

Healthcare Policy: Seven Questions Boards Must Ask

BARRY S. BADER, EDWARD A. KAZEMEK, PAMELA R. KNECHT,
DON SEYMOUR, & ROGER W. WITALIS, FACHE

As the great Congressional debates over healthcare reform pass into history, access to care and cost both continue as unresolved problems. As a result, hospitals and physicians are left with enormous challenges in their mutual quest to provide high-quality patient care.

Policy Implications

The dust is settling and the clear message from policymakers to healthcare providers is this: **take care of more people with more complications and demands, and do it with fewer resources.** From the hospital standpoint there are three major implications:

1. **Problems accessing care.** There is a national shortage of primary care physicians (PCPs) and many people (though they may have newly available health insurance as a result of policy changes) still won't have access to a PCP. Massachusetts, which has more practicing physicians than any state in the U.S. except the District of Columbia, saw wait times for PCP appointments increase significantly after it passed universal coverage legislation in 2006. Consequently, emergency department costs and visits both rose appreciably.
2. **Splitting one check.** Policymakers will be tossing the hot potato of cost containment into the laps of providers in the form of at-risk reimbursement (e.g., bundled payments, pay-for-performance, Accountable Care Organizations, and/or capitation) tied to quality and cost outcomes. Massachusetts is currently considering a statewide move in this direction, replacing fee-for-service with mandatory, global payments¹ to contain the escalating costs of universal coverage. Doctors and hospitals will essentially get one check and they will have to figure out how to divide it among the various providers.
3. **Flat or declining payment.** Average payment per increment of service will, at best, stay the same when adjusted for inflation. The "tax the rich, feed the poor" scenario (i.e., increasing income taxes and taxing "Cadillac health plans" in order to cover the cost of the uninsured) won't generate enough revenue to sustain current reimbursement levels (Massachusetts increased state taxes more than 20 percent and still faces a deficit). The potential for cost savings from Medicare and Medicaid remain elusive.

Seven Questions Boards Must Ask

There are seven specific issues hospital boards should pay particular attention to.

1. What are our core mission and our core business, respectively?

That's right, they might not be the same. Explicitly or implicitly, most community hospitals have a *core mission* to take care of the sick, injured, and frail members of their service area, whether their needs are acute or chronic, while also providing wellness and prevention services. But the *core business* for most hospitals is the provision of acute care services: inpatient, ambulatory, and emergent/urgent. This is a unique service

to the community and also where the hospital generates most of its revenue. Boards should assess their ability to continue providing other, non-acute care services; especially if another organization might do a better job and/or if the service takes resources away from the core business.

"We will do everything for everybody' has never been a viable value proposition for any successful business... yet that's the value proposition... of general hospitals..."²

The notion of being all things to all people is well intended, speaks to the mission of most non-profit hospitals, and poses a significant dilemma for boards in a time of increasingly limited resources. In the past, a hospital service could be justified because it was "good for the community."

Hospitals have been saying they can't do everything—but they will have to be far more disciplined about this in the future. Increasingly, hospital boards will need to debate these fundamental questions:

- What is the highest and best use of the organization's limited resources?
- What changes, if any, need to be made to our mission and vision so they reflect our core business?

2. Are our clinical outcomes as good as they could/should be?


As payment is tied to quality, clinical outcomes—which have always been important indicators of patient care—will take on economic importance as well. Boards can continue their quest for quality improvement by asking the following questions:

- What do our metrics tell us about the quality of care in our hospital?
- Are we using the right metrics?
- What systems and processes does the hospital have in place to ensure continuous quality improvement?

continued on page 2

1 Steve Leblanc, "Mass. weighs 'global' health care payment system," Associated Press, July 16, 2009.

2 Clayton M. Christensen, et al., *The Innovator's Prescription: A Disruptive Solution for Healthcare*, McGraw-Hill, 2008.



Healthcare Policy...

continued from page 1

3. Are we doing all we can to optimize the bottom line?

Profitability in most hospitals is driven by a small number of services. Hospitals need to assess their portfolios to identify “cash cows” and determine if they have sufficient resources (physicians, facilities, equipment, and staff) for continued success. Hospitals should also look at the expense side of the ledger and identify opportunities to cut costs. Lower costs and higher quality often go together when savings are driven by evidence-based process improvements, not by indiscriminate budget cuts. Questions for further discussion include:

- How will the “rising stars” in our current portfolio become the “cash cows” of 2015?
- What do our comparative cost profiles indicate about opportunities to reduce expenses?

4. Do we have a five-year capital plan, and do we actively use it as a strategic management tool?

Every hospital should have a five-year “sources and uses of capital” statement in place as a component of its strategic plan and the board should participate in at least annual reviews of these projections. During these reviews boards should start with three questions:

- What are the underlying assumptions and do they take into account the vagaries of future revenue streams and the probability of increased expenses?
- What is the contingency plan to cut “uses” if the “sources” don’t materialize?
- Does the capital plan support our core mission and core business?

5. What is our vision and plan for integration with physicians?

Integration goes beyond alignment and employment to create one cohesive organization focused on patient care, quality improvement, and economic efficiency. Many hospitals and their physicians have begun the heroic journey towards integration. The easy part is changing the structure; the heroic part is changing from a culture that encourages and rewards individual efforts to one that supports and rewards a systemic approach to patient care. Two structural approaches provide vehicles for facilitating an integrated approach: the formation of a multi-specialty group (MSG) and/or the creation of an Accountable Care Organization (ACO). Both are designed to improve patient care while simultaneously enhancing provider ability to succeed financially under at-risk contracts. Boards should be engaged in discussing the pros and cons of the following questions:

- Should our employed physician group begin the transition to becoming an MSG?
- Should our hospital, employed physicians, and independent physicians participate in an ACO?

6. How severe is our PCP shortage and what are we going to do about it?

Hint: simply trying to recruit more PCPs or making them work harder won’t work; there are too few of them nationally and only 24 hours in a day.

While there are no easy solutions to the shortage of PCPs there are some steps that innovative organizations are taking. Board questions include:

- What does our physician development plan tell us about the severity of this challenge over the next five years?
- Will the highly touted medical home model of practice help to eliminate the shortage?
- What approach are we taking to differentiating ourselves in recruitment of PCPs?
- What approach are we taking to recruitment of mid-level practitioners to supplement the work of PCPs?
- Should we establish an urgent care center, fast track in the ED, and/or a retail clinic?

7. Can we continue to go it alone or do we need to join/form a larger hospital system?

The policy challenges are daunting and many hospitals may not be satisfied with the answers they give themselves for the previous six questions. What then? For some the answer is turning to a larger system; for others it may be forming a system; for still others it may be adding to an existing system. Among other potential benefits, hospital systems may provide clinical scale (i.e., larger volumes and therefore the ability for greater specialization), economic scale, the ability to negotiate better contracts, and diversification of risk. But the benefits can be elusive and all come at the price of autonomy. As they start down this road, hospital boards should ask themselves at least three questions:

- What are the principles driving this potential relationship—what are we trying to accomplish?
- What are we willing to give up in order to develop the relationship?
- Assuming we joined with others, how would our answers to the previous six questions change?

Conclusion

The issues of policy change are complex and, of course, we are not clairvoyant. We encourage hospital boards to use this article as a jumping-off point for discussion about policy changes and their implications for hospital governance.