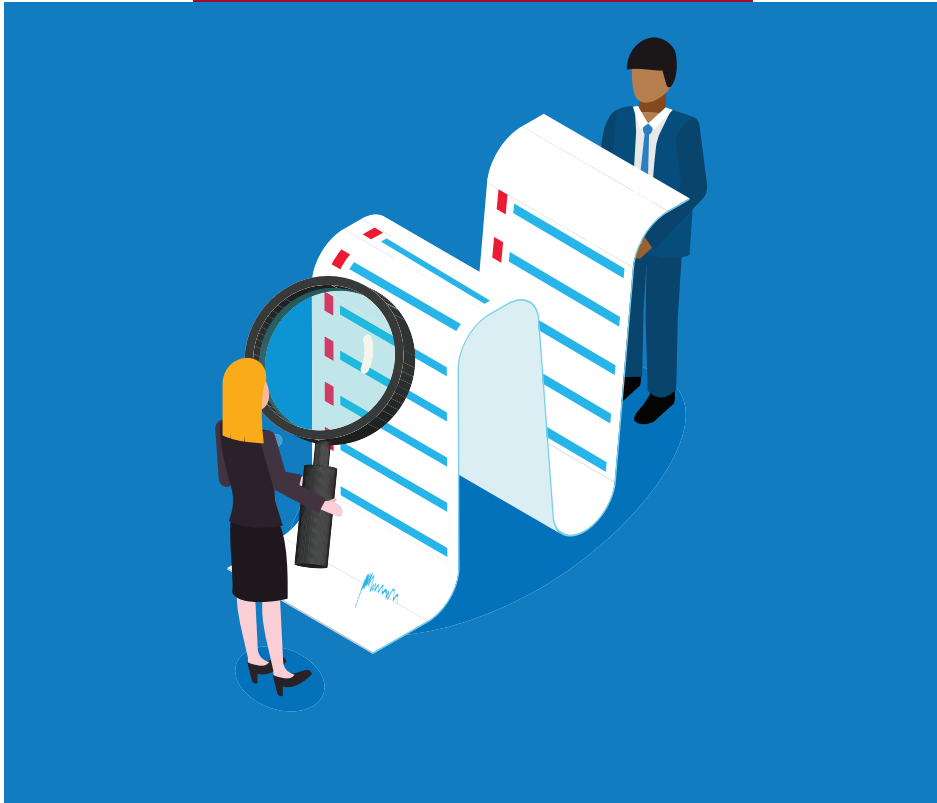


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BOARD RESPONSIBILITIES



Financial Turnaround Needs Board Oversight

Challenging Times Call for Deeper Board Engagement

BY JAMIE ORLIKOFF

American hospitals and health systems face a severe financial crisis that emerged suddenly in January 2022 following the Omicron surge specifically, and two years of Covid surges in general. This ongoing crisis was caused by

an unprecedented and unpredictable confluence of pandemic related factors combined with sharp reversals of economic trends. These factors include workforce shortages and corresponding skyrocketing labor costs; declining revenues; persistent supply chain disruptions and shortages, significant general inflation, higher interest rates, and volatility in capital markets. This perfect storm has devastated health care finances and created a crisis of unprecedented

proportions. Recovery to financial stability will be a long, painful process for many hospitals and health care systems; for many others this is nothing less than an existential crisis.

Because of this, boards must become more involved in the oversight of the financial turnaround of their organizations than they did in past periods of lesser financial challenge. This may involve a board monitoring levels of detail that would have previously been inappropriate. But, when a hospital or system is facing an existential threat, it becomes a governance issue and it is appropriate and necessary for a board to engage more deeply than it did in the past. Following are a series of strategies and approaches for boards to effectively oversee the financial turnaround of their organizations.

Do not rush to blame management. Because of the suddenness and severity of the financial decline, many boards wonder why they were “surprised” and question if this is a management failure. It is not! This crisis happened all around the country, the same way, at the same time. Hardly any hospitals or systems were left unscathed. Large systems, rural hospitals, and Critical Access Hospitals were all hit by an unprecedented and unpredictable financial crisis, and most had very poor financial performance as median hospital operating margins across the US were negative for the entire first quarter of 2022, and hospital revenues declined by 7% in

April. This was not the fault of your CEO, and the board should be clear that it understands this.

Do not expect management to have easy fixes. It is also important for boards to understand that their CEOs and executive teams have never been through a crisis of this magnitude, with these causes, and with so few clear pathways to recovery. So, boards must realize that their CEOs do not have a defined, tested recovery playbook at the ready, and that developing one will not be easy. Rather, the board must quickly establish a working partnership with the CEO and executive team that recognizes the uncharted territory the organization is in and achieves a new balance in the governance/management partnership. The board may be more involved, but it still must respect and support the role of the CEO.

Prepare to make the most difficult decisions your board has ever made. Most organizations will need to make incredibly tough decisions and make them quickly. The board must be willing to make and be accountable for these decisions to provide “top cover” and support for their CEOs; and, because many of these decisions will be mission critical – the board is the ultimate keeper of the mission. During the height of the Covid surges, your organization established an incident command structure which approved and oversaw crisis standards of care. These were rationing criteria to guide difficult clinical decisions about scarce resource allocation that influenced which patients lived and which died. Similarly, your board is likely to face equally difficult organizational rationing decisions

about prioritizing resources, cutting services, and laying off staff.

Your board must approach these decisions from the perspective of what is most consistent with the mission and is legally required to do just that under the fiduciary duty of obedience to charitable purpose. Many boards may face a foundational mission question: is it better to go out of business doing the right thing, providing money losing services that are needed by the community; or, to cut those services, retrench, and remain in business for the long-term benefit of the community? Your board must focus on making the difficult decisions to oversee a successful financial turnaround and organizational survival but must use the mission as its guide in doing so. This may require making decisions that are inconsistent with your current strategy, but for many boards the strategy is now simply one of survival.

Ask about your commercial revenue. Much of your financial turnaround efforts will focus on cutting expenses; but remember the old saying “you can’t cut your way to sustainable profitability.” Do not forget to focus on revenue, specifically on your commercial rates. Boards should become familiar with the rates their organizations are being paid for commercially insured patients. Prior to the financial crisis, for a hospital to maintain profitability its commercial rates must have been about three times greater than what Medicare paid for the same services, or about 240% above break-even level. This crisis requires that these ratios be at these levels at a minimum, and they likely must

be higher. Boards should determine what their commercial rate ratios are, and then probe to see if their organization has any leverage to get increased rates. For example, if your organization is a sole community provider you may be able to negotiate higher rates. Rates are key, and one of your turnaround strategies must include how to leverage better rates, likely through tougher negotiating with payers. The rub? Higher rates will result in higher health-care costs for your community, contribute to higher inflation, and you can certainly expect aggressive push back from the payers.

Examine ways to reduce your expenses. Inflated labor costs are the primary driver of expenses outpacing revenues. In fact, hospital labor expenses are up by more than 33% from pre-pandemic levels, equaling a 37% increase per patient adjusted discharge. So, your board must assure that staffing costs are closely examined. Do not dwell on the seeming paradox of high labor costs co-existing with high staff vacancy rates as this is cause and effect: the high vacancy rates are a driver of the high labor costs. Labor is the single highest cost category for hospitals, so there are likely staff layoffs in your future. The board must assure that an honest and rapid assessment of the necessity of layoffs is performed, that areas that will not negatively impact revenues are targeted, and then act quickly.

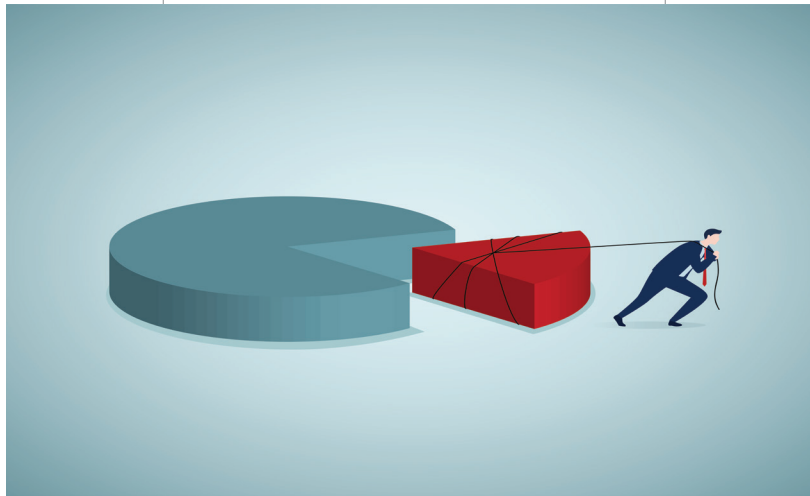
Identify underperforming services and facilities and shut them down. The board must assure that the big areas of cost, of money losers, are identified. Then, the board must verify that

an honest assessment is made about the likelihood of bringing these areas to profitability through focused improvement efforts. If this is not realistic, or cannot be done in a timely manner, these areas must likely be eliminated. The greater the financial challenge your hospital or system faces, the more the board must recognize that less painful, incremental cost reductions will not solve the problem and contribute to a turnaround and sustained financial recovery. Along with layoffs, these will be the hardest decisions your board will face. But the board must not tolerate delays in making these decisions once the big underperforming areas are identified or it risks a slow, inexorable death of a thousand cuts.

Ask about the revenue cycle.

Briefly, revenue cycle management (RCM) is the financial process to track patient care from registration, admission, procedural and medical services, billing, and collection of payment. Because of the incredibly complex and arcane rules, systems, and multiple payers involved in this, the revenue cycle tends to be one of the largest areas of inefficiency, of “leaving money on the table” for hospitals. Thus, it also tends to be one of the areas with the greatest potential of immediate and significant financial return if it can be significantly improved. But the suggestion that the revenue cycle can be improved or should be examined also tends to generate defensiveness and resistance on the

part of the CFO and financial team who often believe that it implies that they have not been doing their job well. The Board must push past this and question if there are opportunities for improvement in the revenue cycle. If your organization has not done an assessment of its revenue cycle in the past three to five years, the board should request that outside assessments of the



potential revenue capture opportunity be performed and be willing to direct management to engage consultants who specialize in RCM improvements. Should inefficiencies exist in your RCM process, focused improvement efforts can add significant dollars to your bottom line in a relatively brief period.

De-emphasize money losers and emphasize money makers. In the past this was a simpler challenge, as most hospitals (other than Critical Access Hospitals) generally made money on surgeries and lost money on medical admissions. It was a one-dimensional issue consisting of increasing surgical volume relative to medical volume. While still broadly true, a strategy of just emphasizing surgery over

medical admissions is insufficient. It is a much more complicated challenge now as all surgeries are not equal from a profitability perspective, and many are now money losers. It is now a four-dimensional issue involving payer mix; case mix; severity index; and expense profile. It is the careful consideration and combination of these four dimensions that can generate the surgical sweet spot of profitability. The board should request information from executive management to assure that these issues are being measured and managed to maximize profitability.

Assess your capacity and focus on your “back door.”

Many boards are surprised to find that there is often demand for profitable surgeries and procedures, but their hospital does not have the capacity to satisfy the demand. This can be for several reasons, but the two big ones tend to be staff vacancies in surgical services; and poorly reimbursed (money losing) medical and other patients occupying inpatient beds when there is no clinical need for them to be there. Rather, they are often taking up inpatient bed capacity because the “back door” of the hospital is clogged. The “back door” refers to the ability of the hospital to discharge patients to appropriate levels of care that are a step down from inpatient care, such as skilled nursing facilities, long term acute care; rehabilitation facilities; assisted care and memory care facil-

ities; and even the patient's home with appropriate support. When this post-acute capacity is maxed out, the hospital becomes clogged with the backlog, housing patients who should not be in an inpatient bed but have nowhere else to go. This is a major cause of a hospital not being able to respond to demand and increase its ratio of profitable surgical services. So, boards should query management about their "back door" status, as well as on strategies to improve flow to mini-

mize clogging and maximize surgical and procedural capacity.

These are very difficult issues driven by even more difficult times. Because of this it is necessary for many boards to engage with their CEOs and executive teams in ways they may not have done before. This can tee up the exceedingly difficult decisions necessary to immediately right the ship and financially recover, to assure that your organization survives for the long term to fulfill your mission.

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