing $4.5 million.
- Direct labor over-charges of $2.3 million.
- Payroll tax project charges of $3 million.
- Inappropriate workers' compensation insurance costing $12 million.
- Duplicate payments of $4 million.

Issues that lead to construction project problems can come from a variety of areas. Project financial records and reports may be inaccurate. Unclear or multiple channels of management direction can lead to excessive requirements and scope creep. Loose monitoring of contractor financial controls can result in costly practices and overcharges. Errors and/or project delays may lead to excessive change order costs, claims, disputes and budget management issues. Design and construction quality issues may lead to unfulfilled occupant requirements and excessive lifetime maintenance costs. Project staffing may be insufficient to deliver projects on-time and within budget.

Addressing construction project exposures can be a daunting task but there is hope. If the right controls are implemented, there is a good chance to succeed, limit surprises, and avoid costly overruns. Depending on the nature of your project arrangements and risks, you will benefit from implementation of appropriate controls in the following areas:

- Facility needs assessment and master planning processes
- Communication and fulfillment of hospital and occupant expectations.
- Procurement controls and contract administration
- Defined safety program and insurance plan
- Contracting methods and contractual arrangements
- Cost, schedule, and financial budgetary management and reporting
- Change order management
- Program staffing
- Project labor, materials, rental equipment and overhead cost control.
- Project close out processes
- Compliance of spending with bond requirements

Hospital management must be held accountable for the strategic imperatives that advance the hospital's mission and vision. Management's actions taken to mitigate construction project risks will be well worth the effort however, the time to begin developing the project

Auditing

By Curtis Matthews, Managing Partner, Business Risk Management & Control Solutions Practice, Moss Adams

control structure is before the project begins. Having a competent professional with construction project controls expertise present during contract negotiations will provide further assessment of key provisions and clarifications that should be included in the contract to help protect the owner. For example, one district hospital saved $2.1 million on a subsequent phase of its project by building the right control structure before construction began.

Oversight of District hospital trustees and executive management can be important in each stage of facilities planning and construction:

- Capital planning – ensure the plan is consistent with the hospital's strategy and mission.
- Community relations and fundraising – cultivate support for the hospital's vision.
- Selection of outside contractors and architects – evaluate selection criteria, and consider potential firm's track record, qualifications, and achievement of objectives.
- Design presentation – present probing questions to help management stay on track to accomplish long term objectives (i.e., "How will our facility compare to others in the area?")
- Budget and schedule concerns – consider how budget overruns or delays in the project schedule will affect the hospital's strategic imperatives.

Your hospital will need to hire competent professional service and construction firms to help with the construction project, but the responsibility for management of project scope, cost, quality and safety cannot be delegated. Experience, knowledge and reliance on trusted advisors will help you monitor your project from the time it is a conceptual idea, through development and construction to completion. Performing construction cost audits and assessing program exposures periodically throughout your capital expansion project will provide high pay-offs. Construction project problems have enormous consequences, but prudent control structures and construction auditing techniques can serve as a valuable and much-needed dose of preventive financial medicine.

For more information on construction auditing, please contact Curtis Matthews at 503-478-2187 or Sharon Hartzel at 480-366-8342. For a comprehensive list of tax, audit, and health care consulting services, please visit www.mossadams.com. ▲

Three Critical Trends that will Shape California Healthcare District Strategic and Financial

By Guy M. Masters, Senior Vice President and Steven T. Valentine, President, The Camden Group

Three essential trends should be top priority for California Health Care Districts in 2010. With healthcare reform well on its way to complete passage, these trends will shape success or failure, and must be dealt with strategically and operationally now.

The following are The Camden Group's red flag trends and strategic implications for Health Care District board members and senior leaders in 2010 and beyond:

1. Economic Recovery and Healthcare Payment Reform

Key issues to watch for the next 12 months include the recovering economy, continued high unemployment in California, State deficits and healthcare payment reform. While the overall economy seems to be in early recovery, high unemployment in the State will keep demand soft for healthcare services. Expect that charity care and bad debt levels will remain high or increase.

Changes in reimbursement rates expected under reform will impact all California Healthcare District hospitals. Rural Health Clinics (RHCs) and Critical Access Hospitals (CAHs) will likely benefit from enhanced reimbursement as funds will be channeled to support these organizations. Hospitals in urban areas will be less fortunate. It is likely that reimbursement rates for nearly all payer classes in urban areas will migrate toward Medicare levels (see illustrations in sidebar). This includes rates paid to providers for the anticipated 30 million newly insured individuals covered by reform, as well as existing commercial HMO and PPO patients. It will be the result of natural market forces as commercial health plans enter into competition for enrollees in new market structures (e.g., co-ops, insurance exchanges, others). Lower premiums will result in lower payments to providers. Will Medicare become your dominant payer in 2010? Act as if it will be, and you'll be better off financially than if you expect the status quo for the next few years.

Impact Hospitals Performance in 2010

Steps Health Care District Leaders Can Take

- *Determine the potential financial impact of different payer class rates being reduced to Medicare payment levels. Explore various scenarios and brainstorm proactive responses.*
- *Examine your hospital's cost structure (clinical and non-clinical) and outline initiatives to lower expenses by up to 10 to 15 percent.*
- *Identify and implement ways to lower length-of-stay, improve throughput, and streamline access to services. Eliminate bottlenecks, redundancies and duplication throughout the care delivery process.*

2. Physician-Hospital Alignment: Physicians as Economic and Clinical Partners

Physicians must be engaged partners with hospitals (formal or informal, virtual

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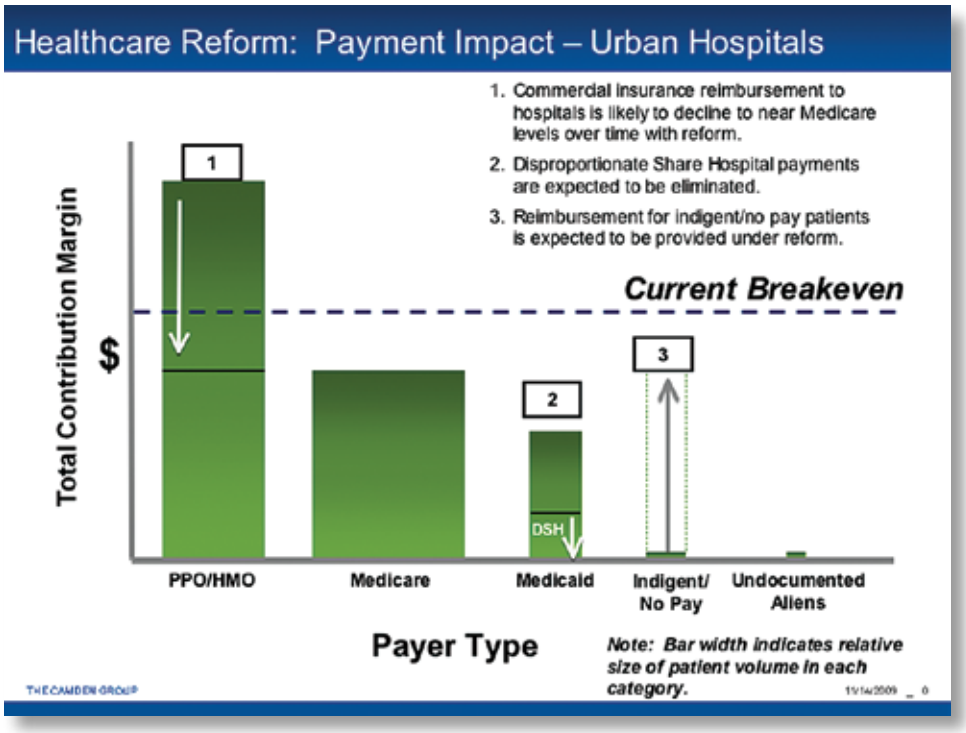

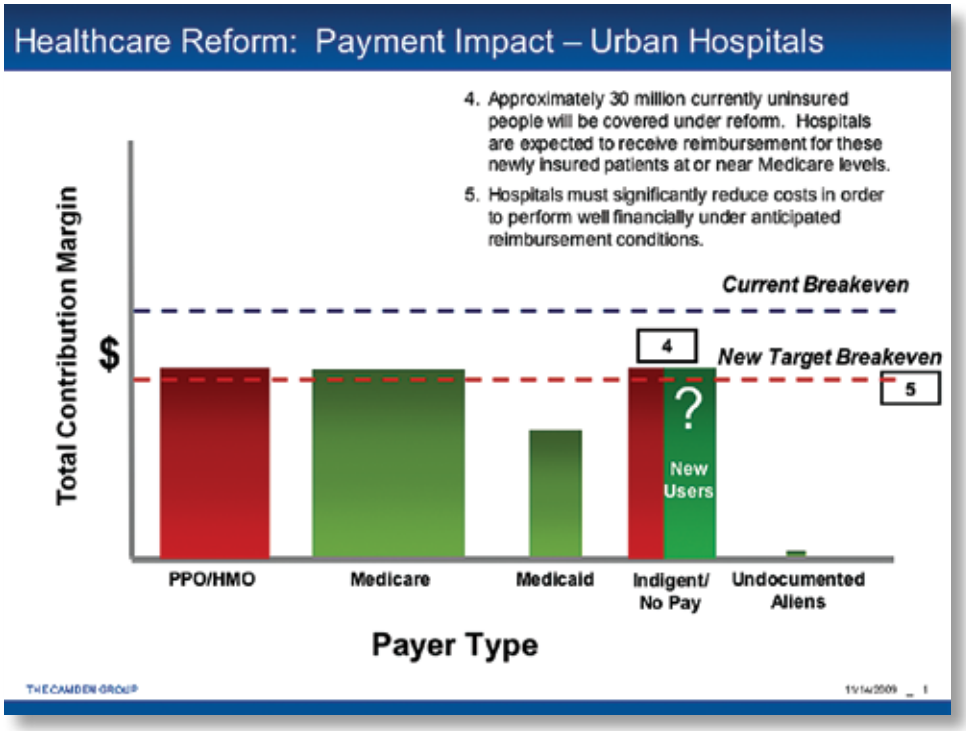

Three Critical Trends…

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or actual) in order for both to meet the challenges of healthcare payment reform head-on. Clinical integration is the latest stage in the evolution of strategies that achieve a high degree of physician-hospital alignment. Clinical integration is a core competency required to perform well under new reimbursement models that are being embraced and piloted under reform. These include gain sharing, bundled payment (CMS (Centers for Medicare and Medicaid Services) currently has pilot projects underway for selected cardiac and orthopedic procedures), Value Based Purchasing (VBP) program, and Accountable Care Organizations (ACOs). ACOs are provider organizations that are capable of assuming financial risk for all costs associated with providing a continuum of healthcare services for defined patient populations. All of these programs will require aligned, cohesive providers unified by common financial and clinical incentives, capable of delivering comprehensive coordinated care.

During 2010 physician recruitment will remain difficult as competition intensifies for recruitment of a shrinking supply of primary care and selected specialist physicians. New physician candidates now prefer to join groups, be employed by hospitals in order to seamlessly transition into medical practice.

Steps Health Care District Leaders Can Take

- *Confirm that the hospital has an up-to-date Medical Staff/Community Needs Assessment Plan. Be certain that management is proactive and assertive in succession planning and recruiting sufficient primary care and specialist physicians in potential shortage areas.*
- *Use task forces (e.g., communities, focus groups) to involve physicians in the design, selection and implementation process to create buy-in and "ownership" of decisions and actions taken.*
- *Take inventory of your physician-hospital alignment readiness to further integrate with existing and future medical staff members. Will you need to align with physicians through the 1206(b), Rural Health Clinic, ACO, or other structures? Is there a Physician Hospital Organization or Management Services Organization in your future? What other models or options will you need to be successful at retaining and*

recruiting key physicians?

- *Regularly monitor physician satisfaction survey results. Be sure that management maintains open lines of communication and regularly engages medical staff members in dialogue around internal and external trends, current events, and decisions that impact physicians.*
- *Make smart investments in clinical information systems, Electronic Medical Records, Computerized Physician Order Entry Systems, and other Information Technology infrastructure that links physicians, and other providers to common platforms, systems, and processes.*

3. Quality and Value

In 2010, standards for clinical quality and outcomes must be factored in to every discussion on strategy, operations, physician-hospital alignment, and organizational performance. Accurate reporting on quality will become critical as outcomes data will determine whether or not you receive full payment for services rendered under pay-for-performance programs, bundled payment models, and value-based purchasing arrangements. Payments will be reduced if inpatient readmission rates exceed standards, if "never events" occur, and if other criteria are not met. As premium and reimbursement for all payer classes converge toward a Medicare payment rate, consumers will make choices based on perceived and quantifiable value. Superior value will be determined using criteria such as service, quality and cost measures, patient convenience, satisfaction scores, accessibility, and other value-added enhancers. The ease of public access to data will either elevate or bury providers in the eyes of patients, purchasers, and payers.

Steps Health Care District Leaders Can Take

- *Assure that evidence-based protocols and clinical guidelines are being developed, implemented and adhered to.*
- *Benchmark quality performance using relevant standards and address areas where improvement is needed using ad hoc task forces, existing committees, physician and other clinicians as advisors, and other groups.*
- *Collaborate with physicians to address coordination of care processes and re-design current delivery methods as necessary to streamline care, eliminate inefficiencies, and drive throughput across the continuum of care.*
- *Ensure proper information technology investment (e.g., PACS, EMR, CPOE, test results reporting).*

Summary Note

In the future, 2010 will be looked back on as the baseline year for healthcare redesign in the United States. The changes that we will experience in the next several years will present opportunities and challenges that will require organizations to reinvent and redesign healthcare delivery processes. Use these topics, questions and suggestions to stimulate discussion in your board meetings and strategy sessions during the year ahead. Explore new ideas, challenge the status quo, and make good decisions to ensure the success of your organization and its mission in the future.

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