

## CONTENTS

Developing a Hospital-Physician Alignment Strategy .....	1
Innovative Approaches to Board Orientation .....	8

## Developing a Hospital-Physician Alignment Strategy



### Employment Is Not the Only Answer

By Barry S. Bader

**Hospital-physician relationships have been on a roller coaster of change for several decades.**

A new white paper from The Governance Institute declares that a major transformation is underway:

"The days of loose cooperation—and sometimes competition—between hospitals and their medical staff members in private practice are quickly coming to an end," it says. "Only hospitals that are tightly aligned or integrated with a critical mass of physicians will be able to organize their delivery systems to meet the demands for price, quality, efficiency, and community service from private payers, government, and empowered consumers. Some independent physicians and physician groups will have a secure niche and survive on their own, but hospitals that lack a

strong relationship with a critical mass of aligned doctors will not."

#### How Did We Get Here?

Until the 1960s, community hospitals and physicians lived separate but symbiotic lives: hospitals were the "doctors' workshop" and in turn physicians supported hospital finances by admitting patients. In the 1970s and 1980s, as hospital competition grew, the buzzword was "bonding" as hospitals catered to physicians as "valuable customers" in order to attract their "loyalty."

In the 1990s, believing that managed care and capitation loomed, hospitals built integrated networks and

*continued on page 2 →*

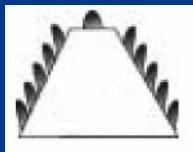
Published by

Bader & Associates

Governance Consultants,

Potomac, MD

Elaine Zablocki, Editor



→ continued from page 1

bought primary care practices by the dozen to ensure a flow of “covered lives” to their hospitals and networks of specialists. When capitation fizzled, many hospitals were left with big losses on their physician practices. Most said “never again” and swore off employing physicians except as a last resort to meet community or hospital needs.

Here and there, though, some health systems such as Aurora Health Care in Wisconsin, Sentara Healthcare in Virginia, Mayo Health System in the Midwest, and Sutter Health in California pressed forward with their integrated delivery models including system-owned or affiliated medical group practices. They’re now market leaders and national models.

Ed Howe, the now-retired CEO who built Aurora, recently wrote in his blog: “I continue to support integrated delivery as the best organizational solution. Some hospitals look at the employment model as a way to fill hospital beds. Successful integrated systems such as Aurora Healthcare, Mayo Clinic, Cleveland Clinic, and Geisinger Health System do not share that view. Rather, the central focus is on how to deliver the best care to patients. Good doctors want to practice good medicine—not fill hospital beds. Good care should reduce the need for and use of inpatient care.”

Many others agree. In a recent survey of more than 200 healthcare leaders by the Commonwealth Fund and Modern Healthcare, nearly nine of 10 respondents said “the way the delivery system is organized needs an overhaul.” Of those favoring a major overhaul, 88 percent think it is “likely or very likely that integrated delivery systems or large multispecialty groups are the best means to achieve effective care delivery.” Just 27 percent think “independent practice associations” of physicians are the best answer to providing effective and efficient care, and just 23 percent think “virtual connections” such as common information systems and payment incentives such as gain sharing will be sufficient.

Today, with hospitals and doctors each facing unprecedented economic pressures (see the sidebar “12 Signs You Need a Hospital-Physician Alignment Strategy”), hospitals and physicians are rediscovering the benefits of combining forces, gradually in some markets and more rapidly in others.

### White Paper Describes New Era of Hospital-Physician Alignment

The white paper entitled “Aligning Hospitals and Physicians: Formulating Strategy in a Changing Environment” (by Barry S. Bader, Edward A. Kazemek, and Pamela R. Knecht, with contributions from

continued on page 3 →

## 12 Signs You Need a Hospital-Physician Alignment Strategy

1. Shortage of primary care physicians.
2. Difficulty recruiting physician specialists.
3. On-call coverage problems in the emergency department.
4. Insufficient engagement of physicians in hospital-wide strategic planning.
5. Insufficient engagement of physicians in managing hospital product and service lines.
6. Insufficient engagement of physicians in hospital programs to improve efficiency, clinical quality, and patient safety.
7. Disconnected silos of currently employed physicians, owned practices, and joint ventures that don’t collaborate to manage costs and quality.
8. Hospitals lack options for private practice physicians not interested in employment.
9. Medical staff organization isn’t an effective forum for aligning interests.
10. Physicians are unwilling to volunteer for medical staff leadership roles.
11. Inability to respond to market demands for bundled pricing.
12. Inability to create a single hospital-physician “brand.”

→ continued from page 2

William F. Jessee, Donald S. Seymour, Dan Grauman, and John Harris), emphasizes that “alignment does not necessarily require employment of physicians by the hospital or a hospital-owned medical group (or in states like California, by a medical foundation).” However, alignment does mean that “the traditional relationships and structures connecting hospitals and physicians must change from loosely coupled to tightly coupled arrangements.”

“Hospital-physician alignment” may be defined as a close working relationship in which a hospital and physicians place a priority on working toward common economic and patient-centered goals, and they each avoid conduct that damages the other.

Employment of physicians by the hospital or a hospital-owned medical group can facilitate but does not guarantee alignment, nor is employment the only way to align with physicians. Joint ventures, professional services agreements or contracts, medical directorships, clinical institutes, medical service organizations (MSOs), and physician-hospital organizations (PHOs) also offer the ability to align with physicians to varying degrees. So, who is an “aligned physician?”

“Hospital-physician alignment” may be defined as a close working relationship in which a hospital and physicians place a priority on working toward common economic and patient-centered goals, and they each avoid conduct that damages the other.

Behavior rather than structure defines whether a hospital or health system, and a physician or physician group, are aligned. Alignment exists when:

- ☞ Physicians and the hospital or system share a common vision and strategic plan that they developed together.
- ☞ Physicians and the hospital or system practice according to common values, such as respect, trust, collaboration, and a commitment to excellence.
- ☞ Physicians are actively engaged in leadership roles in organization-wide strategic planning and in planning or co-managing hospital product and service lines.
- ☞ Physicians actively participate in programs to increase hospital efficiency, including timely turnaround of test results and operating rooms

for physicians, and lower lengths of stay and resource use.

- ☞ Physicians can recruit new colleagues without taking financial risk. The hospital can legally implement programs that help them live more predictable lives that balance professional and personal time.
- ☞ Physicians' compensation is based on their productivity, participation in organizational leadership, and achievement of shared economic and quality goals.
- ☞ Physicians and hospitals take responsibility to help each other comply with quality and safety standards and implement best practices.
- ☞ Physicians keep patient referrals within the system as much as possible.
- ☞ Physicians and the hospital participate together in pay-for-performance arrangements, and they can successfully bid for and manage bundled hospital-physician payments to care for particular conditions or treatments, such as joint replacements or cardiac surgery.
- ☞ The hospital medical staff leadership structure is populated by aligned, compensated physicians who are interested and trained in leadership, not by reluctant volunteers whose “turn” it is to chair a department or committee.
- ☞ Patients experience easy access and consistent standards of quality across the system, from physicians' offices and outpatient facilities to hospital inpatient care and sub-acute services such as rehabilitation and home care.

continued on page 4 →

→ continued from page 3

## Why Alignment Now?

Hospitals seek tighter physician ties to collaborate on pay-for-performance, quality improvement and efficiency projects, to maintain or grow market share, and to meet community needs such as on-call coverage in the emergency department.

At the same time, physicians are knocking on hospitals' doors seeking closer relationships, for a variety of reasons:

☞ Economic security. Declining reimbursement, higher malpractice costs, and increased regulatory burdens and practice expenses stress the financial viability of many physician practices. So do demands that practices invest in information systems in order to bill Medicare and private health plans. Many doctors are working harder and earning less, and thus are readier than ever for the economic security of an employment relationship.

☞ Retirement planning. Some medical practices want to recruit more physicians to meet rising community demand and to replace retiring physicians, but independent physicians and groups may be reluctant to risk the capital needed to recruit and support new physicians while they build a practice.

☞ New physicians' expectations. Many recently trained physicians are more interested in predictable hours and a guaranteed income than in becoming entrepreneurs in private practice. Some want support for

teaching and research. In markets where hospitals and large group practices offer these benefits, smaller groups and independent physicians are challenged to offer competitive packages and flexible scheduling to attract newly minted doctors.

☞ Payment system changes. Large employers and Medicare are moving toward bundled payments, single price contracting and pay-for-performance, but independent physician practices lack the capital and infrastructure needed to respond to these opportunities.

**“Over the next 10-20 years, it is likely that most physicians will be employed by systems, hospitals, or medical groups.”**

In the 1990s, physician interest in selling practices was motivated by fear and greed—fear that unless they joined an integrated system they'd be left out in the cold by managed care plans and greed when they saw colleagues get fat checks for “good will” when they sold their practices. The fear of freeze-out proved unfounded when capitated managed care floundered, and many practices that sold out experienced financial reverses or even bankruptcy. Some hospitals that bought practices spun them off or renegotiated physician compensation.

What's different this time around? Hospitals understand what it takes to run a viable physician practice. They aren't paying inflated prices to buy practices, and income guarantees have been replaced by physician compensation plans that reward productivity and quality. Physicians' expectations are more realistic. Physician compensation plans also recognize that practices which refer patients to hospital-based ancillary services and specialists are net gainers, not losers, for the system.

In addition, there's widespread agreement the healthcare system is broken and needs fundamental change from Congress to control rising costs while reducing the number of uninsured. Whatever legislation comes out of Congress is likely to tighten the screws on providers' revenues. So will interim steps by public and private payers. Pressures to manage expenses, improve efficiency, and meet quality standards will grow, driving further consolidation of hospitals and tighter relationships with physicians to manage care, costs, and quality.

“Over the next 10-20 years, it is likely that most physicians will be employed by systems, hospitals, or medical groups,” says the white paper.

continued on page 5 →

→ continued from page 4

## Developing the Right Alignment Strategy for Your Hospital

The challenge for a health system or hospital is to attract a critical mass of aligned physicians at a time when many physicians are still hesitant to relinquish their independence and become employed by a hospital. In response, hospitals are opening their tool kit of alignment vehicles, hiring doctors and buying practices, and also forming joint ventures, contracting with hospital-based physicians, experimenting with gain sharing, and so forth.

The risk is that all these deals will prove too costly, saddling systems with financial losses, and adding up to less than the sum of their parts, with a delivery system that's too weak to manage costs and quality.

To manage the risks, hospitals and health systems need to develop a strategic plan for physician alignment that is an integral part of the organization's overall strategic plan. The planning process should be inclusive, bringing board, senior management, and physicians together for education and discussion that builds mutual understanding and trust.

Many physicians, trustees, and even executives think alignment requires employment. Therefore, the planning process should incorporate education on the various alignment mechanisms that are available, including but not limited to:

- ☞ Employment, either by the hospital or by a hospital-owned medical group.
- ☞ Joint ventures for specific services and facilities.
- ☞ Professional services contracts for specific services.
- ☞ Gain sharing plans for inpatient services.
- ☞ Clinical institutes co-owned or co-managed by the system and physicians.
- ☞ Medical Services Organizations (MSOs) and Physician Hospital Organizations (PHOs) that offer support services to affiliated private physicians and organize providers to work jointly to manage clinical care quality and efficiency.
- ☞ IT linkages to physician offices.
- ☞ Collaboration on patient-centered quality improvement projects.
- ☞ "Physician Cabinet" of active clinicians in various specialties to provide advice on clinical priorities, strategic plans, and medical capital spending.
- ☞ Full-time clinical department chairs and medical directors.
- ☞ Restructured medical staff organization.

Education should examine the pros and cons of each alignment option. For example, although joint ventures for specific services and facilities, such as an outpatient surgery center, can be effective in maintaining or growing market share in one service line, they don't improve the hospital's broader ability to partner with physicians to manage quality and costs in all inpatient and outpatient facilities, or to provide ED coverage or fill medical staff leadership roles.

Figure 1, based on the white paper, presents an alignment continuum that illustrates how as a system employs increasing numbers of doctors, implements other alignment strategies, and builds a common culture among once competing independent practices, it increases the percentage of its physicians who are aligned.

- ☞ At the extreme left of the continuum, hospitals and physicians are "fully independent," economically and organizationally.
- ☞ In the middle, integration increases through multiple mechanisms such as employed physician leaders, joint ventures, and a small number of system-owned, physician practices.
- ☞ At the extreme right, hospitals and physicians are "fully integrated" clinically and economically, often in a system-owned multispecialty group practice or practices.

In a strategic planning process, leaders can determine where their organization stands today on the continuum, where it hopes to be in three to five years, and how it plans to achieve its targets.

## Five Key Elements of a Strategic Plan for Physician Alignment

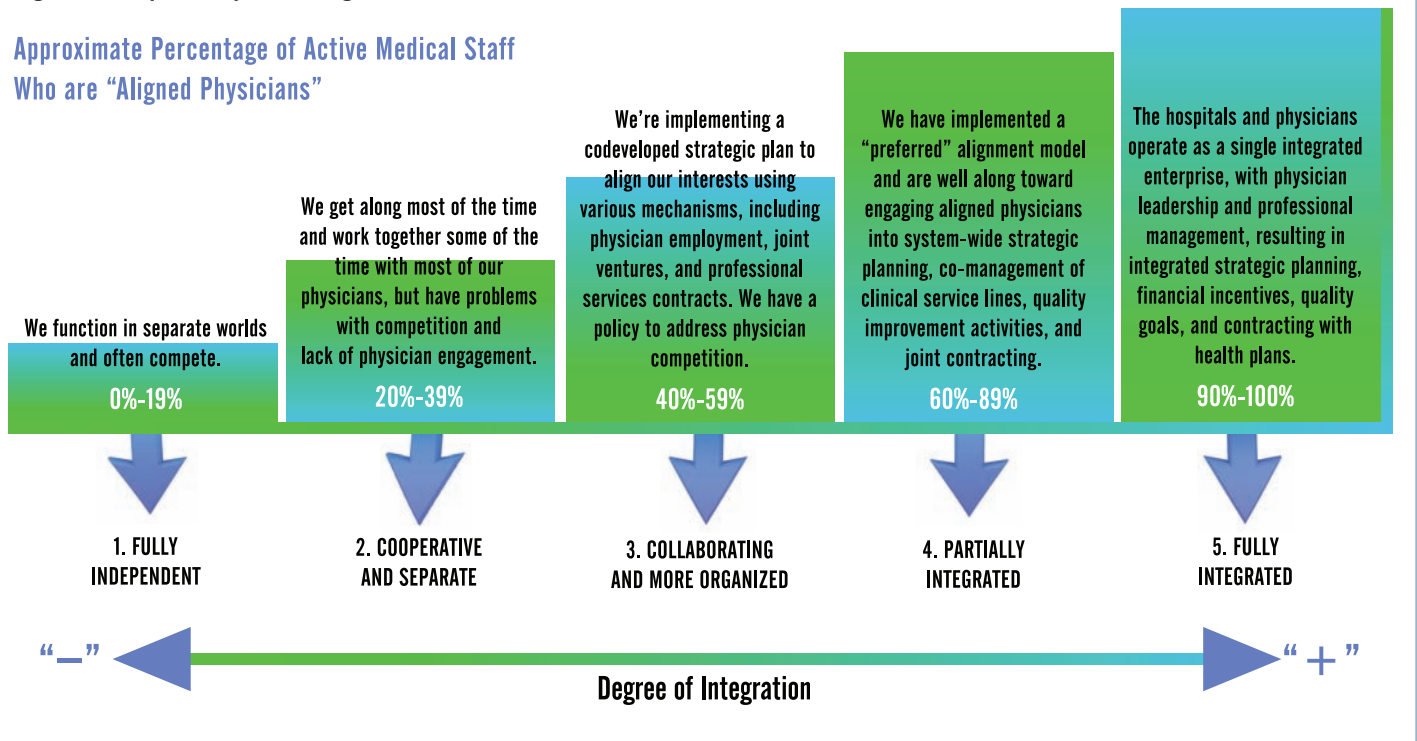
The physician alignment plan should include at least these elements:

1. Vision statement that is quality- or patient-centered. Hospitals and physicians share a common interest in providing better quality and safer, more accessible patient care. The vision statement should excite

continued on page 6 →

**Figure 1. Hospital-Physician Alignment Continuum**

Approximate Percentage of Active Medical Staff Who are “Aligned Physicians”



→ continued from page 5

prospective physician partners about the benefits to their patients of aligning with the hospital, as well as the economic benefits physicians and the hospital will receive.

2. Rationale for alignment. The plan should review the major environmental forces that are driving hospitals and physicians to develop closer ties.

3. High level and measurable strategic goals. The plan should answer the question, “What will our integrated system look like in five years if we are successful?” For example, how many physicians will be aligned, and what percentage of

system revenues will be generated by aligned physicians? What will be our market share? How will our quality scores improve?

4. Clearly defined alignment model. The plan should indicate whether the hospital has a “preferred alignment model,” such as a multi-specialty group practice, and whether it will consider alternatives such as joint ventures and professional services contracts.

5. Major strategic initiatives. Under each strategic goal, the plan should describe specific strategic initiatives and identify a timeline and assignment of responsibility.

Examples include:

- ☞ Organize employed physicians and hospital-owned groups into a single group practice within one year.
- ☞ Recruit 50-75 new physicians to the community in specialties identified in the medical staff development plan.
- ☞ Develop a hospitalist program.
- ☞ Develop an intensivist program.
- ☞ Meet with medical groups in targeted specialties to identify their interest in employment, a joint venture, or other alignment entity, and proceed accordingly.

continued on page 7 →

→ continued from page 6

## Employment: Is It the End Game?

The white paper profiles a number of health systems that are in varying stages of physician alignment. In all of them, trust was a foundational element, and each is pursuing alignment in ways suited to its local market and physician culture:

☞ DeKalb Medical in Decatur, Ga., employs only 25 primary care physicians but it's using a PHO that includes 80 percent of medical staff members to team up on joint information technology, best practices, and performance improvement projects.

☞ Eastern Maine Medical Center employs 50 percent of its physicians—a trend in many Maine systems—and has just one joint venture. All employed physicians are on

incentive plans that align physician and system goals, and the financial results of every service line are transparent to build trust with doctors.

☞ Aurora Health Care in Milwaukee, Wis., generates 73 percent of system volume from aligned physicians, including the 750-member Aurora Medical Group. The system was built on “the vision that an integrated system is a better way to deliver care,” says retired Aurora executive Elliott Huxley, M.D.

☞ Sentara Healthcare in Norfolk, Va., employs 360 physicians in its medical group today and is on an aggressive path to reach more than 500 by 2012. Sentara still has private practice physicians, but it promotes employment in the physician-led group as its “preferred model.”

☞ Essentia Health in Duluth, Minn. has 10 hospitals and has 700 fully integrated physicians, most of them employed.

The integrated systems profiled in the white paper and several others, including St. John's Health System in Springfield, Mo.; Mayo Health System based in Rochester, Minn.; and Guthrie Clinic in Sayre, Pa., all have made physician engagement in governance and leadership a cornerstone of their integrated organizations.

“We say we are ‘physician-driven and professionally managed,’” says Don Sorensen, a senior executive with St. John's. It's that partnership that's made St. John's one of the nation's highest-ranked integrated systems in recent Solucient surveys of top systems.

Peter Person, M.D., CEO of Essentia Health, says in the long run, employment of physicians by health systems will prove to be the “superior” model at managing care and costs, in comparison to the “portfolio of deals” many health systems are pursuing. However, Person cautions that unless physicians are viewed as “full partners” in the clinical enterprise, not “just employees,” the employment model will fail. To cement a partnership built on trust, Essentia embeds physicians throughout the system's leadership. The CEO is a doctor, four physicians serve on the 15-member system board, and physician-administrator teams manage each of Essentia's three regions and every system service line.

“The goal is to streamline the organization,” says Person. “Complexity (the kind of complexity that results from multiple deals with doctors) brings the potential for conflicts and internecine warfare.”

Employment may well be the end game, but when independent physicians simply aren't interested in employment, then agreeing to a joint venture or contractual relationship may be better than losing the physicians or turning their practice into a competitor. Hospitals and physicians who join together to craft a strategic plan for alignment that's right for their situation will have a leg up in addressing the massive changes in healthcare that lie ahead.

— 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](mailto:bbader@GreatBoards.org) or call 301-340-0903.

### Get Your Copy of “Aligning Hospital's and Physicians: Formulating Strategy in a Changing Environment”

You can get your copy of The Governance Institute's white paper by calling 1-877-712-8778 or by going to [www.governanceinstitute.com](http://www.governanceinstitute.com). Copies for nonmembers are \$95 each. Members may download a PDF copy free or order printed copies at deep discounts.

## Turn Off the Fire Hose:



## Innovative Approaches to Board Orientation

By Elaine Zablocki

Hospital and health system boards are implementing a variety of innovative ideas to get new directors up to speed quickly. Traditional approaches, such as meeting for a few hours with the CEO and reviewing a thick board orientation manual, are still part of the process. However, this approach is often called “orientation by fire hose.” Directors are hit with too much too quickly, without the context of real board work, and they often don’t absorb the deeper implications of this deluge of information.

Consequently, boards and senior managers are reconsidering their approaches to orientation, offering a more gradual process, with additional support for new members. They are seeking ways to let new trustee members experience healthcare from the clinician’s and patient’s viewpoint. They are encouraging new members to seek long-term education at external conferences and internal retreats. In this issue of *Great Boards*, we gather pointers from innovative hospitals and health systems that are pioneering new ways to orient board members most effectively.

### Ten Great Ways to Orient New Board Members

- Offer a preselection orientation.
- Schedule an initial meeting with the CEO and senior management.
- Set up mentoring relationships.
- Develop a White Coat Program.
- Encourage attendance at national conferences.
- Develop a comprehensive governance manual.
- Provide system-wide orientation for new directors in a system.
- Encourage exploratory committee rotations.
- Apply adult learning methods.
- Customize orientation for individual needs.

### Complex System Relies on One-Year Orientation Process

Northeast Health (NEH), in Troy, N.Y., is an integrated system with two community hospitals, plus extensive long-term care services at The Eddy (home health, nursing home, housing, and rehabilitation). In the end, the system board is responsible for a total of 18 corporations. “Each board member has a lot of responsibility. We find it takes years to really understand our system, both long-term care and acute care,” says Tricia Brown, vice president for corporate affairs.

NEH has developed a one-year personalized orientation process that could serve as a model for other complex organizations. The most essential information comes first, and the picture is broadened and deepened over the first year. One key part of the process is that each new board member is teamed with a more experienced trustee for orientation and support.

Before election, during the selection process, a potential board member generally meets with the chair and CEO. “They get a good introduction to our system, not so much the paperwork and documentation, but just a general discussion on our strategy and where we’re going . . . whether they are a good fit for us, and we are a good fit for them,” Brown says.

*continued on page 9 →*

→ continued from page 8

Then, before the first board meeting, new members meet with the CEO and CFO and other top executives of the hospital division and the long-term care division to get a basic orientation to the two aspects of the system and to financial issues.

A new board member is immediately paired with a mentor, an experienced board member who is often the person who recruited or recommended the individual for the board. This mentor welcomes the new member with a phone call or visit, offers an orientation to the first board meeting, and answers any questions. The mentor may sit next to the new board member at meetings to offer background information and explain the process. The mentor may also call the new board member between meetings to touch base and offer any needed assistance.

Northeast Health has invested resources in developing an online board portal, which only board members can access. It includes member bios and contact information, the board calendar, meeting materials, legal documents, strategic plan, and other resources. A new board member sits down with the administrative assistant to the CEO to establish a working relationship and take a tour through the portal. "This is nice, because you don't have to constantly update sections in the printed board manual," Brown says. "However, I have to tell you honestly, it isn't accessed as often as we would like. At one point, board members utilized the portal to pull off

meeting materials. Then we had a major board restructuring and reverted to our old ways of sending packets."

During their first three months on the board, new members meet one on one with key staffers in various functional areas, including patient

care, finance, medical affairs/quality, legal issues, corporate compliance, strategy, human resources, information services, marketing, and corporate affairs.

Over the first six months a new board member has an opportunity to attend

continued on page 10 →

## Use Adult Learning Principles for Effective Board Orientation

Board members have a great deal of expertise in various fields. In fact, they are often on the board precisely because they're highly respected in the fields to which they have devoted their lives.

However, while they may be extremely knowledgeable in these areas, they may not be experts in the healthcare industry and/or not-for-profit board service. They may need to learn that body of information and skills.

To offer the most effective board orientation process, learn from the large body of knowledge on adult learning developed by Malcolm Knowles and others in the fields of training and development. To begin with, it is important to understand that the way adults learn is very different from the way children learn. Here are some of the key differences, according to Knowles:

**Adults are autonomous and self-directed.** That means board orientation and education should be based on trustee needs and interests. At least annually we should ask both the full board and each individual board member "what do you think you need to learn more about?" This question will uncover information gaps that should be filled. As an important side benefit, board members will be more interested in and responsive to the educational process, because the information relates directly to their own questions.

At the same time, a brand new board member won't generally know exactly what they need to know, so the orientation process needs to be respectful of their existing expertise while providing a sensitive presentation of most-needed information.

continued on page 10 →

→ continued from page 9

a meeting of each committee, and then decide which committee assignments he or she would prefer. Over the first year, they have an opportunity to visit some of the sites. This can be challenging since there are 16 different sites in the system plus clinics. “We definitely want to get them out to one of the hospitals as soon as we can,” Brown says. “If they visit a nursing home, our Alzheimer’s center, the rehab hospital, and one of our retirement communities, that gives them a feel for some of our (sub-acute) service lines.” Some board members eventually visit every one of the sites, but it takes years.

### *Donning a White Coat to Absorb the Clinician’s Viewpoint*

Hospital tours for new trustees are common. Washington Hospital Center (WHC), in Washington, D.C., gives new trustees a tour and a half-day individual orientation session—and then it goes a step further.

About five years ago, WHC, a regional referral center with 926 beds and 6,000 employees, implemented a White Coat Program designed to help new trustees better understand what the hospital looks like from the clinician’s and patient’s perspective.

During their first year, new board members are expected to spend a 12-hour day wearing a white coat and observing care in various hospital departments, accompanied by a senior physician. Many scrub in to watch surgery, observe faculty quizzing residents, or talk directly

→ *Adult Learning Principles continued from page 9*

**Adults have accumulated a foundation of relevant life experiences and knowledge**, based on their work, family responsibilities, and education. Learning is most effective when it connects to this knowledge/experience base, so presentations should draw out participants’ relevant knowledge. Expect and welcome comments and examples based on board members’ own experiences.

**Adults are goal-oriented.** That means any orientation or education program should be focused and clearly organized. Start out by listing the objectives and agenda for the day, so people understand what they’re expected to accomplish in the available time.

**Adults are relevancy-oriented;** they need to see a reason for learning something. In board orientation, we need to be able to explain why they need the information, and how they’re going to use it. Too often board members are given intricate data but don’t know how to link it to the larger strategic questions the board must address.

Instead of detailed data printouts, offer information in the context of the strategic issues facing the organization. It’s important for board members to receive this type of governance level information from the very beginning. Senior management needs to make a conscious effort to focus board packet information and presentations on high-level strategic trends presented in graphic summaries.

**Adults are practical** and tend to focus on information that will be most useful to them in their work. The board orientation should include practical, take-home tools that new board members can use right away.

**All learners, both children and adults, should be treated with respect** throughout the learning process. Adult learning is a peer-to-peer relationship.

Pamela R. Knecht, President  
**ACCORD LIMITED**, Chicago

with patients about the care they’ve experienced.

The hospital’s strategic service lines include cardiac care, cancer, neurosciences, imaging, and ER/trauma. “We try to offer each board member

some of the flavor of these services,” says James F. Caldas, WHC president. “We may show them the gamma knife, and/or cardiac surgery, and/or the latest imaging equipment in our cancer institute. They get a

continued on page 11 →

→ continued from page 10

vivid sense of the technology and science, as well as the people and personalities that comprise these services.” While many hospitals give new board members a tour of the facility, Caldas doesn’t know of any other hospital that puts them right on the floor wearing a white coat.

WHC board member Bill Edwards, president of Edwards and Associates, LLC, recalls his days in a white coat as an eye-opening experience. During his first year on the board, he spent a full day in the catheterization lab and spent additional time observing a gastroenterologist’s office and the ER.

“I watched them bring in a woman from a rural area who was flat-lining,” he recalls. “They used electronic paddles, put in a medicated stent, and she walked away a few days later.” After his day in the cath lab he took away a fuller understanding of the board’s responsibility “to clear away bureaucratic and equipment hassles so the medical people can concentrate on what they need to do. The White Coat Program allows a nonmedical person to understand the pressures a doctor faces.”

Edwards used to be area vice president for the mid-Atlantic region of Hilton Hotels, with an office in the Washington Hilton. The pressure of managing an inaugural ball is nothing, he says, compared to the pressure of front-line medical care. “If something goes wrong in the hotel, you always have a fallback position. Physicians generally do not get an

opportunity to do things over. Watching the constant interaction between the doctor and his staff is like a football team. You walk away with a new understanding of what the nursing shortage actually means.”

### Using External Conferences to Broaden Perspective

Because board members need to absorb so much information, many hospital and health systems encourage them to attend external conferences. For example, The Governance Institute (TGI) in San Diego presents a three-hour orientation for new trustees at each of its eight leadership conferences a year in various parts of the country. Orientation sessions cover a board’s fiduciary duties, the difference between the roles of board and management, and best practices for executing governance responsibilities for strategy, quality, finance, management oversight, advocacy, and governance. New trustees then attend the conference’s regular sessions featuring national speakers on current hot topics.

“We try to instill the importance of developing a director’s temperament,” says Barry S. Bader, a governance consultant who conducts some of the orientations. “We stress the importance of being informed and engaged, being a partner to the CEO while assertively raising questions and holding management accountable. The boardroom is no place for wallflowers.”

Covenant Health, Knoxville, Tenn., an integrated system that includes six tertiary care hospitals, encourages board members to go to TGI conferences at least once every three years, but many board members attend more often.

“Our board members come from a wide variety of backgrounds, including business people, military retirees, bankers, county leaders, and physicians,” says Board Chair Fran Olmstead. “These meetings are extremely valuable in orienting new members because there is so much to learn: financing, government regulations, healthcare quality.” Generally, three or four board members go as a group, together with a member of the executive team. At present, 85 percent of Covenant’s board members have attended at least one TGI conference.

Fisher-Titus Medical Center, a community hospital in Norwalk, Ohio, with 88 acute beds and 69 long-term care beds, encourages members of both the hospital board and parent board to attend an external conference once a year. “We use conferences such as The Governance Institute for new board orientation and continuing education,” says Patrick Martin, president and CEO. “It is never mandatory, but it is something we encourage.” Medical staff and administrators are also urged to attend. “Our philosophy here is to encourage more than one person to go, since there are several different tracks and that’s the only way you can cover all the material.

continued on page 12 →

→ continued from page 11

In addition, these conferences offer a valuable way for board members to get to know each other, and for bonding experiences between members of the management team, the medical staff, and the board.”

Back home, Fisher-Titus generally offers new board members an opportunity to rotate through various committees, to see where their interests lie. They may serve on one committee for two or three years, and then move to another committee, or add a second committee. Martin emphasizes that it takes a long while for board members to be fully oriented to the hospital’s needs and organization. “Our facility covers eight acres under one roof, and it’s a quarter of a mile from the ER to the nursing home. It takes a couple of years just to find out where all the bathrooms are.”

### *Imbuing New Board Members with a Sense of Continuing Mission*

The Sisters of Charity of Leavenworth Health System (SCLHS) has nine hospitals and four clinics, operating in Kansas, Colorado, Montana, and California. The system was founded 150 years ago by nuns who traveled in covered wagons to serve western pioneers. Inculcating new board members with the history and mission of the organization spirit is an important part of their orientation process.

## **Making the Complexity of Healthcare Less Overwhelming**

Leslie Stoneham, who farms 2,000 acres of soybeans, corn, and wheat, joined the Fisher-Titus board in April 2003. Currently he is the vice chair. “I had no previous experience serving on a hospital board,” he says. “At first I was overwhelmed with the complexity of the healthcare system.” During his day-long orientation he appreciated the tour of the hospital, visiting all departments, and chatting with staff. “We saw everything from the roof to the underground tunnel. We visited maintenance, housekeeping, and of course all the medical areas. That broad overview was really helpful,” he says.

Fisher-Titus continues to involve board members with a hands-on approach. They regularly attend Christmas parties and the annual employee picnic. “At Christmas, we have three holiday meals for the various shifts, and board members carve the roast beef, turkey, and ham,” Stoneham says. “At my first Christmas party, our CEO invited me to stand next to him so he could introduce me to everyone. I find that when we mingle with employees and listen to their input, it helps improve the quality of our hospital.”

SCLHS has a three-tiered governance model. The Sisters of Charity of Leavenworth, as sponsors of the system, retain certain rights over mission-critical matters, the SCLHS board acts as the system’s governing board, and each hospital and clinic has its own (affiliate) board. Members serve for a three-year term (and possibly one additional term), so each year there’s a substantial crop of new members to orient. The system holds a two-day affiliate board orientation meeting in Kansas City each fall before new members attend their first board meeting in November.

“We generally have about 75 people,” says Peggy Ford, SCLHS director of governance. “Since they come from four states, we need a way for people to get acquainted. We start out with our own version of the Jeopardy game, based on little-known facts about our hospitals.”

After an informal evening, the next day begins with a prayer, a poem, or a moment of silence. The morning is filled with talks on the SCLHS governance model and the basic principles of governance excellence. Then there’s a change of pace, and everyone leaves in small groups for a four-hour tour of the Mother House, where the first sisters lived, and some still live. New board members view photos of those first mission days, and visit the cemetery where the pioneering nuns are buried.

“Then the groups visit the chapel. Each new board member is commissioned by the sisters with a blessing

continued on page 13→

→ continued from page 12

and a pin on their lapel,” Ford says. “We believe this grounds them in the true sense of our mission; we think this is critical for the success of our boards.”

The rest of the orientation schedule is filled with technical material and ways to get acquainted, in equal measure. All the system officers offer presentations, so new board members have a chance to “put a face with a name.” They go home with an exceptionally clear 40-page governance manual summarizing board structure and responsibilities. The appendices, which show how authority and responsibility for various functions are portioned out among the three SCLHS governance levels, include a detailed list of all governance responsibilities, a list that would be a valuable resource for all governing boards. (The SCLHS Governance Manual will be available on the Great Boards Web site in 2009.)

In addition, each hospital and clinic provides its own half-day to full day orientation for new board members. Every new board member is paired with an experienced board member as a mentor. They’re encouraged to attend at least one meeting of each committee during their first year as a way of becoming more familiar with board processes, and seeing where they might serve in committee work.

Accurate preliminary discussions with potential board members are a major factor in successful board orientation. “When someone asks about the time commitment in this work, we tell them it could be 150 to 200 hours per year,” Ford says. “That is a huge commitment, and people take it on because they are volunteers who care about healthcare in the community where they live.”

New board members bring a wide variety of interests and skills. Some of them have professional backgrounds that add depth to their view of healthcare—like Bill Edwards, for example, whose previous hotel experience gives him a unique viewpoint on the customer service aspects of hospital management. Others bring a special interest in finance or a nursing background or a wealth of community contacts.

Think about ways to customize the orientation process so it meets each director’s specific needs, and maximizes the value directors bring to your board. If they already have clearly defined areas of special interest, then target their orientation and mentor to match those areas. If someone is a generalist, give him or her an opportunity to rotate through committees and tour other areas of the hospital. There’s no need for a rigid “one size fits all” orientation process. Since time is so valuable, think ahead and plan the best possible use of each new board member’s orientation time.

## \*\* FOR MORE INFORMATION:

**Tricia Brown**

**Brownt@nehealth.com**

**James F. Caldas**

**James.F.Caldas@Medstar.net**

**Bill Edwards**

**Bill.Edwards@gmail.com**

**Peggy Ford**

**Peggy.Ford@sclhs.net**

**Pamela R. Knecht**

**Pknecht@accordlimited.com**

**Patrick Martin**

**Pmartin@ftmc.com**

**Fran Olmstead**

**Fhomho@aol.com**

**Leslie Stoneham**

**Stoneles@accnorwalk.com**

**The Governance Institute**

**www.governanceinstitute.com**

— 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, e-mail [greatboards@ezab.net](mailto:greatboards@ezab.net).

GREAT BOARDS is published by Bader & Associates  
Governance Consultants | 12225 Seline Way,  
Potomac, Maryland 20854

Phone: 301-340-0903

E-mail: [bbader@GreatBoards.org](mailto:bbader@GreatBoards.org)

[www.GreatBoards.org](http://www.GreatBoards.org)

Graphic Design by: Ruzow Graphics, Inc.

[www.ruzowgraphics.com](http://www.ruzowgraphics.com)

© 2008 Bader & Associates. Information in *Great Boards* may be used by individual organizations for their own board education and development, but may not otherwise be published or reproduced for distribution without the permission of Bader & Associates.