

Published by

Bader & Associates

Governance Consultants,

Potomac, MD



CONTENTS

Physician Compensation: Managing the Risks	7
How to Develop Board Goals.....	11

Recruiting a More Diverse Board

By Elaine Zablocki

As governing boards seek greater diversity in ethnicity, race, and gender, they face a significant challenge: how to successfully recruit women and minorities with pertinent professional backgrounds and governance skills, while other not-for-profits and corporations seek directors from the very same pool of candidates.

Executives and trustees “absolutely” say recruiting for diversity is difficult, explains Vernetta Walker, director of consulting for BoardSource, a Washington, D.C.-based educational group for not-for-profits. “Often, they identify ‘perfect’ candidates based on ethnicity and skill sets, and these people are overcommitted and say no.”

The imperative to increase diversity is growing. As hospital and health system boards look at the changing demographics of the patients and communities they serve, they find a significant disconnect between how the board and the broader community appear. For example, Kingsbrook Jewish Medical Center, in Brooklyn, N.Y., was founded 82 years ago to meet the special needs of the local, predominantly Jewish, community. When CEO Linda Brady, MD, took the reins in 1999, the board was white, Jewish, and generally lived outside the hospital’s catchment area. Only one woman served on the 15-member board. The hospital served a

of African-Americans, immigrants from the Caribbean, and ultra-orthodox, Lubavitcher (very observant) Jews.

Some people dismiss diversity as mere political correctness, but as any organization’s customers and constituencies change, the business case for increasing board diversity grows. The U.S. Census projects that 90% of population growth between 2000 and 2050 will be in the minority population. In dense urban areas, many hospitals already serve a “majority minority” population. The workforce is diversifying too. The U.S. Bureau of Labor Statistics estimates that by 2008, 70% of all new entrants into the workforce will be women and minorities.

These statistics mean that any hospital that cares about maintaining public trust and increasing market share needs to convince community groups that their needs will be met. “You want to maintain and grow your consumer base,” says

continued on page 2 →

→ continued from page 1

Mary E. Medina, executive director of the Center for Trustee Initiatives and Recruitment of the Greater New York Hospital Association. “If you want to attract these groups, as a competitive business you will adjust and respond to their needs. You want to offer culturally sensitive care. People with limited English skills place a high value on language assistance. Islamic women value female healthcare providers.”

In addition, as the federal and state governments examine how well not-for-profit hospitals fulfill their community benefit obligations, “they are looking at board composition and whether it reflects the community,” Medina says. “This is yet another reason why it makes sense to move in the direction of greater diversity.”

Practical Steps

“In some ways, diversity is like motherhood,” observes Frank A. Calamari, president and CEO of Calvary Hospital, which offers palliative care for advanced cancer patients in the New York boroughs of the Bronx and Brooklyn. “Everyone believes we should become more diverse. The big question is how to make this idea concrete and actually get it implemented. That’s the hard part.”

BoardSource has created a seminar curriculum on how to increase not-for-profit board diversity. “The primary theme is getting the board to engage in a serious conversation about diversity,” says Walker. “There can be sensitive issues. We get the board get to talk about them in a thoughtful manner.” She asks boards to identify what’s been successful and what hasn’t worked, and to share and brainstorm ideas on new approaches.

The first step, says Medina, is to make a visible commitment. “It is important to say that diversity is a value our board embraces, that we want to be sure there are voices of the community on our board,” she says. It could be in the mission statement, the strategic plan, or a board development plan.

Key Do’s and Don’ts in Recruiting for Diversity

DO’S

- ✦ Continually monitor and understand the community’s changing demographics.
- ✦ Engage the board in a candid discussion of whether “diversity” should be a priority for the board – and why.
- ✦ Invite experts to discuss and engage the board on diversity. Consult associations such as the Institute for Diversity in Healthcare, the National Forum for Latinos in Healthcare, and others committed to bridging the racial and cultural gaps between boards and their local communities.
- ✦ Avoid “tokenism.” Identify board qualifications and skill sets the board wishes to enhance, and seek out women and minorities who potentially match up.
- ✦ Invest in orientation and offer experienced directors as mentors to new members
- ✦ Appoint new directors to meaningful committees consistent with their abilities.
- ✦ Get involved in the community on a regular basis.

DON’TS

- ✦ Don’t be overzealous. Expect progress to be incremental.
- ✦ Don’t overlook advisory boards as a source of potential members – tap into their members and diverse personal networks.
- ✦ Don’t give up and abandon diversity if a new director doesn’t work out. Instead, understand what went wrong and improve the process the next time.

Source: Mary E. Medina, Center for Trustee Initiatives and Recruitment, Greater New York Hospital Association

continued on page 3 →

→ continued from page 2

“It’s also important to make the business case – just saying it’s the right thing to do doesn’t motivate anyone.”

Medina describes recruiting for diversity as a multi-step process:

1. Look at community demographics and board demographics to understand the need for change.
2. Examine healthcare disparities in terms of community demographics to understand the business case for increasing diversity.
3. Tap into community relationships to identify potential members who can bring desired skills and diversity.

The next step is planning how the board will go about identifying and vetting prospective board members, and orienting them after election. “Having a plan with specifics, such as identifying organizations to reach out to, helps,” says Medina. “People are busy. Without specific tasks, deadlines, and assignment of responsibility, things may not get done.”

“Everyone believes we should become more diverse. The big question is how to make this idea concrete and actually get it implemented.”

— Frank A. Calamari,
President and CEO, Calvary Hospital.

Walker agrees it’s vital to clarify who takes responsibility for change. “Who is going to look at changing demographics and the makeup of the board? Is it the governance committee or a special task force? Will they report to the board on a periodic basis?” These are questions a board must answer before seeking new, more diverse, board members.

One often overlooked success factor, says Walker, is for a board to reflect seriously on what diversity could mean for board dynamics. Culturally diverse board members bring new viewpoints to board discussions. Will the board value these new insights? Suppose they lead to potentially difficult changes in the hospital? “Is the organization ready

to embrace change?” Walker asks. “Not just to accept change, but to appreciate and embrace it?”

Medina agrees. “‘Recruited for diversity but wanted for conformity’ is something we often see,” she says. Newly recruited members “may not know how things are done here,” says Medina, so they may interject comments or raise questions in ways that are the norm in other organizations but out of sync on a hospital board. New members can be educated in effective boardmanship skills, and similarly, the existing board must be prepared to embrace change, she says.

“If a board is thinking about ‘increasing diversity for diversity’s sake,’ and hasn’t explicitly talked about wanting new members to bring views that challenge traditional thinking, it may unintentionally be dismissive of new viewpoints and send an unspoken message that new members should conform or leave.”

Diverse board members “will provide points of view that take longer to digest, rather than the homogeneity that currently lets the board rubber stamp issues and move on,” adds Linda Galindo, president of Versera Performance Consulting in Park City, Utah. A diverse board reflective of its community is more likely to understand ethnic preferences, to ask management to pay increased attention to serving a culturally diverse community, and to view traditional reports, such as patient satisfaction surveys, in a new light. For example, when Hispanic patients come to the ER or visit a family member in the hospital, it is not unusual for their entire family to come with them. “The traditional reaction might be to make bigger signs saying, ‘Keep Out, Patients and Staff Only,’” Galindo says. “Culturally sensitive care could mean changing the rules, creating a larger waiting area, and/or revising staff training.”

continued on page 4 →

→ continued from page 3

Until recently Kingsbrook served a kosher menu throughout its hospital and nursing home, even though only 10% of the patients were Jewish. This meant that during Passover everyone ate cardboard-like matzoh, and there was no bread. Meanwhile, the ultra-orthodox Jews in the community didn't trust the hospital kitchen and brought in their own food. To meet current community needs, the hospital set up a separate kosher kitchen, supervised by a rabbi esteemed by that community, while the main kitchen switched to non-kosher food. This was a significant change (saving \$250,000 per year) but it was a step away from Kingsbrook's historic traditions, and one board member resigned in protest.

A conversation about diversity should go beyond race, ethnicity, and gender, Galindo says. "The younger generation tends to work hard and rely on technology to be most effective and productive, but they resist overtime and value balance in their lives," she says. "Healthcare organizations need to recognize that workforce motivation and incentives are very different in this generation, and that viewpoint should be represented on the board.

There are many cultures within healthcare: physicians, nurses, finance, and administration. Those viewpoints, too, should have a voice on the board."

Identifying Prospective Directors

The next question is how to find the best possible candidates. Edward L. Martinez, MS, senior consultant for the National Association of Public Hospitals and Health Systems, Washington, D.C., believes board recruitment flows naturally from solid community relationships. "If you know all the sectors of your community, the various ethnic and linguistic groups, the educators and business leaders and heads of grassroots organizations, then you know people who are suitable hospital board members," he says. "When someone tells me they just can't find capable leaders, that seems a bit disingenuous. It tells me they haven't done their homework; they don't know their community."

Who develops a roster of potential board candidates? It may be the board chair, the nominating committee, other board members with a flair for networking, or the CEO. Hospitals in the New York area benefit

"You need to step outside your comfort zone. It doesn't really take any more time than the traditional methods; it's just that the locale is different."

— Frederick D. Hobby,
President and CEO, Institute for Diversity
in Health Management, AHA affiliate.

from Medina's specialized expertise; she has developed extensive networking contacts to facilitate recruitment for diversity.

In our interviews, we found that hospitals use a wide variety of outreach strategies to identify diverse board candidates. CEO Brady relies on personal networking. She talks regularly with local union leaders and elected officials; they call her to chat when a member or constituent has a problem. She spends her evenings attending local community meetings. In fact, personal working relationships dating back 20 years have been a fruitful source of diverse board members. "An African-

American nurse from Bedford Stuyvesant led a rehab team back when I was a geriatric psychiatrist in our nursing home. Later, when I became CEO, she called me to ask, 'Is there anything I can do to help?' Now, she's on our board."

Calamari notes that current board members can be a fruitful source for new, more diverse, members. "They probably already know the people you're looking for, but they may not realize it," he says. "They may be business colleagues or friends of friends or next-door neighbors." He recounts how one board member, an

continued on page 5 →

→ continued from page 4

employee of a big power company, opened discussions about electrical cogeneration, and thanks to those conversations Calvary found a new board member.

Integrus Health System, in Oklahoma City, serves a population that includes Native Americans, African-Americans, and a growing Hispanic community. “We don’t have any magic when it comes to seeking new board members,” says president and CEO Stanley F. Hupfeld. “Most of our board members are involved in philanthropic organizations and organizations such as the Chamber of Commerce. They’ve got a good sense of where leadership is coming from in the minority communities, and it just kind of happens naturally.” Hospital leaders who seek board diversity can network through a wide variety of organizations, including professional associations, religious groups, fraternities and sororities (particularly important in the African-American community), and grassroots community organizations.

But isn’t all this personal networking and outreach extremely time consuming? “You need to step outside your comfort zone and reach out to opinion makers and leaders of influence in the communities in your service area,” says Frederick D. Hobby, president and CEO of the Institute for Diversity in Health Management, an affiliate of the American Hospital Association, in Chicago. “It doesn’t really take any more time than the traditional methods used to recruit white male members at the country club. It’s just that the locale is different.”

“The board benefits most when it hears, and listens to, and responds to, a wide range of viewpoints.”

— Linda Galindo,
President
Versera Performance
Consulting

There are certain key steps hospitals generally follow as they move forward to recruit a more diverse board. They include identifying potential candidates, checking the candidate’s background and reputation, inviting the candidate to visit the hospital and learn more about its programs, education about the role of the hospital board, and informal conversations over lunch or dinner. However, we found hospitals often differ about the order of these steps. Not surprisingly, they may bring very different “styles” to the recruitment process.

For example, Hobby recommends checking a candidate’s reputation informally, before a face-to-face meeting. He pictures a lunch or dinner meeting, “and that’s when you make the appeal. If you’re smart, you’ll invite the candidate and his or her spouse, because if you can’t get one, you might be able to get the other.”

Arthur Y. Webb, president and CEO of Village Care of New York, uses a different approach. Village Care offers long-term care in a range of settings, and Webb believes prospective board members need to start out with an on-site visit. “How do they feel about serving someone who’s living with AIDS or dying in a nursing home?

How do they feel about serving a drug addict, a homeless person, or someone who’s mentally ill? If you don’t feel comfortable with our clients, don’t serve on our board,” he says. Webb never takes anyone out to dinner. “To me, that would send the wrong message. That’s not the way not-for-profit dollars should be spent.”

Opening a Continuing Conversation

Volunteering for hospital boards hasn’t been a priority for most minority communities, says Medina. “They consistently aim at university boards, foundations, and philanthropic groups. When you open a discussion on the subject, they soon realize that health and healthcare are indeed a top priority, in terms of their goals for themselves and their families.”

“When someone has a lifelong connection with a particular community, then it’s an easy conversation, because often they are ready to give back,” says Brady. “Recently we recruited a board member from outside the community, someone who had foundation and fundraising experience. We said to him, ‘We really need you. We aren’t

continued on page 6 →

→ continued from page 5

nationally known, and we don't have a \$100 million endowment, but our services are vital and needed. On our board, you really make a difference.' For some candidates, this appeal has great resonance."

Potential board members may turn you down because they're already serving on other boards or they're just overloaded. That should be the start of a conversation, says Walker. "Maintain the relationship, because at some point even the busiest people do rotate off boards. It may be your turn next."

If they really are too overloaded, ask them to suggest additional potential candidates, suggests Hobby. "If someone is the kind of person you want on your board, they probably know others who would be a good fit."

Training and Mentoring New Board Members

Everyone agrees that training and mentoring newly appointed board members is a big factor in successful board diversity, but each board has its own methods. Integris Health has developed an orientation manual that includes organizational history, bylaws, financial information, and descriptions of community service projects." We'll spend several hours with each incoming board member going over this in great detail," Hupfeld says. "I do it for corporate board members, and our hospital administrators do it for the hospital boards."

At Village Care, new board members are invited to attend all board committees at least once and are then assigned to at least two committees that are a good match. "We make a point of senior staff members orienting them to the program areas. I spend considerable time orienting them to their fiduciary role and state and federal regulations," says Webb. State associations and national groups such as The Governance Institute also provide new director orientation.

Suppose the new director doesn't work out? "All directors, new or experienced, need to meet performance standards," says Medina. "The board should define standards to assess its performance as a group, as well as each individual director's performance. If there are problems due to absenteeism or lack of preparation, hopefully the board chair will be able to speak with the director, clarify performance expectations, and resolve the issue in a collegial manner."

Recruiting a more diverse board is just the first step in an ongoing process, Galindo observes. The strongest board will recruit people who are integrated into their communities, and can express the community's values and needs. "New board members who are treated as 'tokens' often drift away," she says. "The board isn't just looking for human diversity; it is seeking value system diversity. It benefits most when it hears, and listens to, and responds to, a wide range of viewpoints."

— 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. To contact her, email greatboards@ezab.net.

For More Information:

Linda Brady, MD
LBradyKJMC@aol.com

Frank A. Calamari
sgarry@calvaryhospital.org

Linda Galindo
Linda.Galindo@verseraconsulting.com

Frederick D. Hobby
FHobby@aha.org

Stanley F. Hupfeld
Stanley.Hupfeld@Integris-health.com

Edward L. Martinez
edwardm20@aol.com

Mary E. Medina
medina@gnyha.org

Vernetta Walker
VWalker@BoardSource.org

Arthur Y. Webb
ARTHURW@vcny.org

PHYSICIAN Compensation:

Managing the Risks

By Daniel M. Grauman

Hospitals and health systems generally employ more physicians than executives. At the same time it's likely that the board of directors spends far more time on compensation issues in the C-suite than on physician compensation and its associated regulatory and business risks. As physician employment grows, it's time to give physician compensation the attention it deserves.

Even when healthcare organizations aren't paying physicians on a full-time basis, total payments for physician compensation arrangements may be considerable (see box, "Follow the Money"). These compensation arrangements expose the organization to significant risk, but they also present an opportunity to align physician compensation with strategic goals.

This article reviews regulatory and business risks associated with payments to physicians by a hospital or health system, and lays out an approach to effectively manage those risks and align compensation with strategy.

Follow the Money

To understand a hospital's compensation patterns, and how much it is spending for physicians, consider potential expenses in each of the following categories:

- * Fully employed primary care physicians
- * Fully employed specialists
- * Fully employed hospitalists
- * Fully employed intensivists
- * Medical directorships (generally part-time)
- * Administrative, Supervisory and Training (AS&T) arrangements (generally part-time)
- * On-call coverage arrangements
- * Other contractual arrangements or part-time employment for specific clinical services
- * Professional services arrangements in which physicians provide clinical interpretation services
- * Space and equipment rentals

Regulatory Risk

While tax-exempt hospitals are not covered under the Sarbanes-Oxley Act, many of the practices required by the act are rapidly becoming standard governance practice in the hospital industry. Boards of directors are increasingly concerned with and paying attention to compensation-related issues.

Rule number one is: "All payments by a healthcare organization to physicians must be made at fair market value." This includes payments for clinical services, teaching and administration, physician rent payments and more. Boards should be aware of several key sets of regulations (and of regulators!)

They include:

* *IRS regulations* prohibit "private benefit" (aka inurement – where a transaction or exchange between a tax-exempt organization and one of its "insiders" furthers private interests rather than the public interest). To avoid inurement, a compensation arrangement must:

- * Be consistent with exempt purposes
- * Result from arm's-length bargaining
- * Result in "reasonable" compensation

Hospitals that pay more than fair market value for services can lose their tax-exempt status under IRS regulations. Tax-exempt status is based on the premise that an entity is

using its assets for the public good. Modern Health Care Services, a Florida hospital, lost its tax-exempt status when the IRS concluded that it did not provide services in a charitable manner because it operated for the private, rather than public, interest. In this case, excessive spending by management for private benefit was the culprit. However, the ruling specifically identifies physician employees as potential recipients of these public assets.

* *The Medicare and Medicaid Patient Protection Act of 1987* (the "Anti-Kickback Statute") makes it a crime to pay physicians in return for referrals or recommendations to purchase supplies and services. In 2002, a whistleblower brought action against McLeod Regional Medical Center (Florence, S.C.) for purchasing practices and paying physicians well above fair market value to ensure strong referral relationships, in violation of Stark II and the Anti-Kickback Statute. The hospital agreed to pay more than \$15 million and enter into a corporate integrity agreement with the Office of the Inspector General.

continued on page 8 →

→ continued from page 7

* The *physician self-referral law* (Stark, Stark II, and now Stark III) prohibits physicians from making referrals for certain “designated health services to an entity to which they have a financial relationship (ownership or compensation)” unless that relationship is at fair market value. In *Barbera vs. Tenet Healthcare*, North Ridge Medical Center (Ft. Lauderdale, Fla.) was accused of paying physicians above fair market value, allegedly in return for referrals. It cost Tenet Healthcare a whopping \$22.5 million to resolve these violations. Subsequently, the in-house counsel at the time was brought to court for submitting false documents to the Department of Health and Human Services stating that Tenet had complied with the Physician Self-Referral Act.

Managing the Regulatory Risk

Managing regulatory risk requires careful analysis and benchmarking to ensure that all physician remuneration is at fair market value, plus rigorous documentation to show that this is the case. Benchmarking for all physician compensation

While tax-exempt hospitals are not covered under the Sarbanes-Oxley Act, many of the practices required by the act are rapidly becoming standard governance practice in the hospital industry.

arrangements must be performed on a regular and systematic basis (annually), as fair market value changes based on varying market conditions.

Several reference sources are available to help hospitals analyze and benchmark compensation levels. Compensation for certain subspecialists or for highly specialized clinical programs and services can be particularly challenging, and data may need to be developed or extrapolated from multiple sources. In these complex situations, it often helps to have the assistance of an objective third party in the benchmarking process.

Many part-time employment arrangements set compensation based on actual time spent by the physician and a fair market value hourly rate. Also, a hospital’s healthcare legal counsel is an expert on these matters and can offer

detailed information on fair market value regulations. For example, health attorneys generally advise that hospitals must ensure there is proper record-keeping (time sheets) to support physician payments.

Business Risk

Physician compensation systems should be designed to achieve specific goals for the hospital or health system, congruent with its overall philosophy and strategy. Business risk is, very simply, the risk that compensation models and systems either will not or cannot achieve those goals. Strategic business goals may include successfully serving specific populations, growing new clinical programs and services, and achieving specific financial results.

The hospital may believe that employed physicians, taken as a whole, need to be a “break-even enterprise.” That is, the hospital or health system can’t afford to, or believes it should not, subsidize physician income, so the physicians collectively need to bring in income that is at least equal to their compensation and related expenses of operating the practices.

Other hospitals and health systems take the view that employed physicians can help support and build clinical programs and services. That strategic perspective allows them to accept defined losses on the physician enterprise as long as the financial health of the hospital or health system overall is strong.

continued on page 9 →

→ continued from page 8

For hospitals serving low-income communities, employing physicians may be the only way for the hospital to achieve its mission, serve the community, and maintain economic viability.

Hospitals that pay more than fair market value for services can lose their tax-exempt status under IRS regulations.

Managing Business Risk: Alternative Compensation Models

To manage the business risks of physician compensation, the hospital or health system must design compensation models that will align physician incentives with hospital goals.

In the late 1990s and into 2000, many hospitals and health systems lost a substantial amount of money on their hospital-owned practices, resulting in many divestitures. In most cases, physicians were paid too much, with little of their compensation at risk.

Over the years, several general compensation models have evolved, with some degree of overlap and each with numerous variations. The right model for a given situation will take into account the differing realities of hospital-based and community-based primary care, and of specialty care.

* **The Fixed Salary**

Model: This model may be useful when trying to attract new physicians, particularly in a shortage situation, or where the aim is to entice a physician to locate in a strategically important spot for the hospital. Because there is no incentive to increase productivity or to control

costs, this model can lead to decreased productivity and increased expenses. It is therefore not appropriate if the organization seeks a break-even physician enterprise.

* **Net Economic Contribution Model:**

In this model, which can be applied individually or on a practice basis, the amount of compensation equals net revenues minus expenses. Losses and gains can be shared in a risk-sharing arrangement. From a strategic viewpoint, this model supports both goals relating to clinical activity (productivity) and to profitability (expense management).

The model poses certain practical problems, such as a difficulty in assessing the physician or practice "contribution." It also does not take into account the payer mix of a practice, which may be beyond physician control. This model does not address goals which may support the mission of a hospital or health system, such as caring for patients with Medicaid or no insurance at all.

* **Production Incentive At-Risk Salary Model:**

Here, total compensation is targeted. A lower base salary is set while a bonus pool of 20-25% of total compensation is established. If a physician meets

his or her productivity goals, then the physician receives a bonus. Productivity can be measured by visits, or more typically by RVUs ("relative value units," a standard measure of the relative value of various physician services).

This model provides a clear incentive for higher productivity, but may foster competition among physicians in a given practice or setting, rather than encouraging them to work toward common goals. Typically, this model does not account for mission objectives, payer mix, or expense management. It may be useful in a location with an unfavorable payer mix.

* **Multiple Incentive**

Model: This model is appropriate in large, sophisticated hospitals and health systems that have the administrative systems and resources to measure and track multiple performance metrics. Again, base salaries are set at 75-80% of total targeted compensation, and bonuses are based on performance on indicators relating to productivity, expense management, patient satisfaction, quality measures, citizenship, etc. Weighting factors are typically used to determine the relative importance of each indicator.

continued on page 10 →

→ continued from page 9

Experience shows that multiple incentive models retain stability over time, and promote focus on broader objectives, not just productivity. Their downside is the greater time and resources required to monitor these models, and the risk of excessive complexity.

There are also public relations considerations regarding physician compensation. When payments to physicians become public knowledge, the hospital wants them to make sense to the public. Each year many local newspapers publish a list of the most highly compensated employees

of a city's hospitals and medical centers. This list often includes many doctors, and the average reader thinks that the payments are absurd. Trying to defend figures based on formulas that are not intuitively obvious is a public relations nightmare.

If the hospital has done its homework on complying with regulations and dealing with strategic risk, it is likely to be in a much better position from a public relations viewpoint. The hospital will have the documentation it needs to respond in a calm and convincing way and a cohesive strategic framework from which to speak.

To manage the business risks of physician compensation, the hospital or health system must design compensation models that will align physician incentives with hospital goals.

Questions Boards Should Ask

In the coming decade, it is likely that physician employment will be a growing concern to hospitals and health systems. By giving these issues the attention they deserve, a hospital board can provide physician compensation without putting itself in jeopardy, and achieve maximum benefit from its payments to physicians.

Therefore, boards ought to be asking these questions of their CEO, CMO, general counsel, and expert physician compensation consultants:

1. Is there a comprehensive list of all physician compensation arrangements?
2. Are there current contracts in place?
3. Are all payments at fair market value? What is the support for conclusions around fair market value?
4. For employed physicians, how were the compensation models designed, and what were the guiding principles?
5. Are financial results of employed practices consistent with the organization's philosophy and strategy?
6. How frequently are payment arrangement and compensation models reviewed and evaluated, from both the fair market value and business perspectives?

— Daniel M. Grauman is president/CEO of DGA Partners, a Philadelphia-based consulting firm providing services to hospitals and health systems. To contact him, e-mail dgrauman@dgapartners.com or 610-667-8782.

HOW TO DEVELOP BOARD GOALS

By Barry S. Bader

It's that time of year again, a time for making New Year's resolutions. For governing boards, each New Year is an opportunity to determine the major areas on which it wants to focus its most precious commodity, its time.

Many governing boards are frustrated because most board meetings and committee meeting agendas are so full of both important and routine business that little time is left over for interactive discussion and questions concerning highly significant or future-oriented strategy and policy issues.

For example, one hospital has struggled for years to maintain a positive bottom line. Its board monitors management's aggressive pursuit of operational improvements, including revenue cycle enhancement and group purchasing arrangements to control supply costs. The proverbial "elephant in the room," on everyone's minds, but never discussed, is whether the hospital can survive on its own or must seek a strategic partner through merger, sale, or affiliation. Yet the board has spent almost no time discussing this question, as the hospital's financial condition weakens. The CEO has raised the issue, but gently, because the board might misread his analysis as an admission that he can't run the organization successfully.

At another hospital, margins are good and revenues are growing, but some physicians are opening competing ventures and want rich compensation for on-call coverage, while other physicians seek the security of

hospital employment. The landscape is rapidly changing, and management responds to crises and opportunities, but the board has never taken the time to ask the questions, "What is our vision for hospital-physician relationships? What is our strategic plan to achieve that vision? Should we continue to be reactive, or adopt a proactive stance, relying on steps such as actively recruiting hospital-employed physicians or building an aligned, multi-specialty medical group?"

In these instances, and on virtually every board, the practice of establishing annual board goals can rebalance the board's time. Goals help directors reduce emphasis on the routine matters and increase discussion of significant issues that are critical to the organization's viability and achievement of excellence.

Establishing Board Goals Can Help

For years governance experts have recommended the technique of adopting board goals, yet boards have a hard time translating this recommendation into action. Many don't understand the difference between an ongoing board responsibility, such as monitoring financial performance or overseeing clinical quality

and patient safety, and a board goal. Others mistake the goals contained in the organization's strategic plan for the board's goals.

The proverbial "elephant in the room" is whether the hospital can survive on its own.

A board goal is a topic, a specific major action item, or a critical area of board responsibility that deserves special, intense attention from governance and management – over and above the board's performance of ongoing responsibilities. Board goals may reflect priorities in the strategic plan, or they may reflect emerging issues or policy matters that are not specifically addressed in the current plan.

continued on page 12 →

→ continued from page 11

Here are examples of the three types of board goals:

Type 1 Board Goal: An area, topic, or question for major study or oversight

Examples:

- * Long-term vision for hospital physician relationships.
- * How to increase physician engagement in quality and strategic planning.
- * Impact of changes in cardiac care technology on our future plans for growing these services.
- * Innovative methods of serving a growing uninsured population.
- * Achieving breakthroughs in quality improvement.

Type 2 Board Goal: A specific, major action item requiring significant board work.

Examples:

- * Determine whether to build a new hospital or renovate an existing one.
- * Decide whether to pursue the Malcolm Baldrige National Quality Award.
- * Adopt new multi-year strategic plan.
- * Adopt a board policy on physician competition.
- * Adopt and implement a new policy on CEO goal-setting and compensation.

Type 3 Board Goal: An area of board responsibility to receive special attention

Examples:

- * Activities to strengthen the balance sheet.
- * Engagement of the full board on quality and patient safety.
- * Oversight of community benefit.
- * Strengthening the parent board's relationship with the foundation board in order to enhance philanthropic efforts.

Using Board Goals

A board should limit itself to a small number of annual goals or focus areas. One truly big goal may be enough; more than four or five is probably too many.

To determine its goals, the board should engage in a brainstorming discussion in which every member of the board and senior management suggests possible goals. Then the board can choose its priorities, or it can delegate the final choice of goals to its executive or governance committee.

The next step is to incorporate the goals into an annual board work and education plan. (See Great Boards, Winter 2005, "10 Ways to Improve Board Meetings," for a discussion of how to establish an annual board work plan.) Discussion and education pertinent to the goals can be incorporated into the

board's work in a variety of ways. A board that uses a consent agenda to dispense with routine business efficiently can spend half or more of its meeting time on an in-depth discussion of a board goal at most of its meetings. A board committee or special task force might be asked to engage in preparatory work prior to full board discussion.

Management might be asked to present a white paper or background articles to inform the board before discussions. Outside speakers and consultants may be invited to lead educational sessions pertinent to the goals. One or more board goals could be a significant focus at the board's annual retreat or a mini-retreat.

One of my clients refers to board goals simply as "our Topic A issues." In other words, these are the critical few matters on which the board can make a real difference in time spent now to enhance the organization's sustainable viability and fulfillment of its mission. Consider making the adoption of board goals a New Year's resolution for your board.

— Barry S. Bader, publisher of Great Boards, is the president of Bader & Associates, a Maryland-based governance consulting firm. To contact him, e-mail bbader@GreatBoards.org or call 301-340-0903.

GREAT BOARDS

is published by
Bader & Associates
Governance
Consultants

12225 Seline Way
Potomac, Maryland
20854

Phone: 301-340-0903
Fax: 301-340-1345
E-mail:
bbader@GreatBoards.org
GreatBoards.org
www.GreatBoards.org

Graphic Design by:
Ruzow Graphics, Inc.
www.ruzowgraphics.com