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Best Practices for Public Hospital Governance

By Elaine Zablocki

Grady Memorial Hospital, Georgia's largest safety net hospital, faces a \$120 million shortfall and may run out of money by year's end. In June, a business-led task force called for a change in governance as a key element in keeping the hospital's doors open.

DeKalb and Fulton counties fund the Atlanta-based hospital with more than \$100 million per year, and the county commissioners appoint Grady's 10-member board. According to the *Atlanta Business Chronicle*, proponents argue a new, not-for-profit governance structure would permit an expanded board with specialized expertise in finance and information technology, and open the doors to new sources of funds. In mid-August, several hundred people turned out for a contentious debate on how to save the hospital. State Senator David Shafer announced plans to introduce the Public Hospital Accountability Act of 2008 in the General Assembly. His bill would require county hospital authorities that run hospitals above a certain bed capacity to delegate day-to-day management to a nonprofit corporation and adopt "standards of governance."

Grady's travails illustrate the special governance challenges facing public hospitals across the country. Like Grady, their appointed boards may lack the independence or expert backgrounds needed to oversee a complex healthcare organization in a highly competitive environment. Public hospitals must open their records and function under open meeting standards, while their competitors meet behind closed doors.

Public hospitals range from urban safety-net hospitals with sophisticated trauma units and burn centers, to county-owned community hospitals. While they operate on different scales and face a variety of problems, they also face common challenges.

"Their governance grows out of their public mission, and they rely on public dollars," says Larry S. Gage, president of the National Association of Public Hospitals and Health Systems in Washington, DC. "The first challenge public hospitals face is balancing the ability to function like a hospital in the hospital industry, with the need to be accountable for the use of public funds. They may operate under elaborate procurement codes and civil service rules. Often a public hospital can't make decisions in a timely fashion, or enter into joint ventures with physician groups."

Barry Bader, a governance consultant (and publisher of Great Boards) adds, "Look at many of the best practices being advised for corporate and not-for-profit boards, from competency-

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based selection to creating a culture of candor and teamwork. Every one of those practices is compromised by the constraints placed on public hospitals. It's a credit to their ingenuity and commitment that they accomplish all they do." Indeed, clever workarounds are a tool of the trade for effective public hospital CEOs and their boards. In conjunction with The Governance Institute (TGI),

Great Boards set out to discover how public hospitals are coping with potential barriers to good governance. A TGI survey conducted in July drew detailed responses from 65 out of 390 public hospitals.

The top problems? Participating hospitals report that board meetings open to the public have a chilling effect on candid discussions, that board and committee minutes can be accessed by competitors, that it's difficult to hold

board members accountable for attendance and performance when they're named by government officials, and that public hospitals face significant restrictions in accessing capital or entering into joint ventures.

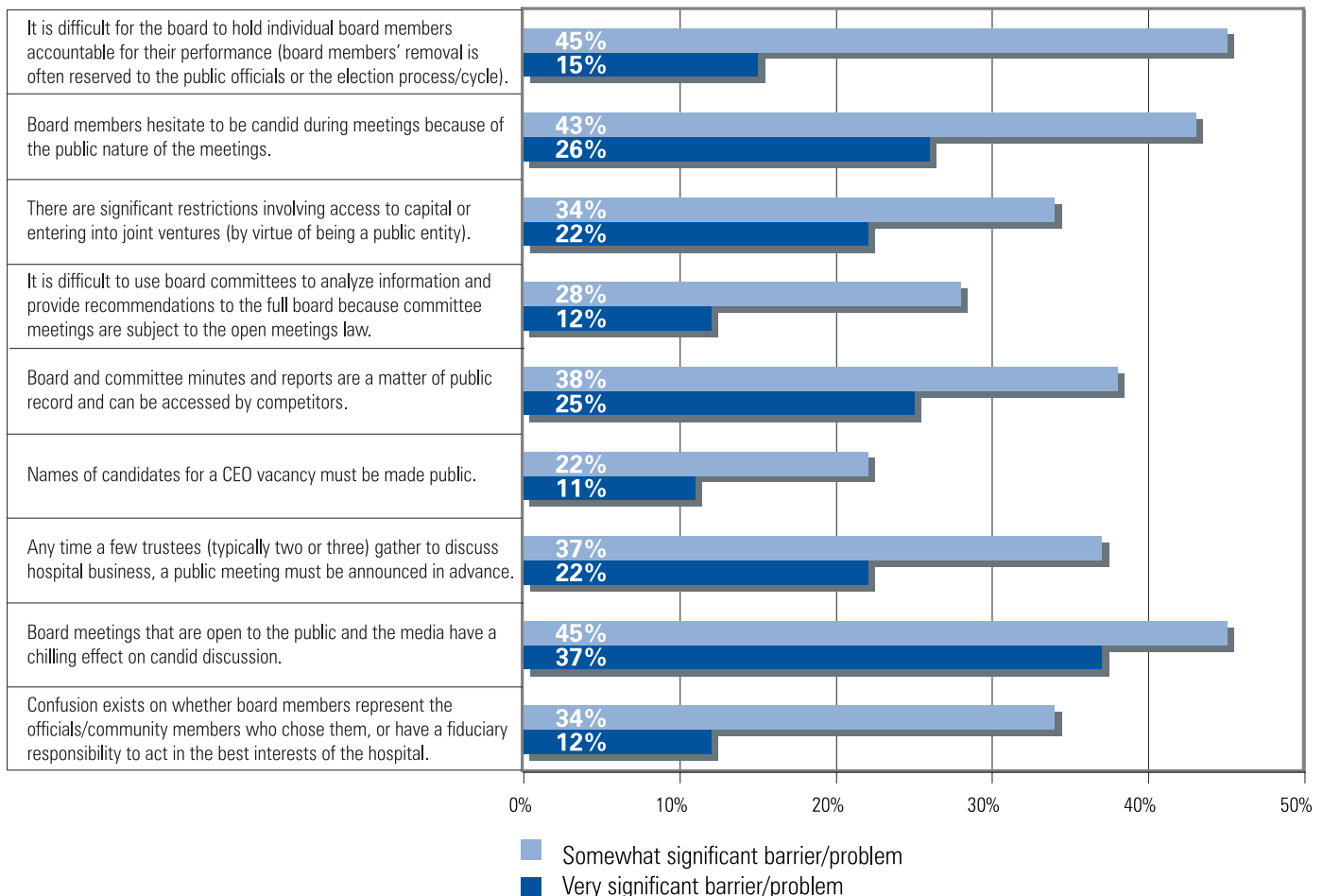
However, more than 45% of the respondent hospitals said their board had instituted policies and practices that are successfully addressing potential barriers to effective governance.

Open Meetings and Records

Virtually all public hospitals operate under state or local laws in which their meetings and their records are open to the public, including the press. The precise requirements vary considerably among the states, and a meeting may be defined as any discussion among two or three trustees. Usually

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Potential Problems and Barriers to Effective Governance of Public Hospitals



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there's an exception for certain subjects, such as confidential personnel and credentialing matters, and for discussions with the hospital's attorney. Some state laws authorize closed meetings for strategic planning purposes.

In any case, open meeting laws put public hospitals in a very different position from the non-public hospitals who are their direct competitors. It is difficult to have open, candid interactions among board members, and between the board and senior management, when board discussions are on public display.

About 82% of TGI respondents say that having board meetings open to the public and the media has a chilling effect on candid discussion. This issue received the strongest response of any of the situations discussed in the survey, with about 37% calling it "a very significant problem." About 59% reported that any time a few trustees gather to discuss hospital business, a public meeting must be announced in advance, and this is a significant problem for them, while 37% said it was not a problem. About 40% said that it is difficult

When reporters call about a situation that may be a bit difficult, we make sure to give them full, accurate information. In 2003 we had to lay off 18 employees.... We didn't hide anything, and the press treated us fairly.

— Sharon Tanner, president and CEO, Albemarle Health

to use board committees to analyze information and provide recommendations to the full board, because committee meetings also are subject to the open meetings law.

"In Florida you can't get two board members together for dinner unless you notify the public; you could go to jail for it," says Gage. "That's an example of one extreme. But there are valid reasons for open meeting laws. Where you have public funds being spent, and vulnerable patients being served, you've got to have a balance."

Some public hospitals have found ways to keep the doors open while creating such good communications and trust between the hospital and the press, and between the hospital and community groups, that neither feels a need to attend meetings. That means the board or committee can be more candid.

Albemarle Health, in Elizabeth City, NC, a 182-bed regional medical center serving seven counties, has worked hard to establish an open relationship with the press. "When reporters call about a situation that

may be a bit difficult, we make sure to give them full, accurate information," says president and CEO Sharon Tanner. "In 2003 we had to lay off 18 employees, and we worked closely with the press to communicate what was happening and why. We didn't hide anything, and the press treated us fairly." As a result, the press actually doesn't attend many Albemarle board meetings, Tanner says, "because we are so open; and because most of the business we do is quite routine." Good reporters know the real stories come out of in-depth interviews, not public meetings. One of the hospitals responding to the TGI survey says it limits board committees to three members, which exempts them from the public meetings law in that state. The burden here is on those few directors to become educated and to engage in candid dialogue with the staff at committee meetings so the board oversight process works, Bader says. "Dashboard reports are a huge help."

Health Central, a 180-bed hospital in Ocoee, FL, plus a 228-bed nursing home in Winter Garden, FL, keeps its board meetings, which are usually attended by the press, crisp and

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businesslike, primarily for approving minutes and committee actions. Substantive discussions are much more likely to occur during board committee meetings. While

We established a joint conference committee... We find this helps create a teamwork approach to solving problems, rather than a tattle-tale approach.

— Patrick M. Hermanson,
president and CEO,
Portneuf Medical Center

committee meetings also are open to the public, reporters seldom come.

Another challenge is that medical staffs may like open meetings because they provide a forum and safety valve to air concerns about hospital problems. However, CEOs and boards bristle at what they perceive as doctors making end runs to board members.

A better way is to establish a good structure where doctors can resolve issues without needing to go to the full board. For example, Portneuf Medical Center, a 256-bed hospital in Pocatello, ID, established a joint conference committee about five years ago. The monthly meetings include four board officers, four top administrators, medical staff leaders and by invitation the chair of the county commissioners. "Usually, a joint conference committee just includes board members and medical staff leaders," says Patrick M. Hermanson, president and CEO. "Our medical staff thought these discussions would be more productive if all three parties were sitting around the table. We find this helps create a teamwork approach to solving problems, rather than a tattle-tale approach."

Open meeting laws also affect the board's ability to review information on hospital performance, including quality, patient satisfaction and patient safety. About 38% of respondents to the TGI survey said that since board and committee meetings are public, it is difficult for the board to engage significantly in quality improvement oversight.

Bader offers several suggestions he's seen public hospitals use. One is to use a board quality committee that's closed under the state's peer review protection law. Another is to limit the board quality committee's size so its meetings may be closed under state law. "Above all, the majority of hospital quality and safety data are becoming transparent and publicly available," he says. "Boards have got to get themselves educated and comfortable discussing the hospital's efforts to improve."

Selecting a CEO

Some public hospitals recruiting a new CEO must make candidates' or finalists' names public. About 33% of responding hospitals said this is a significant problem for them, while 43% said it is

not a problem, and 6% said it is an asset. William Mahoney, President and CEO of Labette Health in Parsons, KS, says it is an asset to the hospital, because "the good ol' boy system can't kick in. Everyone can see the candidates and their résumés, and that is appropriate, because after all the public owns this hospital."

However, executive search consultant Roger A. Quick says, "the most difficult CEO searches to conduct are those for public hospitals, where candidate identification is required. Candidates who may be 'p-pie-perfect' for the job, and who are sincerely interested for all the right reasons, are often unwilling to have their names identified before a search is completed. The executive selection process should be treated as a confidential personnel matter, and the public interest is not well-served when candidate names must be revealed during the search." Quick is the president and CEO of Quick Leonard Kieffer, in Chicago.

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Martha C. Hauser, a senior vice president at executive search firm Witt/Kieffer in Atlanta, estimates that about one-third of the candidates who might normally be prospects for any given search are willing to step forward when there's no guarantee of confidentiality. "We are not able to develop the best possible slate of candidates on behalf of the organization when candidate names must be released to the public and/or the press," she says. "As search consultants, we feel that public disclosure requirements prior to the selection of 'the' final candidate are significant detractors to the overall process."

Board Appointments and Composition

Most public hospital boards don't select their own members. Instead, trustees are appointed by public officials, or they run for the office in general elections. What's more, some boards include elected officials such as county commissioners who rarely attend board meetings because of other commitments.

The TGI survey found that 28% of responding hospitals have board members appointed by a government entity that accepts no input from the board, and this is a significant problem for them – because there's no way to encourage appointment of trustees with the right mix of

expertise and backgrounds to fulfill governance responsibilities.

Some public officials welcome input or nominations from the hospital board, and this can strengthen their relationship. For example, Daviess Community Hospital in Washington, IN, a 74-bed hospital, has an 11-member board that includes three county commissioners, five members appointed by the County Council, and three members appointed by the county commissioners. When there's a vacancy, the board presents three possible names for each open slot, in order of preference based on the sorts of expertise most needed on the board. "It has been a participative relationship;

we give them good candidates, and they count on us to give them good feedback on whether board members are doing their job," says CEO Robert Heckert.

Health Central has an unusual way of selecting its board. In 1949, when the state legislature created the West Orange Healthcare District, it chose 11 different local towns and organizations (such as Rotary, the West Orange Junior League and the Orange County Homeowners Association) to each make recommendations to the governor for positions on the 16-member board. To encourage capable nominees, "we try hard to

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keep these groups in tune with what's happening at the hospital; we go out several times a year to their meetings, and we coach them on selecting appropriate nominees," says Richard Irwin, President and CEO. "If you do this well, the organizations become hospital advocates."

A related problem for public hospitals is that when board members are appointed by another body, it may be quite difficult to remove a trustee, even if he or she fails to attend meetings. About 60% of responding hospitals said this is a significant problem for them. Health Central copes with this problem directly but tactfully. One trustee only attended two board meetings in two years, Irwin recalls. The board chair discussed the situation with the trustee, and he has now written a letter of resignation. At Albemarle, the board chair sent a letter and had a conversation with a member who had missed several meetings. "We obtained a recommitment to the board, and since then it hasn't been an issue," Tanner says. Conflicts of interest can pose a special challenge if non-performing board

members may be removed only by the public body that named them. Labette Health, in Parsons, KS, a county-owned 109 bed hospital, tries to address this by stressing trustees' fiduciary responsibilities. Two years ago, it passed a strict conflict of interest policy. Possible conflicts of interest were disclosed on the front page of the local paper. "Anyone with a possible conflict can't serve on related committees, and has to leave the boardroom during related votes," says William Mahoney, president and CEO. "The benefit of having a policy set out in advance is that it clarifies that this is not a matter of personalities."

Confusion About Public Board Members' Role

There is considerable confusion about the external role of a public hospital board member. In general, not-for-profit board members are expected to leave internal disagreements behind them when they exit the boardroom. Once the board has made a decision, board members should go forward with a unified public message.

But it's more difficult to do this when board meetings are public and the news media report differences of opinion and divided votes. Sometimes public board members feel they represent a particular constituency (such as a labor union, an ethnic group, or a geographic area) and need to advocate on its behalf.

About 46% of responding hospitals say there is confusion about whether elected or appointed board members represent those who chose them, or whether they have a fiduciary responsibility to act in the best interests of the hospital, and that this is a significant problem; 51% say it is not a problem.

This was an issue at Albemarle in the past, Tanner says, and it has been a substantial focus for board education at meetings and board retreats. "Today the atmosphere has shifted. All our board members realize that as a board member, you represent the entire community. You may do it through the eyes of a woman, as a physician, as an African-American, but when you come to the table in the boardroom you wear your hospital hat. Nobody crosses that line. If someone looks like they're getting near that line, another board member will gently pull them back."

Should Public Hospitals Consider Changes in Structure?

Some localities have turned their facilities over to separate not-for-profit corporations, and others have contracted with a non-profit to run the hospital with minimal government interference, as is being proposed for Grady Memorial. When TGI asked public hospitals whether their board or its parent government had considered conversion to another ownership structure within the past decade, more than 40% of respondents answered yes. More than 12% are considering conversion to another structure right now.

Since 1904, the Denver Health System had been an agency of the city and county of Denver. Eventually, that became a problem. The hospital couldn't join a national purchasing consortium; all purchasing had to go through the city. During the first Gulf War, there was a shortage of nurse anesthetists, but by the time the City Council could raise salaries, the shortage was over. It took weeks to get a contract signed, and six months or more to create a new hospital position.

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Under a state law passed in 1994, all health system assets were transferred to the newly-created Denver Health and Hospital Authority (DHHA), a political subdivision of Colorado. The mayor appoints DHHA governing board members; the City Council approves them, and can remove them for cause. Should the Authority cease to exist, the property would revert to the city, but the city has no control over DHHA operations.

What this means, says Darlene Ebert, general counsel for Denver Health, is that now a contract only needs one signature, the CEO's. In the past, the hospital could raise funds only as part of a general city request to voters; now it can raise its own funds in the bond market. "Overall the new structure has allowed DHHA and its governing board to really concentrate on Denver Health," Ebert says. "We're not distracted by being part of a larger city system, and the board can focus on setting strategy for the future, in terms of both finances and quality of care."

Short of a change in corporate structure, anyone seeking an easy fix for the governance challenges facing public hospitals is likely to be disappointed.

Portneuf Medical Center faces an unusual challenge that could lead to a change in structure. The hospital is part way through a \$200 million building project using revenue bonds issued in 2005, and it expected to use additional bond proceeds to finance the rest of the project. However, in

April 2006 the Idaho Supreme Court ruled that with very limited exceptions, public entities cannot issue revenue bonds; instead they must issue general obligation bonds, requiring a public vote. The hospital governing board recommends conversion to a 501(c)(3), but this plan is controversial. CEO Hermanson predicts the hospital's structure will change dramatically (either to a free-standing not-for-profit, or to become part of a chain) within the next six to nine months.

* * *

Short of a change in corporate structure, anyone seeking an easy fix for the governance challenges facing public hospitals is likely to be disappointed. Although public hospital boards are finding ways to populate themselves with well-qualified members and to have candid discussions based on good information, there's no guarantee that the same practices transplanted elsewhere will have the same result.

"Board members have to understand they share a fiduciary responsibility for the success of the organization and its mission, and they have to put that interest ahead of any political or personal agendas," says

Bader. "They have to build trust in each other and in management. When they do, the best practices have a good chance to succeed."

— Elaine Zablocki, editor of *Great Boards*, is a freelance healthcare journalist whose work has appeared in *Physicians Practice*, *Internal Medicine News*, *Medicine on the Net*, and numerous other publications.

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CREATING A MORE STRATEGIC BOARD AND ORGANIZATION:

A Case Study

By Pamela R. Knecht

How can a board that's traditionally been reactive and operationally focused transform itself to play a more strategic role and advise management without usurping management's responsibilities? Here's how one board and CEO accomplished the task.

When Kenneth Lukhard became the new president of Advocate Christ Medical Center and Hope Children's Hospital (ACMC/HCH), outside Chicago, he saw a system with amazing potential. However, he quickly surmised that it lacked a number of critical components, including clear plans for market share growth, focused attention on lowering length of stay, and specific tactics for increasing operating margin. He recognized that addressing these and other critical issues would require an experienced planning executive plus a board fully engaged in strategic-level planning.

Lukhard asked Peter Hughes – a seasoned business development executive at the parent organization (Advocate Health Care) – to become the Vice President of Business Development/Strategic Planning and provide full-time support for ACMC/HCH. In addition, he worked with the chair of the ACMC/HCH board (called the governing council) to make significant modifications in the way the council conducted its business.

Changes in the Culture

Lukhard says his first governing council meeting represented a “180 degree turn” in the council's meeting culture. He insisted on actively engaging the council in dialogue, instead of letting them listen to lengthy monologues from management. They were surprised, but delighted. Council members quickly learned they were expected to read their packets of materials and come to board meetings ready for active participation.

Next, Lukhard asked the council to support a change in the entire organization's culture. ACMC/HCH executives had begun tracking factors that could influence its ability to provide excellent care, win market share, and improve financial results. They tracked this data hourly, daily, and weekly, instead of monthly or quarterly. As a result, associates were focused on “leading indicators” of current and future performance, versus “lagging indicators” of past performance. This change enabled the council and senior management to look forward into the future, not backward in a rear-view mirror.

The new council and organizational cultures were characterized by truth telling, a focus on accuracy and excellence, and an insistence on mutual accountability.

The cultural changes didn't stop with longer, more probing discussions and future-oriented performance indicators. In addition, deeper behavioural issues were addressed. The new council and organizational

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cultures were characterized by truth telling, a focus on accuracy and excellence, and an insistence on mutual accountability.

Early on, Lukhard discussed his view that ACMC/HCH was experiencing decreased capacity, lower patient and associate satisfaction rates, flat market share growth, unfavourable quality scores and declining profitability. He told the council that this was a “burning platform.” In other words, if these issues were not addressed aggressively, the hospital would “crash and burn” in less than ten years.

and somewhat frightened at first by their new CEO’s frank, negative description – particularly since the situation had developed on their watch. They eventually came to understand that to protect the organization’s mission, they needed a better understanding of ACMC/HCH’s internal and external environments, and its available strategic options.

Strategic Planning Modifications

As part of his turnaround strategy and repositioning for the two-hospital campus, Lukhard asked Hughes to create a

council members, physician leaders, and administrative representatives was formed to oversee the entire process and to provide feedback on the initial work, which was drafted by a separate writing team. (A member of the governing council even agreed to serve on this writing team to learn more about the issues and to provide perspective from an interested “outsider.”)

Hughes and his staff coordinated a massive data-collection process that included a high level of stakeholder engagement. Group and individual input sessions were conducted with all governing council members, over 150 physicians, a significant percentage of associates, and key community leaders such as the mayor. In addition, the planning staff assembled and analyzed information for a detailed situational assessment.

Two weeks before a scheduled environmental assessment retreat, a comprehensive binder was delivered to the council, physician leaders, and administrators. They were expected to arrive at the four-hour retreat prepared and ready to work in small groups to identify critical strategic issues facing the organization. The retreat

was targeted for active conversation, not passive listening; afterwards, some council members said they finally felt as if they had been treated like adult learners, not school children.

One month after that retreat, the council, physician leaders, and administration attended a one-and-a-half day, off-site visioning retreat entitled “Seeing the World Differently.” It emphasized confirming critical strategic issues and fleshing out a vision of what ACMC/HCH should “look like” in 10 years, in each of six ‘pillars,’ or key components of the organization. These pillars included:

1. Growth
2. Clinical Outcomes
3. Physician Relations
4. Patient Satisfaction
5. Associate Satisfaction
6. Funding our Future

Participants also helped identify three-year goals and one-year organization-wide priorities.

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This brutal honesty represented a “huge shift in the culture of the governing council.”

This brutal honesty represented a “huge shift in the culture of the governing council,” according to Lukhard. In fact, in time the council chair admitted to Lukhard that some of his colleagues were irritated

ten-year strategic plan. With the support of the council, ACMC/HCH embarked on a 2017 visioning process that engaged members of the governing council all along the way. A steering committee composed of

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Lukhard and Hughes felt that through this process the council was appropriately involved in helping to determine the “broad brush strokes” of the strategic plan. In the past, council members had gotten “too far down into the weeds” of operational and tactical planning. This time, they left that level of detail to the writing team.

Governing council engagement in strategic thinking and planning continued after the visioning retreat, as Hughes conducted multiple feedback sessions on the draft plan developed by the writing team. Over 75% of the retreat participants attended these highly interactive sessions, in which council members, physicians, and administration worked in mixed groups. Hughes comments that this step helped the council (and other participants) increase their understanding and ownership of the resulting strategic decisions.

Next time around, Lukhard and Hughes will invite key operational and planning executives from the system office at Advocate Health Care to both retreats. (This first time it was important for ACMC/HCH to feel that it was “their” process; not “corporate’s”.)

Now the council was appropriately involved in helping to determine the “broad brush strokes” of the strategic plan.

By involving system-level executives in the entire process of identifying critical strategic issues, developing a long-range vision, and prioritizing shorter-term goals, it will be easier for ACMC/HCH’s governing council to obtain system approval for the significant amount of capital required to build the facilities described in Vision 2017. ACMC/HCH did eventually receive capital approval for the first phase of the plan (through multiple meetings attended by key council members and administration), but the process took longer and was more arduous than the council had hoped.

Seeing the World Differently

Creating a more “strategic” governing council has required both the ACMC/HCH council and adminis-

tration to look at the world differently. Council members have been asked to change the way they’ve functioned for years. In addition to the cultural changes described above, Lukhard and the chair also altered the structure of the council meeting agenda, so that it now follows the six “pillars” representing the major areas of Vision 2017. This agenda re-ordering forces the governing council to address issues of top strategic significance to ACMC/HCH. As a result, they spend less time diving down into operational topics.

The senior management team has modified the way they interact with the council. Now they are spending much more time, staff, and resources educating council members and engaging them in substantive discussions about strategic-level issues.

Medical staff leaders who were involved in multiple strategy meetings have a greater appreciation for the complexity of issues faced by management and the council. They say their active engagement in the process helped improve the relationship between physicians and administration. As a result, the council, administration, and physician leaders are indeed “seeing the world differently.” Now all key stakeholders have a better understanding of the challenges and opportunities facing their health system over the next ten years. More importantly, they are working together to better position ACMC/HCH in its marketplace so it can continue to improve the health of all of the communities it serves.

— Pamela R. Knecht is Vice President of ACCORD LIMITED, a Chicago-based consulting firm providing governance and strategic planning services to hospitals and health systems. She assisted ACMC/HCH with this engagement and appreciates their help with this article. To contact her: pknecht@accordlimited.com or 312-988-7000. For an in-depth look at board involvement in strategic planning, see her recent white paper, “Engaging the Board in Strategic Planning: Rationale, Tools and Techniques”, published by The Governance Institute. For more information, visit www.governanceinstitute.com

Subsidiary Hospital Boards: Window Dressing or Opportunity?

By Barry S. Bader and Edward A. Kazemek

A lot of hospital boards in health systems are confused or downright unhappy with what they perceive as a diminished role. “Why are we here,” they ask, “since we have little to no authority, and the parent board makes most of the important decisions?”

Two years ago, we co-authored a white paper for The Governance Institute that found health systems are moving decision-making authority for financial and strategic matters to the parent corporate level to drive higher system-wide standards for performance and accountability. Some systems have eliminated hospital boards in favor of a single parent board with fiduciary authority for the entire system and each operating entity, but most have adopted some sort of shared governance model that splits authority and responsibility between parent and local boards. And there’s the rub.

When the system board calls the shots on the big financial, strategic and management decisions, local trustees question whether they have a meaningful role.

When the system board calls the shots on the big financial, strategic and management decisions, local trustees question whether they have a meaningful role or are just there for their names and money.

In our experience, the reasons why boards of some hospitals and other operating entities feel disenfranchised and unhappy vary, and may include:

- Their position description is outdated or ambiguous, or they have no clear description of their role at all.
- They have important responsibilities such as quality oversight and medical staff relations, but haven’t received sufficient training and tools for their roles.
- Local boards continue to recruit community leaders with business and financial skills and philanthropic potential, even though the board’s responsibilities have shifted to quality oversight, medical staff and community relations.
- The local board is told its role includes reviewing and approving financial decisions and strategic plans, when in fact it has minimal

influence on management-developed proposals for submission to the corporate board.

- The corporate board and management attempt to hold the local boards accountable for decisions that were imposed on them, including “unfunded mandates.”
- Local trustees feel marginalized if the system board rejects their request for capital or new programs because other system entities have a higher priority.
- Local board members who served on the board when it had final fiduciary authority still mourn their loss of power.
- Some local hospital executives have less experience than their predecessors in how to work with boards and fully use their talents.
- The system consists of just one or two hospitals serving a single geographic area, so there’s little rationale for having separate system and hospital boards.

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The failure to address local board dissatisfaction can be costly. The ranks of local boards include smart, respected, influential leaders who can be enormously helpful. If local trustees feel their time and talents aren't well used, they will lose enthusiasm, resign, or worse, grow antagonistic toward the system.

One common failing is the unintended fiction that although hospital bylaws say the board "approves and recommends" budgets and plans to the system board, the real decisions are made between system and local management; local trustees are supposed to "bless" their recommendations with little fuss. That's none too fulfilling to hospital trustees who are

The core problems are misaligned expectations and poor communications. Health systems have paid too little attention to rethinking, clarifying and communicating the new roles that subsidiary boards are expected to play.

The core problems here are misaligned expectations and poor communications. As health systems have moved away from decentralized governance models in favor of shared governance and centralized governance models, they've paid too little attention to rethinking, clarifying and communicating the new roles that subsidiary boards are expected to play, and to adjusting board practices to the new roles.

passionate about wanting to put their stamp on important clinical programs, buildings and initiatives to serve their communities.

What to do? One answer doesn't fit all situations, but there's a logical process leaders can engage in to choose the right solution for their systems.

1. Reaffirm and communicate the benefits of being part of the health system to local board members. Local trustees are typically less aware of the system's vision, activities and

Why System Boards Need Sufficient Authority to Optimize Performance

- * A local hospital board recruited a group of star OB/Gyns away from another system hospital developing a women's and children's center of excellence, in order to develop its own OB program. It paid far more than system management felt was fair market value for the doctors' practices.
- * A local hospital board worked hard to develop plans for a new patient care tower and engaged a local builder, but the system reversed plans when its analysis found it would get a better price through competitive bidding.
- * A small hospital's board couldn't persuade local physicians to participate in national quality and safety programs until the system said participation was mandatory.
- * A local hospital board would not shut down a marginal, money-losing sports medicine program for fear of upsetting a group of orthopedic physicians, until the system imposed the decision on them.
- * A "cash cow" hospital balked at signing on to the system's Master Trust Indenture debt financing proposal, even though it would save the entire system over a million dollars a year in financing costs.

achievements than system leaders realize. It's easy to take for granted that everyone recognizes the economies of scale, branding advantages, enhanced capital access, better terms on managed care and other benefits that the system delivers. Restate why, in order to achieve these benefits, subsidiaries need to relinquish ultimate

authority to a parent that makes decisions in the best collective interests of the system. Be frank about the need to drive out redundancies, inter-facility competition, and local pet programs that reduce system efficiency and profitability (see box).

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Communicate the tremendous importance of board oversight of quality and patient safety, and the board’s role in overseeing the hospital’s mission, especially with regard to addressing unmet community healthcare needs.

2. Communicate the tremendous importance of board oversight of quality and patient safety, and the board’s role in overseeing the hospital’s mission, especially with regard to addressing unmet community healthcare needs. Some hospital trustees perceive that the quality-related responsibilities delegated to many hospital boards are a demotion from their previous authority over financial and business matters. *Nothing could be further from the truth!*

Table 1. Continuum of Local Hospital Board Roles

← Less Authority of Local Hospital Board More →

Responsibilities	Type I Purely Advisory Board	Type II Quality-focused Board	Type III Shared Authority Board	Type IV Operating Board
Finance	None	Advisory	Makes recommendations and monitors performance	Approves decisions subject to reserved powers
Strategy	None	Advisory	Makes recommendations and monitors performance	Approves decisions subject to reserved powers
Quality and patient safety	None	Fiduciary responsibility	Fiduciary responsibility	Fiduciary responsibility
Medical staff credentials and relationships	None	Fiduciary responsibility	Fiduciary responsibility	Fiduciary responsibility
CEO selection, evaluation and compensation	None	Has input	Has input and a major voice	Has final authority subject to system guidelines and approval
Audit oversight	None	None	Informed	Chooses and oversees auditor subject to system approval
Philanthropy	Advises and participates in efforts	Advises and participates in efforts	Provides leadership for fund raising efforts	Has final authority subject to system reserved powers

What could be more important than quality and safety, overseen by people from the community who actually receive the care and know how to relate with local physicians? The Institute for Healthcare Improvement, the Joint Commission, and other respected organizations all recognize the potential of the board to improve and ensure quality and safety.

3. Engage system and local board leaders in a process to clarify how much authority and responsibility subsidiary hospital boards should have. The responsibilities need to be meaningful and enable local trustees to make a contribution that adds value above and beyond what the parent board can do. Local hospital boards typically fall into one of four categories depending on the relative shares of advisory and

fiduciary responsibility they have, as shown in a continuum in Table 1:

- Type I - Purely advisory board. The board has no fiduciary responsibilities or formal authority, but is asked for its counsel on programs and community relationships, and assists with fund-raising, community outreach and advocacy.

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• Type II - Quality-focused board. The board has delegated fiduciary responsibility for the quality and safety of patient care and medical staff credentialing, is kept informed about organizational performance, and is consulted as management develops strategic plans, budgets and other major decisions.

• Type III – Shared Authority board. The board has fiduciary responsibility for quality, safety and medical staff relations, monitors hospital performance, and the system board gives considerable deference to its review and recommendations on strategic plans, budgets and other major decisions.

• Type IV - Operating board. This board is delegated significant responsibilities for oversight and decision making, subject only to the system's reserved powers, such as approval of large capital expenditures and major transactions.

Develop and communicate a clear position description for the roles and responsibilities of hospital and other operating entity boards. Choose the language with care and precision.

Customize - don't rely on a consultant's boilerplate or another system's document.

4. Develop and communicate a clear position description on the roles and responsibilities delineating hospital and other operating entity boards. Choose the language with care and precision. Don't say the hospital board "approves" the budget if it really makes recommendations subject to system approval.

Customize – don't rely on a consultant's boilerplate or another system's document. Communicate the roles and responsibilities in new director orientation and reinforce them through board education and evaluation.

5. Align board practices with the real roles of hospital boards. For example, if a hospital is a Type II board focused on quality-related responsibilities, develop recruitment criteria weighted toward persons with backgrounds in industrial quality, safety, or customer service; consultants in quality management; attorneys who can understand complex technical matters; and physicians and nurses with training in quality measurement and management. Consider retired physicians, corporate medical directors, and professors of health-care management or quality improvement from local universities. Focus board orientation, education, meetings, and evaluation on the board's quality-related responsibilities, and provide the board with the dashboards and other tools to facilitate oversight and goal-setting. If the board is a Type III, be sure to recruit trustees who are comfortable with the fact that they don't have final authority. Look for a blend of business, community, and quality backgrounds.

Successful multi-hospital systems all have at least one thing in common – a team ethos. They understand that the whole is potentially greater than the sum of its parts, but only if all elements of the system accept and support the team effort. Like any successful team, the players need to be clear on their roles and understand how their efforts contribute to the team's success. They also accept the fact that not everyone can be the leader of the team. The support role players on a winning team experience far greater satisfaction than those who resist and resent a subsidiary role, only to end up losing the game.

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