# Table of Contents

## About [Hospital Name]

- History ................................................................................................. 5
- Our Mission, Vision and Values ................................................................. 5
- Our Board ................................................................................................. 6
- Our Service Area ....................................................................................... 7
- Physical Facilities ..................................................................................... 8
- Hospital Organization Chart ................................................................. 8
- Medical Staff Organization Chart ............................................................ 8
- Hospital Quick Facts ............................................................................... 9
- Related Entities ....................................................................................... 10

## Health Care Basics

- Types of Hospitals .................................................................................. 11
- Regulatory Basics .................................................................................... 13
  - Federal .................................................................................................. 13
    - Health and Human Services (HHS) ....................................................... 13
    - Office of Inspector General (OIG) ...................................................... 14
    - Centers for Medicare and Medicaid Services (CMS) ......................... 14
    - Medicare Conditions of Participation (CoP) ....................................... 15
    - Kansas Foundation for Medical Care (KFMC) .................................... 16
    - Recovery Audit Contractors (RACs) ................................................... 16
    - Medicare Administrative Contractors (MACs) ..................................... 16
    - Federal Trade Commission (FTC) and Department of Justice (DoJ) .... 17
    - Internal Revenue Service (IRS) Form 990 ......................................... 17
    - Community Health Needs Assessments (CHNA) ................................ 17
Leadership Role Overview ........................................................................................................ 26
   CEO/Executive Staff .................................................................................................................. 26
   Medical Staff ............................................................................................................................ 27
   System Affiliations ................................................................................................................... 27

Governance Operations .............................................................................................................. 28
   Fiduciary Duties ........................................................................................................................ 28
   Basic Board Roles ..................................................................................................................... 29
   Trustee Job Description ........................................................................................................... 30
   Board Member Selection .......................................................................................................... 32
   Board Committees ................................................................................................................... 33
   Strategic Planning .................................................................................................................... 42
   Medical Staff Credentialing ...................................................................................................... 43
Legislative and Community Advocacy ........................................................................................................... 43
Conflict of Interest ........................................................................................................................................ 45
Confidentiality .................................................................................................................................................. 45
Legal Protection ............................................................................................................................................ 45
Board Self-Assessment ................................................................................................................................... 46
Meeting Schedules ......................................................................................................................................... 46
Board Bylaws .................................................................................................................................................. 47

Association Memberships ................................................................................................................................. 48
Kansas Hospital Association ........................................................................................................................... 48
American Hospital Association ....................................................................................................................... 49
Other Association Affiliations .......................................................................................................................... 49
About [Hospital Name]

**History**

[Insert information about your hospital’s history here, including when the hospital was founded; by whom; for what purpose; etc.]

**Our Mission, Vision and Values**

Our *mission* is the fundamental purpose or reason for our existence; it serves as the foundation for strategic thinking and strategic planning. Our *values* are the principles that guide our decision making. Our *vision* is a projection of the future that describes how our hospital will look in the future—it imagines our future possibilities, guides our strategic choices and provides a longer-range focus for our near-term and mid-term strategic decision making.

The responsibility and authority for determining the hospital’s mission, values and vision lies with the governing board. The board also is responsible for working with senior management to develop the goals, objectives and policies that grow out of, and are measured against, our mission, values and vision. Defining the hospital’s mission, and outlining a compelling vision of our future, with a recommended course of action to fulfill that vision, are among the most important contributions the board makes to our hospital’s success.

*Our Mission…*

[Insert your mission statement here]

*Our Vision…*

[Insert your vision statement here]

*Our Values…*

[Insert your values or principles here]
Our Board

[Insert picture of board member here - the picture should be about two inches wide]  
[Insert board member name and board title, followed by brief biographical information]  
Appointment/Election Date: [Insert month, year]  
Expiration of Term: [Insert month, year]

[Insert picture of board member here - the picture should be about two inches wide]  
[Insert board member name and board title, followed by brief biographical information]  
Appointment/Election Date: [Insert month, year]  
Expiration of Term: [Insert month, year]

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[Insert board member name and board title, followed by brief biographical information]  
Appointment/Election Date: [Insert month, year]  
Expiration of Term: [Insert month, year]
Our Service Area

[Insert your service area map here, or briefly describe your primary and secondary service areas, including a geographical description, list of zip codes, demographic information, market by age, gender, income, ethnic mix, other demographic factors, etc.]
Physical Facilities
[Insert information about your facilities here (hospital clinics, urgent care centers, home health, long-term care, etc.) including a description of the location, size, length of time in service, personnel, and function of each.]

Hospital Organization Chart
[Insert chart here, or describe the functional levels in the organization and the reporting relationships of each]

Medical Staff Organization Chart
[Insert chart here, or describe the medical staff structure based on the medical staff bylaws]
Hospital Quick Facts: [Year - NOTE: Some of this data can be pulled annually from the KHA STAT annual report]

- **Staffed Beds:** [Insert data]
- **Admissions:** [Insert data]
- **Inpatient Days:** [Insert data]
- **Average Daily Census:** [Insert data]
- **Average Stay:** [Insert data]
- **Surgical Operations:** [Insert data]
- **Births:** [Insert data]
- **Emergency Department Visits:** [Insert data]
- **Other Outpatient Visits:** [Insert data]

- **Active Medical Staff:** [Insert data]
- **Total Number of Employees:** [Insert data]
- **Payroll:** [Insert data]
- **Employee Benefits:** [Insert data]

- **Patient Service Revenue:** [Insert data]
- **Other Revenue:** [Insert data]
- **Total Revenue:** [Insert data]
- **Operating Expense:** [Insert data]
- **Excess Revenue:** [Insert data]
- **Market Share:** [Insert data]

- **Unsponsored Care (charity care + bad debt):** [Insert data]
Related Entities

**Hospital Auxiliary** [Describe the roles and value of the hospital auxiliary, including how it is structured, its leadership, and how it is financed]

**Hospital Foundation** [Describe the role and value of the hospital foundation, including its structure, legal relationship to the hospital, and leadership structure]

**Other** [Describe any other important organizations your hospital has, including the purpose and value of the relationship, how long it has been in effect, and the relationship of the hospital to it]
Health Care Basics

Types of Hospitals

There are many different “types” of hospitals, owned and governed through different methodologies. However, regardless of the type of ownership, community leaders have an opportunity – in fact an obligation – to recommend qualified and viable candidates for board positions. This holds true whether the board is selected through local elections, appointed by a government entity or a corporation with headquarters located out of town, or selected through a self-perpetuating process.

Regardless of the type of hospital, board members must work closely with the hospital CEO/administrator and his/her leadership team who are responsible for the day-to-day operations of the hospital.

[Hospital name] is a [Insert type of hospital] type of hospital.

**General Hospitals (Community, Full-Service Hospitals)**

There are more than 5,700 hospitals in the United States. The majority of them are “general” hospitals set up to deal with the full range of medical conditions for which most people require treatment. There are 128 community hospitals in Kansas and many are designated as Critical Access Hospitals (CAHs).

**Critical Access Hospitals**

Kansas has 84 Critical Access Hospitals (CAHs). These are hospitals that are certified to receive cost-based reimbursement from Medicare. The reimbursement that CAHs receive is intended to improve their financial performance and thereby maintain access to basic health care in rural areas. CAHs are certified under a modified set of Medicare Conditions of Participation that are more flexible than acute care hospital Conditions of Participation.

To be a CAH, hospitals must meet specific requirements, including:

- Being located in a rural area and meeting one of the following criteria:
  - over 35 mile distance from another hospital;
  - 15 miles from another hospital in mountainous terrain or areas with only secondary roads; or
  - state-certified as a necessary provider of health care services to residents in the area.
- A maximum of 25 acute or swing beds.
- Maintaining an annual average length of stay of 96 hours or less for acute care patients (there is no length of stay limit for swing bed patients).
- Providing 24-hour emergency services, with medical staff on-site, or on-call and available on-site within 30 minutes (60 minutes if certain frontier area criteria are met).
- Developing agreements with an acute care hospital related to patient referral and transfer, communication, emergency and non-emergency patient transportation. CAHs also may have an agreement with their referral hospital for quality improvement or choose to have that agreement with another organization.

**Teaching Hospitals**

Large teaching/research hospitals have a variety of goals. In addition to treating patients, they are training sites for physicians and other health professionals. Teaching institutions are affiliated with a medical school, which means patients have access to highly skilled specialists who teach at the school and are familiar with up-to-the-minute technology.

**Governmental Hospitals**

Government hospitals are controlled by a local, regional or state governmental agency. There are five primary types of government-supported hospitals:

- State hospitals, controlled by an agency of the state government.
- County hospitals, controlled by an agency of the county government.
- City hospitals, controlled by an agency of municipal government.
- Hospital district or authority hospitals, controlled by a political subdivision of a state, county or city created solely for the purpose of establishing and maintaining medical care or health-related care institutions.

**Not-for-Profit Hospitals**

A *not-for-profit hospital* is a community facility operating under religious or other voluntary auspices. Ultimate responsibility for all that takes place at the hospital rests with its board of trustees, the members of which are generally selected (based on board competency) from the community’s business and professional community, and typically serve without pay. The trustees appoint a paid CEO/administrator to manage the hospital.
Investor-Owned Hospitals

*Investor-owned hospitals* are owned by shareholders. They are profit-making institutions. Investor-owned hospitals are owned by corporations or individuals such as physicians. Hospital corporations may own several institutions located in Kansas or other states.

Limited Service Facilities

*Limited service facilities* specialize in a particular disease or condition (cancer, rehabilitation, psychiatric illness, cardiac, orthopedic, etc.), or in one type of patient (children, elderly, etc.). These facilities are often physician owned.

Regulatory Basics

Hospitals and hospital trustees must be aware of various regulatory bodies and the health care laws and requirements they oversee and enforce. Below are some of the most important regulatory basics:

**Federal**

Health and Human Services

The United States Department of Health and Human Services (HHS) is a cabinet-level department of the executive branch charged with protecting the health of all Americans and providing essential human services. HHS includes over 300 programs, including research, disease prevention, food and drug safety, Medicare and Medicaid, prevention of child abuse and domestic violence, services for older Americans and health services for Native Americans. Due to the large number of programs under the Department’s umbrella, HHS has many operating divisions, divided into two sections:

**Public Health Service Operating Divisions**

- National Institutes of Health (NIH)
- Food and Drug Administration (FDA)
- Centers for Disease Control and Prevention (CDC)
- Indian Health Service (HIS)
- Health Resources and Services Administration (HRSA)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Agency for Healthcare Research and Quality (AHRQ)
Human Services Operating Divisions

- Centers for Medicare and Medicaid Services (CMS)
- Administration for Children and Families (ACF)
- Administration on Aging (AoA)
- U.S. Public Health Service Commissioned Corps

HHS Office of Inspector General

HHS and Congress established the HHS Office of Inspector General (OIG) in 1976 to promote efficiency and identify and eliminate waste, fraud and abuse in the Department’s operations. The OIG addresses these issues through nationwide audits, investigations and inspections. Part of reducing fraud includes investigating violations of the Medicare and Medicaid anti-kickback statute, which penalizes anyone who knowingly and willfully solicits, receives, offers or pays anything of value as an inducement in return for referring a patient or recommending, purchasing, leasing, or ordering any facility, good or service payable under Medicare or Medicaid. This carries criminal penalties as well as exclusion from participation in the Medicare and Medicaid programs.

Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS) is a federal agency within the US Department of Health and Human Services. CMS is responsible for the implementation, oversight and/or regulation of:

- Medicare
- Medicaid
- Children’s Health Insurance Program (CHIP)
- All laboratory testing (except research) performed on humans in the United States, based on the Clinical Laboratory Improvement Amendments of 1988 (CLIA)
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

As a part of running the Medicare and Medicaid programs, CMS 1) establishes reimbursement policies; 2) assures the programs are properly run to avoid fraud and abuse; 3) conducts research on the effectiveness of methods for health care management, treatment and financing; and 4) assesses the quality of health care facilities receiving Medicare and Medicaid funds, taking appropriate actions if necessary.
CMS is comprised of six centers that support the organization’s functions:

- **The Center for Medicare**, serves as CMS’ focal point for the formulation, coordination, integration, implementation and evaluation of the national Medicare program policies and operations.

- **The Center for Consumer Information and Insurance Oversight (CCIIO)**, CCIIO oversees the implementation of many provisions of the Affordable Care Act, including provisions related to private health insurance and establishment of the new Health Insurance Marketplaces.

- **The Center for Medicaid and CHIP Services (CMCS)**, serves as CMS’ focal point for all national program policies and operations related to Medicaid, the Children’s Health Insurance Program (CHIP) and the Basic Health Program (BHP).

- **The Center for Medicare and Medicaid Innovation**, established by the Affordable Care Act, the Innovation Center supports the development and testing of innovative health care payment and service delivery models to reduce program expenditures, while preserving or enhancing the quality of care for individuals receiving Medicare, Medicaid or Children’s Health Insurance Program (CHIP) benefits.

- **The Center for Clinical Standards and Quality** provides leadership and coordination for the development and implementation of a cohesive, CMS-wide approach to measuring and promoting quality and leads CMS’ priority-setting process for clinical quality improvement. The Center coordinates quality-related activities with outside organizations, monitors the quality of Medicare, Medicaid and the Clinical Laboratory and Improvement Amendments (CLIA) and evaluates the success of interventions.

- **The Center for Program Integrity (CPI)**, serves as CMS’ focal point for all national and state-wide Medicare and Medicaid programs and CHIP integrity fraud and abuse issues; coordinating resources and best practices for overall program improvement in efforts to combat fraud, waste and abuse.

**Medicare Conditions of Participation**

Conditions of Participation (CoP) are the minimum health and safety standards that health care organizations must meet in order to be Medicare and Medicaid certified. The requirements are developed by the Centers for Medicare and Medicaid Services, and address a wide range of topics, from medical records to medications to smoke alarms and hand washing procedures. Hospitals must meet or exceed the CMS requirements to participate in Medicare and Medicaid.
Kansas Foundation for Medical Care

The Kansas Foundation for Medical Care (KFMC) is the Quality Improvement Organization (QIO) for Kansas. The QIO program was established by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 to promote the quality, medical necessity and appropriateness of services reimbursed through Medicare and Medicaid. The federal government hires QIOs to review the care provided to Medicare and Medicaid patients, who use government-approved criteria to measure whether services were used appropriately. Sometimes the care is pre-certified, and in other cases the care is reviewed after the patient is discharged. Each QIO may use a slightly different process, but all QIOs share the common goals of ensuring that:

- Government funded services are medically necessary;
- Care is provided in the appropriate clinical setting; and
- The quality of care is consistent with accepted medical standards.

Recovery Audit Contractors (RACs)

Recovery Audit Contractors (RACs) audit Medicare claims submitted by hospitals and other health care providers, working for Medicare to recover overpayments from providers. They are one of many different contractors tasked by the Centers for Medicare & Medicaid Services (CMS) to evaluate payment accuracy. RACs differ from other types of audit contractors in that they are paid a commission on each claim they deny, which has created significant burden for many hospitals and health systems across the country as they respond to large numbers of RAC record requests and fight high rates of RAC denials. According to the American Hospital Association, the volume of inappropriate RAC denials has grown to such a level that the Medicare appeals system is overloaded, causing at least a two-year delay for appeals to be heard at the Administrative Law Judge (ALJ) level.

Medicare Administrative Contractors (MACs)

The Medicare Administrative Contractor (MAC) serves as the first point of contact for the processing and payment of fee-for-service claims from hospitals, nursing facilities, physicians and practitioners. Wisconsin Physicians Service Insurance Corporation is the MAC that serves Kansas.
Federal Trade Commission and the Department of Justice

The Federal Trade Commission Act of 1914 created the Federal Trade Commission (FTC), an independent administrative agency with the power to study, issue findings and judicially enforce findings regarding “unfair methods of competition” and “unfair or deceptive acts.” The FTC and the US Department of Justice (DOJ) enforce the Sherman Antitrust Act of 1890 and the Clayton Act of 1914 (a supplement to the Sherman Act), which carry both civil and criminal penalties.

Antitrust litigation and enforcement in the health care field was minimal or nonexistent prior to 1975. It has emerged as a major legal issue since then, as the number of health care professionals and alternative delivery systems increased and the health care field became more complex.

The IRS Form 990

The IRS Form 990 is comprised of a Core Form and multiple schedules. Included in the Core Form, is a section entitled “Governance Management and Disclosure,” which is comprised of three sub-parts: A) Governing Body and Management, B) Policies, and C) Disclosures. These sections inquire about the governing structure, board member independence, board management and oversight practices, existence of specific policies, and public disclosure of certain governing documents.

Schedule H of the Form 990 is specifically for not-for-profit hospitals and is comprised of five parts: Part I) Financial Assistance and Certain Other Community Benefits at Cost; Part II) Community Building Activities; Part III) Bad Debt, Medicare and Collection Practices; Part IV) Management Companies and Joint Ventures; and Part V) Facility Information. Among its many questions, the Form 990 asks whether a copy of the form was provided to the governing board prior to being filed with the IRS.

Following evidence of abuse in the for-profit sector and enactment of the Sarbanes-Oxley Act, the IRS and others believe increased transparency and disclosure via the Form 990 will result in better, more accountable governance and better insight and perspective into the tax-exempt sector. The IRS aligns effective governance practices and organizational oversight with a greater likelihood of sound fiscal management and tax compliance.

Community Health Needs Assessments

The Patient Protection and Affordable Care Act (ACA) requires not-for-profit hospitals to conduct a community health needs assessment every three years. The assessment must take into account input from persons representing the broad interests of the community, including those with special knowledge or expertise in public health, and be made widely available to the public. Hospitals are required to submit their community health needs assessment information with their Form 990, including a description of how they are addressing the needs identified in the community health needs assessment, a description
of any needs not being addressed, and the reasons why those needs are not being addressed. Hospitals that do not fulfill the requirement may incur a $50,000 excise tax. Hospital leadership should expect the IRS and lawmakers to use this information as they determine the need for future laws and regulations governing community benefit and tax-exemption.

State

Kansas Department of Health and Environment

The Kansas Department of Health and Environment (KDHE) was established in 1974 to replace the Kansas State Board of Health, established in 1885. The Department consists of four primary areas:

- The Division of Public Health;
- The Division of Environment;
- The Division of Health Care Finance; and
- Health and Environmental Laboratories.

The Division of Health primarily focuses on public health monitoring and education; licensing, registration and credentialing; disease reporting; emergency readiness; and managing local county health departments.

Kansas Board of Healing Arts

The Kansas Board of Healing Arts is the regulatory agency for licensed health care professionals in Kansas.

Kansas Board of Nursing

The Kansas Board of Nursing ensures that all persons and entities conducting business relating to the practice of nursing in Kansas are properly licensed and registered.

Kansas Board of Pharmacy

The Kansas Board of Pharmacy ensures that all persons and entities conducting business relating to the practice of pharmacy in this state are properly licensed and registered.
Other

The Joint Commission

The Joint Commission is an independent, not-for-profit organization that serves as the nation’s predominant standards-setting and accrediting body for health care organizations. The standards established by The Joint Commission are for each component of the health care organization. The hospital standards are categorized into patient-focused functions, organization functions and structural functions. Examples of patient-focused functions are patient rights, organization ethics, patient and family education and assessment of patients. Organization functions include: infection prevention and control, management of human resources, improving organization performance and safety. Structural functions address governance, management/administration, medical staff and nursing. The emphasis is placed on meeting the standards through performance and continuing to improve performance.

The Joint Commission requires each accredited hospital to provide evidence of planning for performance improvement. The purposes of planning are to describe the hospitals’ approach to improving performance and ensure that the efforts are systematic and involve all applicable departments and disciplines.

While trustees do not necessarily have to know each area in detail, they should make sure that the CEO has pertinent review activities taking place on a scheduled basis, that significant results are reported and that needed follow-up is occurring.

Healthcare Facilities Accreditation Program (HFAP)

HFAP is a nationally recognized health care facility accreditation organization, with deeming authority from the Centers for Medicare and Medicaid Services (CMS). HFAP meets or exceeds the standards required by CMS to provide accreditation to all hospitals, ambulatory care/surgical facilities, mental health facilities, physical rehabilitation facilities, clinical laboratories, and critical access. HFAP also provides certification to primary stroke centers.

DNV Healthcare

DNV Healthcare is a wholly owned subsidiary of Det Norske Veritas, a global organization with 8600 employees operating in over 100 countries. DNV Healthcare Inc. is a provider of hospital accreditation, infection risk management and standards development. The Centers for Medicare and Medicaid Services (CMS) approved the DNV program in 2008 to accredit acute care hospitals in the United States and since then has also been granted CMS deeming authority for critical access hospitals. DNV has also developed quality-based certifications for medical specialty areas such as Primary Stroke Centers.
Other Regulatory Bodies with Oversight over Health Care Organizations

Several other regulatory bodies also have varying levels of oversight of health care organizations:

- Drug Enforcement Administration (DEA)
- Organ Procurement Organizations (OPOs)
- Securities and Exchange Commission (SEC)
- Internal Revenue Service (IRS)
- Environmental Protection Agency (EPA)
- Federal Trade Commission (FTC)
- Federal Commerce Commission (FCC)
- Health Resources and Services Administration (HRSA)
- National Institute for Occupational Safety and Health (NIOSH)
- Nuclear Regulatory Commission (NRC)
- Department of Labor (DOL)
- Federal Bureau of Investigation (FBI)
- Occupational Safety and Health Administration (OSHA)
- Department of Transportation (DOT)
- Food and Drug Administration (FDA)

Reimbursement Basics

Hospitals and health systems are reimbursed for services provided through four primary methods:

- Medicare, the federal insurance for individuals over age 65 or with disabilities.
- Medicaid, the state insurance program for low-income individuals.
- Insurance companies.
- Self-pay patients.
Medicare

Medicare is a health insurance program for people 65 years of age and older, some people with disabilities under age 65, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant). Medicare has four parts; Part A, Part B, Part C and Part D. Part A is hospital insurance; most Medicare recipients do not have to pay for this part. It helps pay for care in hospitals as an inpatient, critical access hospitals, skilled nursing facilities, hospice care, and some home health care. Part B is medical insurance; most people pay monthly for this part. It helps cover doctors’ services, outpatient hospital care, and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health care. Part C is the Medicare Managed Care program for HMOs and the Medicare Advantage PPOs. Part D is the Prescription Drug Program for seniors. Hospitals must accept the payment from Medicare and may not bill the patient for the difference other than the patient’s deductible and co-insurance.

Medicaid

Medicaid is a state administered health insurance program available to certain low-income individuals and families who fit an eligibility group that is recognized by federal and state law. Each state has its own guidelines regarding eligibility and services. In Kansas, our Medicaid program is called KanCare. It is operated by three health plans, or managed care organizations (MCOs): Amerigroup of Kansas, Sunflower State Health Plan and United Healthcare Community Plan of Kansas. Specific requirements often include age, whether the recipient is pregnant, disabled, blind, or aged, whether he/she is a U.S. citizen or a lawfully admitted immigrant. The rules for counting income and resources vary from state to state and from group to group.

In large part due to state and federal budget limitations and deficits, adequate, stable and predictable financing is one of the most critical issues facing health care organizations today. According to data collected by the American Hospital Association, the majority of hospitals lose money on both Medicare and Medicaid patients. This issue is compounded for hospitals - while they are struggling with Medicare and Medicaid reimbursement, demographic changes are resulting in a significant growth in enrollment in both programs.

Insurance Companies

Insurance companies are regulated in Kansas by the Kansas Insurance Department under the direction of the Kansas Insurance Commissioner. Hospitals have an opportunity to negotiate individually and accept payment directly from individual insurance companies. For certain managed care insurance plans, which require contract agreements, hospitals may be subject to reduced reimbursement if they are not part of the managed care network.
**Self-Pay Patients**

Patients that are not covered by either Medicare or Medicaid or by an insurance company are generally classified as “self-pay.” Self-pay patients are subject to the hospital’s usual and customary charges from the services they receive. Oftentimes these individuals lack sufficient financial means to pay for the services received. The Affordable Care Act (ACA) requires not-for-profit hospitals to publicize their financial assistance policy, which must specify eligibility criteria. The ACA also prohibits hospitals from charging patients who are eligible for financial assistance more than they charge patients with insurance. The Act further prohibits not-for-profit hospitals from engaging in “extraordinary collection practices” until making an effort to determine if a patient is eligible for financial assistance.

**Health Insurance Exchanges**

One of the key provisions of the ACA is the establishment of health insurance exchanges. The exchanges are marketplaces where individuals or small businesses can buy health insurance coverage. States have had the choice to develop state-based exchanges, a federally supported state based exchange, a state partnership exchange, or a federally facilitated exchange. Kansas has a federally-facilitated exchange, meaning the federal Department of Health and Human Services (HHS) operates all functions of the exchange and consumers shop for and purchase coverage online at www.healthcare.gov. The exchanges, or marketplaces, opened Jan. 1, 2014.

Definitions of health insurance exchanges:

- **State-Based Marketplace.** States running a State-Based Marketplace are responsible for performing all Marketplace functions. Consumers in these states apply for and enroll in coverage through Marketplace websites established and maintained by the states.

- **Federally-Supported State-Based Marketplace.** States with this type of Marketplace are considered to have a State-Based Marketplace, and are responsible for performing all Marketplace functions, except that the state will rely on the Federally-facilitated Marketplace IT platform. Consumers in these states apply for and enroll in coverage through healthcare.gov.

- **State-Partnership Marketplace.** States entering into a Partnership Marketplace may administer in-person consumer assistance functions and HHS will perform the remaining Marketplace functions. Consumers in states with a Partnership Marketplace apply for and enroll in coverage through healthcare.gov.
- **Federally-Facilitated Marketplace.** In a Federally-facilitated Marketplace, HHS performs all Marketplace functions. Consumers in states with a Federally-facilitated Marketplace apply for and enroll in coverage through healthcare.gov.

**New Payment Structures from the Affordable Care Act**

One of the primary objectives of the ACA’s new payment methodologies is to shift the nation’s health care delivery system from one that is paid based on volume (the services received are paid for as they are provided, commonly referred to as “fee-for-service”) to a payment system based on value (payment for high quality, cost-effective care). Accountable Care Organizations (ACOs), bundled payments, readmission penalties, and value-based purchasing (VBP) are among the payment methodologies being implemented under the ACA to encourage the shift toward payment based on value.

**Accountable Care Organizations**

An ACO is a group of providers and suppliers who agree to be accountable for achieving three aims:

- Better care for individuals;
- Better health for populations; and
- Lower growth in health care spending.

If successful in achieving pre-determined quality thresholds and benchmark savings, the ACO will be eligible for a share of the cost-savings. ACOs also must be willing to assume risk for potential losses.

**Bundled Payments**

The “Bundled Payments for Care Improvement Initiative” was rolled out by CMS under the requirements of the ACA. Designed to improve quality and control costs, a bundled payment is one single payment for multiple services received by a patient from one or more providers during an “episode of care.”

Organized systems of hospitals, physicians and other providers participating in a bundled payment program agree contractually to work together to coordinate the patient’s care. They also agree on how the single payment – and financial risk – will be shared. Designed to align the financial incentives of all providers, the initiative includes four different models of bundled payments. The four models differ by the type of health care providers involved and the services covered in the bundled payment for that model.
Health Care Acquired Conditions (HACs)

The Deficit Reduction Act of 2005 required payment adjustments to be implemented for certain health care acquired conditions (HACs). For discharges beginning on or after Oct. 1, 2008, CMS stopped paying for certain HACs. To identify applicable conditions, hospitals are required to report “present on admission” (POA) information on diagnoses for discharges. Under the new rule, hospitals do not receive the higher payment for cases when a HAC is acquired during hospitalization (meaning it was not present on admission). Hospitals are paid if the secondary diagnosis is not present. Hospitals’ HAC performance is published on the Hospital Compare website.

CMS also issued the final rules implementing non-payment to Medicaid programs for hospital-acquired conditions. The implementation essentially extends Medicare HAC provisions to Medicaid programs. The rule is broader than Medicare, however. States may add other conditions for non-payment, as long as implementation doesn’t result in a loss of access to care or services for Medicaid beneficiaries.

Readmission Penalties

Beginning in FY 2013, CMS reduced its payments to hospitals with “high rates” of readmissions in an effort to improve quality and reduce costs. Whether a hospital’s payment is cut depends on how well the hospital controls its preventable readmissions. This is defined as a patient’s return to an acute care hospital within 30 days after discharge to a non-acute setting (home, skilled nursing, rehabilitation, etc.). CMS’ methodology takes into account planned readmissions for applicable measures. The reduction, which applies across all discharges, is limited to three percent. Readmissions are counted following discharge for five conditions:

- Acute myocardial infarction (AMI) (heart attack);
- Heart failure;
- Pneumonia;
- Chronic obstructive pulmonary disorder (COPD); and
- Hip and knee arthroplasty.

CMS plans to add coronary artery bypass graft (CABG) surgical procedures to the list of conditions in FY2017.

Value-Based Purchasing (VBP)

Value-Based Purchasing (VBP) is payment for actual performance vs. payment for just reporting hospital performance. With reporting, the Medicare payment is the same whether the hospital’s performance is good or bad. Under VBP, CMS will keep between one and two
percent of hospitals’ payments – and hospitals will have a chance to earn back the withheld depending on the quality of their care.

CMS began withholding a percentage of Inpatient Prospective Payment System (IPPS) hospital operating payments in FY 2013 at one percent, increasing the amount 0.25 percent annually up to two percent in 2017. It’s estimated the 1.5 percent withhold for FY 2015 represents $1.4 billion. Hospitals have a chance to earn back some or all of this withhold, either by achieving high-level quality scores on specified measures or, if a hospital’s performance is not at achievement levels yet, by improving its quality performance.
Leadership Role Overview

CEO/Executive Staff

The [Hospital Name] board/CEO relationship is a trusting partnership in which both trustees and the CEO understand their respective roles and work together as a team to achieve the highest level of organizational success. The relationship is built upon a collective understanding of one another’s needs, clear communication, shared goals and objectives, structured meetings and a constant sharing of information.

Specific responsibilities of the [Hospital Name] CEO and administrative team include:

- Providing input to the long-term strategic plan.
- Establishing and carrying out the details of implementing both short-term and long-term plans.
- Making all management decisions and developing policies and procedures for day-to-day operations.
- Preparing budgets, assumptions and targets to present to the board for approval.
- Preparing requests and information to present to the board for capital purchases and decisions about the hospital’s facility, renovation, leasing and expansion.
- Following board policies regarding supply purchases and repairs.
- Developing a fee schedule and proposing billing, credit and collections policies for the board to approve, and implementing the policies after they are approved.
- Hiring, assigning responsibilities, determining responsibilities, training, evaluating and terminating staff.
- Recommending personnel policies to the board, negotiating labor contracts and implementing and evaluating employee satisfaction surveys.
- Preparing regular updates about strategic progress for the board.
- Overseeing medical staff affairs and policies.
- Establishing and implementing quality improvement initiatives.
- Establishing a corporate compliance plan.
- Knowledge of current issues and development of legislative/political action plan.
• Providing communication and transparency to the community.
• Establishing a plan and priorities to address the community’s health needs.
• **Educate board on issues at the State or National level that could affect the operations of the hospital and/or the delivery of care to the patients you serve.**
• [Other may be added here.]

**Medical Staff**

[Insert information about the medical staff: how it is comprised, number of physicians by specialty, and how medical staff development (physician needs assessment and recruitment) is undertaken.]

Hospital leadership is a collaborative effort between the medical staff, administration and the board of trustees. The [Hospital Name] medical staff participates meaningfully in hospital governance, serves on committees and actively contributes to strategic direction and decisions.

**System Affiliations**

[Describe any hospital system or network relationships your hospital has with other organizations.]
Governance Operations

Fiduciary Duties

**Duty of Care** requires that trustees apprise themselves of all reasonably available information before taking action; and then, having been so informed, to act with attentiveness and care appropriate under the circumstances in the discharge of their duties.

**Duty of Loyalty** requires trustees to discharge their duties unselfishly, in a manner designed to benefit only the hospital/community and not the trustees personally. It incorporates a duty to disclose situations which may present a potential for conflict with the hospital’s mission, as well as a duty to avoid competition with, and appropriation of the assets of, the hospital.

**Duty of Obedience** requires that trustees be faithful to the underlying charitable purposes and goals of the hospital they serve, as set forth in the hospital’s governing documents. It presumes that the mission of the hospital, and the means to achieve it, are inseparable.

Fulfilling the fiduciary responsibilities includes the following:

- Maintaining the confidentiality of board meetings and executive sessions.
- Preparing for each board meeting by studying the agenda and supporting information.
- Attending the entire board meeting(s). If unable to attend, trustees should notify [name, title, contact information] as far in advance as possible.
- Participating in board meetings and voicing opinions.
- Carrying out committee and board assignments.
- Publicly supporting board actions, even if the trustee may not agree with the decision.
- Having some knowledge about hospital and health care challenges and issues.
- Attending continuing education programs.
- Acting as a trustee for the assets and investments of the hospital for the residents of the service area.
- Selecting, advising, supporting, evaluating and appropriately compensating the CEO.
- Granting physicians staff privileges and ensuring that quality medical care is provided.
• Providing broad direction for the affairs of the hospital and ensuring the development and growth of the institution’s services.
• Participating in and promoting board education and self-evaluation.
• Promoting and maintaining positive external relationships with the community, local business, government, funding sources and other health-related organizations.
• Promoting and maintaining positive external relationships with the medical staff.
• Creating an environment for assessing, maintaining and improving the quality of care provided.
• Ensuring that the hospital complies with and meets regulatory, legal and accreditation standards and requirements.
• [Other may be added here.]

**Basic Board Roles**

Management is responsible for the day-to-day tasks of running the hospital. The board delegates the day-to-day management to the [your hospital’s CEO/administrator]. The [your hospital’s CEO/administrator] and the senior management team is guided, but not directed, by the governing board. They lead the hospital’s staff to carry out the mission and vision that has been developed and approved by the governing board.

The roles and responsibilities of the governing board involves everything from ensuring the cost-effective utilization of resources to determining the hospital’s mission, and establishing a long-range strategic plan to help attain that mission. The board has primary responsibility in six key areas:

• Ensuring the achievement of the hospital’s mission, vision and strategic direction.
• Ensuring quality and patient safety.
• Building strong board/CEO relationships.
• Providing informed and effective financial leadership and oversight.
• Advocating for the hospital’s interests, and building strong community relations.
• Medical staff credentialing.
Trustee Job Description

Major Responsibilities

[Hospital Name] trustees are responsible for overseeing the progress and success of [Hospital Name]. The board of trustees must ensure that [Hospital Name] achieves its mission, vision and values. The board also assists in the development and approval of [Hospital Name]’s strategic plan, evaluation of the plan’s implementation, and taking corrective action when necessary. [Hospital Name]’s board of trustees is responsible for hiring, determining the compensation of and evaluating the CEO. The board of trustees assumes ultimate responsibility for the quality of care and patient safety provided by the hospital, and is accountable for the financial soundness and success of [Hospital Name]. Key duties include:

- Identifying important community constituencies, and designing a plan for trustee involvement that advances the hospital’s image, reputation and market awareness levels; include resource requirements, objectives and projected outcomes.

- Ensuring that the board has a clear and consensus-driven understanding of the most important community health needs and issues.

- Defining and measuring improvement in the community’s health.

- Regularly measuring the public’s perceptions of the hospital’s programs and services, community contribution, perceived trust, economic impact and overall value as a community health asset.

- Working with others in the community to develop collaborative partnerships in building a healthier community.

- Establishing a process for eliciting community input and viewpoints about the value and appropriateness of current services, and future service needs and opportunities; solicit community ideas for ways the hospital can best achieve its mission and vision.

- Relating with other community service organizations, schools and social agencies.

- Developing opportunities for trustees to interact with the public on local health care issues, and demonstrate strong, competent leadership, serving as well-informed “ambassadors” or spokespersons on behalf of the hospital.

- Developing a strategy to ensure that the hospital’s objectives, priorities and challenges are successfully shared with the community, engaging leaders and residents and building community advocates.
• Being well educated on public policy, the board’s role in providing healthy community leadership, and other health care advocacy issues that are critical to hospital success; engaging trustees in a focused advocacy plan of action, when required.

• Acting as a liaison with the institution’s local, state and federal government representatives and agencies.

• Ensuring that patient satisfaction assessments are performed continuously, and that improvement objectives are defined, measured and reported.

• [Other may be added here.]

Trustee Success Factors

The successful [Hospital Name] trustee has strong interpersonal skills, and is comfortable interacting with other board members, the CEO, medical staff leaders and the hospital’s executive team. Trustees must commit the time necessary for successful board service, and have a willingness and a desire to learn and understand the complexities of the health care environment and the challenges of meeting [Hospital Name]’s patient and community needs. The ability to constructively challenge the status quo, understand and evaluate financial information and collaborate with a broad range of diverse stakeholder groups is key to the success of our trustees. It is vital that trustees understand and follow their fiduciary obligations to the organization, and not serve any individual constituency or group.

Necessary Personal Skills and Assets

Successful [Hospital Name] trustees build positive relationships with other board members, the hospital’s executive team, medical staff leaders and the organization’s other key stakeholders. Adaptability, flexibility, organization, initiative, leadership and analytical skills are key qualities which enable our trustees to be successful. Other important personal assets include sound, independent judgments and decisions; the ability to analyze complex issues and develop effective solutions; and the ability to create a vision for the future, given the many uncertainties prevalent in today’s health care environment. Trustees should have a basic general understanding of the health care field, be committed to preparing for active insightful involvement in board and committee meetings, and be able to read, understand, and apply industry information and financial acumen to strategic decisions. Strong communication skills are essential. Trustees must be deeply committed to the hospital and the community we serve, and have no irresolvable conflicts of interest with [Hospital Name]’s operations or key stakeholders. When conflicts of interest do arise, trustees must abstain from discussions and votes surrounding the issue.
Board Member Selection

Properly identifying, assessing and successfully recruiting new trustees is one of the board’s most important functions. Our board begins by conducting a comprehensive governance self-assessment to determine where we may have potential leadership “gaps,” either now or in the future. After identifying specific characteristics and skills sets desired, the board talks with a variety of candidates who may meet our board service requirements. Once specific desired skills and characteristics have been identified, the board recruits individuals that meet these specifications.

Several approaches are used to find candidates, including:

- Maintaining a list of potential board candidates, including the specific skills they can bring to the organization.
- Assessing the leadership potential of individuals who already volunteer for the hospital in other capacities, such as serving on the hospital’s foundation, or participating in ad hoc committees and task forces.
- Seeking out individuals who have a record of successful governing service on other boards, and who have the potential to bring credibility, expertise and community connections to board work.
- Asking the CEO and former board members to suggest replacements for outgoing members.
- Contacting successful former board members who were highly regarded for their leadership skills, and ask if they would be willing to serve again. These individuals are often a deep well of information and perspective.
- Considering expanding the “network” of potential candidates, perhaps looking outside the immediate community for qualified trustees.

Once a potential trustee (or trustees) has been identified, several additional steps are taken before extending an offer to serve on the board:

- Double-check for potential conflicts-of-interest.
- Invite the prospective board member to meet with the board chair and the CEO for a detailed overview of the organization as well as relevant organizational materials, a board member job description, etc.
- Provide the candidate with the names and contact information for board members he or she may contact with questions.
- Invite the prospective new member to observe a board meeting, and follow up with the
candidate after the meeting to discuss his or her continuing interest.

**Board Committees**

Our board consists of [#] committees. Below is a description of each, with its primary
responsibilities.

[NOTE: Eliminate the committees your hospital board does not have and modify the duties of
each committee accordingly. Not all committees are required. Depending on size and need,
hospitals may utilize a "committee of the whole" approach to governance.]

**Executive Committee**

The Executive Committee is comprised of [#] members and meets [frequency with which it
meets]. The committee is charged with the following responsibilities:

- Provides advice and counsel to the CEO related to major organizational development
  issues.

- Acts on the board’s behalf when necessary, while keeping the board fully informed of all
deliberations and decisions that have been made.

**Strategic Planning Committee**

The Strategic Planning Committee is comprised of [#] members and meets [frequency with which it
meets]. The committee is charged with the following responsibilities:

- Provides a written “plan for planning” that describes how strategic planning will occur
  within the hospital, including how key stakeholders at various levels within the hospital
  will be engaged throughout the process.

- Ensures ongoing review and updates of the hospital’s mission and vision statements.

- Receives and reviews an environmental assessment from administration annually, and
  using the assessment to provide advice related to the modification or development of
goals and strategies.

- Provides a final review and refinement of the strategic plan, ensuring its support of
  achieving the vision and long-term success of the hospital.

- Ensures that a comprehensive strategic planning process is implemented for the hospital
  every three to five years.
• Reviews and comments on business plans for specific actions identified within the strategic plan, such as discontinuing major services.

• Monitors the ongoing implementation of the strategic plan and recommends modifications to the plan when it considers appropriate.

• Ensures that the strategic planning process involves and communicates with all key stakeholders, including the medical staff, to develop adequate understanding and support for strategic directions.

**Finance Committee**

The Finance Committee is comprised of [#] members and meets [frequency with which it meets]. The committee is charged with the following responsibilities:

• Reviews and refines the annual operating and capital development budget prepared by management.

• Presents reviewed budgets to the entire board for approval.

• Monitors the implementation of major initiatives that impact strategic and financial objectives, making appropriate recommendations to the board on an as-needed basis.

• Reviews monthly financial statements.

• Recommends hospital investment policies and monitors the hospital’s investments.

• Recommends an auditing firm to the board to audit the hospital’s records every five years.

**Nominating / Governance / Board Compliance Committee**

The Nominating / Governance / Board Compliance Committee is comprised of [#] members and meets [frequency with which it meets]. The committee is charged with the following responsibilities:

• Develops and implements policies and procedures to ensure that the board will be appropriately organized to meet fiduciary obligations.

• Establishes codes of ethics and conduct for board members, management and employees of the hospital, periodically reviewing the codes and recommending proposed changes to the board for approval.

• Monitors compliance with codes of ethics.

• Identify and brings to the attention of the board and management current and emerging governance issues, trends and best practices that may affect business operations, performance or the public image of the hospital.
Ensures that the board and individual committees develop written objectives annually.

Reviews and makes recommendations to the board regarding the nature and duties of the board committees, including evaluation of their charters, duties and powers and criteria for membership.

Makes recommendations regarding appointments to board committees and the election of committee chairs, including rotation, reassignment or removal of any committee member.

Develops and implements a formal trustee orientation plan.

Develops and implements ongoing education for all board members to further enhance their knowledge and skill related to effective governance.

Conducts an annual self-assessment of the board and its committees, and discusses outcomes with the board.

Uses the self-assessment results to create an action plan designed to support ongoing development of the board.

Conducts a self-evaluation of individual board members annually.

Reviews individual board members’ performance on an annual basis in relationship to board-approved performance standards.

Develops criteria for selection of new board members and committee members, such as independence/lack of conflict-of-interest, personal experience in the context of the needs of the board, diversity and age.

Annually reviews the board member and committee selection criteria with the board.

Ensures that there is appropriate succession planning related to filling the officer positions within the board.

Nominates board members for each committee.

Identifies individuals qualified to become board members, developing a pool of potential future board members that can strengthen the board’s ability to govern effectively.

Nominates individuals for appointment to the board as current terms expire.

Considers the qualifications of all individuals properly recommended for election to the board.

**Physician Advisory Committee**

The Physician Advisory Committee is comprised of [#] members and meets [frequency with which it meets]. The committee is charged with the following responsibilities:
Ensures physician leadership and support for achieving the mission and vision.
Ensures a broad base of physician input into the definition of clinical priorities and in the ongoing planning of clinical services within the hospital.
Ensures opportunities for developing a more collaborative relationship between and among physicians affiliated with the hospital.
Ensures opportunities for developing a more collaborative relationship between the board and medical staff.
Oversees the development and implementation of an appropriate medical staff development plan.
Provides advice and counsel related to economic partnerships between the hospital and physicians.
Recommends approaches for education that would help physicians and the hospital’s leadership to develop a shared understanding of challenges presented by changes occurring within the local and regional health care environment.
Recommends approaches to addressing the concerns of specific groups of physicians, when differences develop and conflicts need to be resolved.

**Quality Committee**

The Quality Committee is comprised of [#] members and meets [frequency with which it meets]. The committee is charged with the following responsibilities:

- Oversees the development, implementation and reporting of a hospital-wide program that measures quality, risk management and clinical resource utilization.
- Reviews results of regulatory and accrediting body review of the hospital’s performance.
- Monitors the performance of all hospital programs in developing and implementing quality improvement programs.
- Reviews quality and patient safety indicators.
- Reviews and makes recommendations related to policies and procedures that enable the medical staff to process applications and re-appointments and the granting of clinical privileges in a timely and appropriate manner.
- Reviews medical staff success in carrying out its responsibilities for evaluating and improving the delivery of medical care.
- Periodically reviews trend reports that reflect the overall performance of the hospital in providing quality care in a customer-focused, cost-effective manner.
Compensation Committee

The Compensation Committee is comprised of [#] members and meets [frequency with which it meets]. The committee is charged with the following responsibilities:

- Annually reviews and approves the hospital’s goals and objectives relevant to the compensation of the CEO.
- Evaluates the CEO’s performance at least one a year in light of the established performance goals and objectives, using the evaluation to set the CEO’s annual compensation, including salary, bonus, incentive and equity compensation.
- Annually reviews and approves the evaluation process and compensation structure for all the hospital’s officers.
- Annually evaluates the performance of the hospital’s executive officers, and approves the annual compensation, including salary, bonus, incentive and equity compensation.
- Provides oversight of management’s decisions concerning the performance and compensation of hospital officers other than the CEO and executive officers.
- Approves any employment agreements for the hospital’s CEO and other executive officers.
- Approves the terms of any consulting or severance agreements with current or former executive officers or trustees of the hospital.
- Members are free from relationships that would interfere with the exercise of their independent judgment as a member of the committee.
- Ensures that the CEO’s performance evaluation is based on pre-determined and clearly communicated performance criteria.
- Recommends the CEO’s annual compensation package.
- Ensures that the CEO’s compensation package is tied to performance and is comparable to CEO salaries of health care organizations similar in size and scope.
- Develops a plan for the succession of the hospital’s CEO and key members of senior management, including requirements for qualifications, character, skills and availability of potential successors based on the hospital’s needs.

Physician Transactions Committee

The Physician Transactions Committee is comprised of [#] members and meets [frequency with which it meets]. The committee is responsible for reviewing financial transactions with physicians to ensure compliance with applicable laws.
Audit Committee

The Audit Committee is comprised of [#] members and meets [frequency with which it meets]. The committee is charged with the following responsibilities:

- Encourages continuous improvement of, and fosters adherence to, the hospital’s finance, accounting and legal policies, procedures and practices at all levels.

- Assists the board of trustees in fulfilling its oversight responsibilities with respect to the integrity of the financial reports and other financial information provided by the hospital to any governmental body or the public.

- Assists the board of trustees in fulfilling its oversight responsibilities with respect to the hospital’s compliance with legal and regulatory requirements.

- Assists the board of trustees in fulfilling its oversight responsibilities with respect to the independent auditors’ qualifications and independence.

- Assists the board of trustees in fulfilling its oversight responsibilities with respect to the performance of the hospital’s systems of internal controls regarding finance, accounting and legal compliance and independent auditors.

- Assists the board of trustees in fulfilling its oversight responsibilities with respect to the performance of the hospital’s auditing, accounting and financial reporting processes.

Audit Committee Membership Composition

- Is financially literate and possess a general understanding of basic finance and accounting practices.

- Maintains at least one member that is determined to be an “audit committee financial expert,” possessing accounting or related financial management expertise.

Audit Committee’s Review and Discussions with Management and Auditors

- Discusses with management, independent auditors and internal auditors the critical accounting policies, the auditors’ judgments of the quality and appropriateness of accounting policies and financial disclosure practices of the hospital.

- Discusses with management, independent auditors and internal auditors any disagreements with management over the application of accounting principles.

- Discusses with management, independent auditors and internal auditors accounting policies applied, especially significant estimates made by management or significant changes in accounting methods.
Discusses with management, independent auditors and internal auditors significant transactions or courses of dealing with parties related to the hospital which are relevant to an understanding of the hospital’s financial condition or results of operation.

Discusses with management, independent auditors and internal auditors significant audit adjustments.

Discusses with management, independent auditors and internal auditors any difficulties encountered during the audit, including any restrictions on the scope of work or access to required information.

Discusses with management, independent auditors and internal auditors any material financial or non-financial arrangements of the hospital which do not appear on the financial statements of the hospital.

Discusses with management, independent auditors and internal auditors the hospital’s internal controls regarding finance, accounting and legal compliance.

Discusses with management, independent auditors and internal auditors any other matters related to the conduct of the audit required to be communicated to the Audit Committee by the independent auditors or that any member of the Audit Committee desires to review or discuss.

Audit Committee’s Independent Auditors' Report

- Annually receives and reviews a report from the independent auditors.
- Ensures that the annual auditors’ report reviews all accounting policies and practices used by the hospital.
- Ensures that the annual auditors’ report includes all alternative accounting treatments of financial information within generally accepted accounting principles (GAAP) related to material items that have been discussed with management, including the ramifications of the use of such alternative treatments and disclosures and the treatment preferred by the accounting firm.
- Ensures that the annual auditors’ report includes other material written communication between the accounting firm and management.

Audit Committee’s Selection and Roles of Independent Auditors

- Selects, engages and fixes the compensation and other terms of engagement for the independent auditors.
- Ensures the independence and effectiveness of the independent auditors, including internal quality control procedures, any material issues or concerns raised by internal quality control review, peer review, or any inquiry or investigation by governmental or professional authorities in the previous five years, and relationships between the independent auditors and the hospital.

- Evaluates the independent auditors’ qualifications and performance, including review of the lead partner and reviewing the partner of the independent auditors.

- Ensures regular rotation of the lead audit partner.

- Considers the periodic rotation of the independent auditors, if necessary.

- Considers if the proposed provision of any non-audit services by the independent auditors is compatible with maintaining the auditors’ independence.

- Reviews and discusses with the independent auditors and the trustee of internal audit the audit plan and the procedures to be followed, including the scope and timing of the audit, staffing, locations, foreseeable issues, priorities, the coordination between the independent auditors and the trustee of internal audit in executing the audit plan and, after completion of the annual audit, the results of the annual audit examination and the accompanying management letters, and any reports of the independent auditors with respect to the interim periods.

- Regularly reviews with the independent auditors any difficulties that the audit team encountered during the course of audit work, such as restrictions on the scope of the independent auditors’ activities or access to requested information, or significant disagreements with management.

- Reviews with the independent auditors any accounting adjustments that were noted or proposed by the audit team but were “passed.”

- Reviews with the independent auditors any communications between the audit team and the audit firms’ national office respecting auditing or accounting issues presented by the engagement.

- Reviews with the independent auditors any “management” or “internal control” letter issued, or proposed to be issued, by the audit firm to the hospital.

- Consults at least quarterly with the independent auditors outside the presence of management about internal controls and the completeness and accuracy of the hospital’s audited annual financial statements and quarterly financial statements.
Audit Committee’s Financial Reporting Process

- Reviews and discusses with management and the independent auditors the integrity of the hospital’s financial reporting process, both internal and external.

- Reviews and discusses with management and the independent auditors the hospital’s critical accounting policies, the auditors’ judgments about the quality of the hospital’s accounting policies, and any significant changes to the hospital’s accounting policies and practices suggested by the independent auditors and management.

- Reviews and discusses with management and the independent auditors the hospital’s disclosure controls and its internal controls and procedures for financial reporting.

Audit Committee’s Additional Audit Committee Roles

- Reviews and reassess the adequacy of its committee charter.

- Reviews and discusses with management, the hospital’s legal counsel and the board’s compliance committee pending legal proceedings or investigations, compliance issues and other contingent liabilities that could have a significant impact on the hospital’s financial statements.

- Reviews and discusses with management the hospital’s policies with respect to risk assessment and risk management, including significant financial risk exposures and the steps management has taken to monitor and control such exposure.

- Sets clear policies consistent with applicable law regarding the hiring of employees or former employees of the hospital’s independent auditors.

- Coordinates with the nominating and governance committee to establish procedures for the receipt, retention and treatment of complaints received by the hospital regarding accounting internal controls and procedures for financial reporting and auditing related matters.

- Establishes procedures for the confidential and anonymous submission by hospital employees of concerns regarding questionable accounting or auditing matters.

- Reviews and reassess the adequacy of its committee charter.

- Reviews and discusses with management, the hospital’s legal counsel and the board’s compliance committee pending legal proceedings or investigations, compliance issues and other contingent liabilities that could have a significant impact on the hospital’s financial statements.
Strategic Planning

The board governs and leads the strategic plan, it does not create or manage it.

The board has a fiduciary duty of trust to the stakeholders of the organization to ensure that the hospital is healthy, serves the interests of the stakeholders, and moves in the right future direction. The board is the driver and keeper of the [Hospital Name] mission, values, vision, goals and strategic development process, but it does not dictate the plans for delivering on those expectations.

The board of trustees is accountable to the organization’s stakeholders—patients, community members, employees, physicians, donors and others. The board serves as the stakeholders’ representatives, bearing the duty of trust, or fiduciary responsibility, to secure their interests in achieving the mission, vision and values.

Although the board is not involved in the details of the strategic plan development and implementation, it plays a pivotal role in the strategic planning process, determining the path for the [Hospital Name] future and setting a course for the organization to achieve its mission and vision.

The board bears ultimate responsibility for the design of the strategic planning process and for the organization’s success or failure. Key trustee responsibilities throughout the strategic planning process include:

- Ensuring that a productive planning process is in place.
- Aligning responsibility to successfully oversee the process.
- Making policy decisions on the strategic direction of the organization.
- Ensuring that the strategic direction is consistent with the mission and vision, and is appropriate relative to the environment.
- Reviewing and approving specific projects and actions to verify that they are consistent with and support the strategic plan.
- Monitoring the implementation of the strategic plan and how goals and objectives are being achieved.
- Modifying and updating the plan on a regular basis.

Our Strategic Plan

[Insert a brief summary of your strategic plan here]
Medical Staff Credentialing

Medical staff credentialing is one of the most important tasks our board undertakes to ensure the quality of care in our organization. Credentialing is conducted by the Medical Executive Committee (MEC). Approval of MEC recommendations is done by the board.

The overall objective of credentialing is to ensure that only qualified doctors are admitted to (and remain on) the hospital’s medical staff, and that they practice within their scope of experience and competence.

Medical staff credentialing is a two-pronged process that involves establishing requirements and evaluating individual qualifications for entry into a particular medical staff status. Credentialing first involves considering and establishing the professional training, experience, and other requirements for medical staff membership. The second aspect of credentialing involves obtaining and evaluating evidence of the qualifications of an individual applicant.

Credentialing requires primary source verification – direct contact of the sources of credentialing, such as schools, residency programs, and licensing agencies – to assure that statements of education, training, experience and other qualifications are legitimate. Primary source verification is not only important in meeting the requirements of main accreditors, such as The Joint Commission, but also critical in avoiding legal problems and ensuring quality patient care.

Another aspect of the credentialing process is privileging the medical staff applicant. Privileging is a three-pronged process that determines:

- The diagnostic and treatment procedures a hospital is equipped and staffed to support.
- The minimum training and experience necessary for a clinician to competently carry out each procedure.
- Whether the credentials of applicants meet minimum requirements and allow authorization to carry out requested procedures.

Often called “delineation of clinical privileges,” this process determines what procedures may be performed or which conditions each medical staff member may treat. Delineation of privileges is an ongoing process that must not only be flexible enough to add new procedures or conditions to treat, but also be firm, fair and consistent.

Legislative and Community Advocacy

One of the most important roles of the board is to maintain strong and vibrant community relationships that build community understanding and loyalty to the hospital. Our trustees play a vital role in securing strong public perceptions of the hospital and raising its profile as a premier
community financial, health care and social services asset.

Our community has a wide range of key constituencies or stakeholders who should be communicated with and influenced by the hospital. The board of trustees is the ideal conduit between the hospital and these community groups, which include, but are not limited to:

- Community spokespersons or health advocates.
- Purchasers of health care.
- Insurers and other payers.
- Patients and families.
- Legislative and regulatory bodies.
- The news media.
- Civic groups, agencies and organizations.
- Religious leaders.
- Business owners.
- Educational institutions.

These stakeholder groups have varied interests in the activities of the hospital, but all are dependent in one way or another on the long-term success of the hospital.

The board of trustees is accountable to the community for the quality of care provided by the hospital and the efficacy of the various services provided by the hospital. Trustees ensure that the hospital’s community service role is well-articulated in the hospital’s mission statement, and ensure strong and meaningful understanding by various community segments of the challenges facing the hospital today and the challenges it will face in the future. By building this level of awareness and understanding, the hospital will be in a better position to solidify needed community support, build strong bridges, and ensure broad based and wide-spread loyalty to the hospital as an economic engine and as a vital health care resource.

**Key Roles**

**Advocate:** Taking the hospital’s message to legislators through lobbying or delivering testimony at hearings; representing the community’s interests in board decision making.

**Educator:** Speaking on issues facing the hospital at schools or civic groups; appearing on local television or radio shows to discuss health care.

**Spokesperson:** Being a designated board contact for the news media.
**Conduit:** Participating in public forums to discuss issues facing the hospital and to learn about community opinions or health care needs.

**Ambassador:** Representing the hospital at important community social gatherings.

**Host:** Presiding over visits of legislators, senior citizens, or key business leaders to the hospital to help them learn about available services and to hear about their interests or needs.

## Conflict of Interest

To be “independent,” a trustee must disclose his or her outside relationships with the organization or management that might influence his or her ability to make decisions. Potentially conflicting relationships include indirect links through family, business or charitable organizations where an individual may hold an officer or trustee position.

By ensuring ethical, independent, and conflict of interest-free behavior, health care organizations will be able to sustain greater fiscal solvency and provide the highest quality of care to patients while simultaneously earning and reinforcing employee and community trust.

[Insert hospital conflict of interest or code of conduct policy here]

## Confidentiality

The confidentiality of governance discussions and decisions is an absolute requirement of our hospital board members. Significant damage may be done if board members reveal confidential matters with anyone outside of the board meetings.

[Insert hospital confidentiality statement here]

## Legal Protection

Trustees have protection when their duties are exercised according to the duty of care standard. That duty requires that at trustee perform their responsibilities in good faith, in a manner reasonably believed to be in the best interest of the hospital, and with the care that a prudent person would reasonably be expected to exercise in a like position and under similar circumstances. In order to meet this standard, trustees must make reasonable inquiry, demonstrate a deliberative process, and make an informed decision. Even in those instances in which a trustee has not exercise the functions of the duty of care standard, the trustee may not be held liable unless the breach of duty was the cause of the damage suffered by the hospital.
Additionally, a trustee needs to exercise such reasonable care and skill as a person of ordinary prudence would employ in dealing with personal property. This standard is known as the “prudent person” standard.

Board members can be protected from liability by 1) responsible governance; 2) indemnification; 3) directors’ and officers’ liability insurance; and 4) general hospital liability insurance. Responsible governance is the first line of defense for board members. Trustees who are knowledgeable about their legal responsibilities and mindful of their duties to the hospital are protected from liability in most cases.

Directors’ and Officers’ Liability Insurance

[Insert a summary of your hospital’s directors’ and officers liability insurance]

General and Other Liability Insurance

[Insert a summary of your hospital’s general and other liability insurance]

Board Self-Assessment

Our board of trustees’ leadership self-assessment is a quantitative and qualitative evaluation of the board’s satisfaction with all aspects of its performance in fulfilling its governance responsibilities. It combines ratings of various statements about the hospital’s governance environment, processes, focus and performance with trustee recommendations for change to improve leadership performance. Our board self-assessment process (a combination of the assessment and the action plans created from it) enables the board to identify critical “leadership gaps”, and achieve and maintain the level of governing excellence required for success in today’s challenging health care environment.

Meeting Schedules

Our board meetings are organized and focused on the important, timely, strategic planning decisions facing the organization. These meetings are designed around a carefully-crafted agenda, allowing board members to prepare ahead of time for discussions and become informed on the relevant topics.

Board meetings are [insert day, time and location of board meetings]

Committee meetings are [list committee and day, time and location of committee meetings]
Board Bylaws

[insert a copy of your board's bylaws]
Association Memberships

**Kansas Hospital Association**

KHA is a voluntary non-profit organization existing to provide leadership and services to member hospitals. KHA is the lead organization in a group of companies and affiliates that provides a wide array of services to the hospitals of Kansas and the Midwest region.

KHAs vision is “an organization of hospitals working together to improve access, quality and the affordability of health care for all Kansans. KHA Mission: To be the voice and resource for community-based hospitals by meeting member needs for advocacy and service.”

KHA membership includes 216 member facilities, of which 127 are full-service community hospitals.

**Kansas Health Education and Research Foundation**

Kansas Health Education and Research Foundation (KHERF), a not-for-profit 501(c)3 organization, was formed in 1969 whose mission is to facilitate collaboration and innovation to improve health delivery for Kansas communities.

**Kansas Health Service Corporation/KHA Workers’ Compensation Fund**

The Kansas Health Service Corporation (KHSC) is a for-profit subsidiary of the Kansas Hospital Association and provides needed products and services to KHA member hospitals. The KHA Workers’ Compensation Fund, Inc., is a taxable workers’ compensation pool operated by KHSC.

**Political Action Committee**

State and federal governments pay for well over half of Kansas hospital care and regulate 100 percent of our activities. Those are the main reasons why the work of the Kansas Hospital Association and its political action committee, KHA-PAC, is so important.

**APS**

APS (formally Associated Purchasing Services) is a for-profit group purchasing company organized in the state of Kansas. It is owned by the Kansas Hospital Association and the Missouri Hospital Association.
The Kansas Healthcare Collaborative
The Kansas Healthcare Collaborative (KHC) is a provider-led organization dedicated to transforming health care through patient-centered initiatives that improve quality, safety and value.

The Kansas City Metropolitan Healthcare Council
The Kansas City Metropolitan Healthcare Council (KCMHC) is a policy division of The Health Alliance of MidAmerica. The Council, formerly known as the Greater Kansas City Health Council, works with local hospitals on areas of collective interest.

The Health Alliance of MidAmerica
The Health Alliance of MidAmerica (The Alliance), a Delaware-limited liability company, was formed in 1999. It has two members: the Kansas Hospital Association and the Missouri Hospital Association.

American Hospital Association
The American Hospital Association (AHA) is the national organization that represents and serves all types of hospitals, health care networks, and their patients and communities. Nearly 5,000 hospitals, health care systems, networks, other providers of care and 43,000 individual members come together to form the AHA.

Through representation and advocacy activities, AHA ensures that members’ perspectives and needs are heard and addressed in national health policy development, legislative and regulatory debates, and judicial matters. Its advocacy efforts include the legislative and executive branches and include the legislative and regulatory arenas.

The vision of the AHA is “a society of healthy communities, where all individuals reach their highest potential for health.”

The mission of the AHA is “to advance the health of individuals and communities. The AHA leads, represents and serves hospitals, health systems and other related organizations that are accountable to the community and committed to health improvement.”

The KHA is independent of AHA, but works closely with AHA on federal advocacy and resources.

Other Association Affiliations
[List other associations your hospital is affiliated with, and the purpose of each]