

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-

continued on page 2 →

Published by
Bader & Associates
Governance Consultants,
Potomac, MD



→ continued from page 1

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.

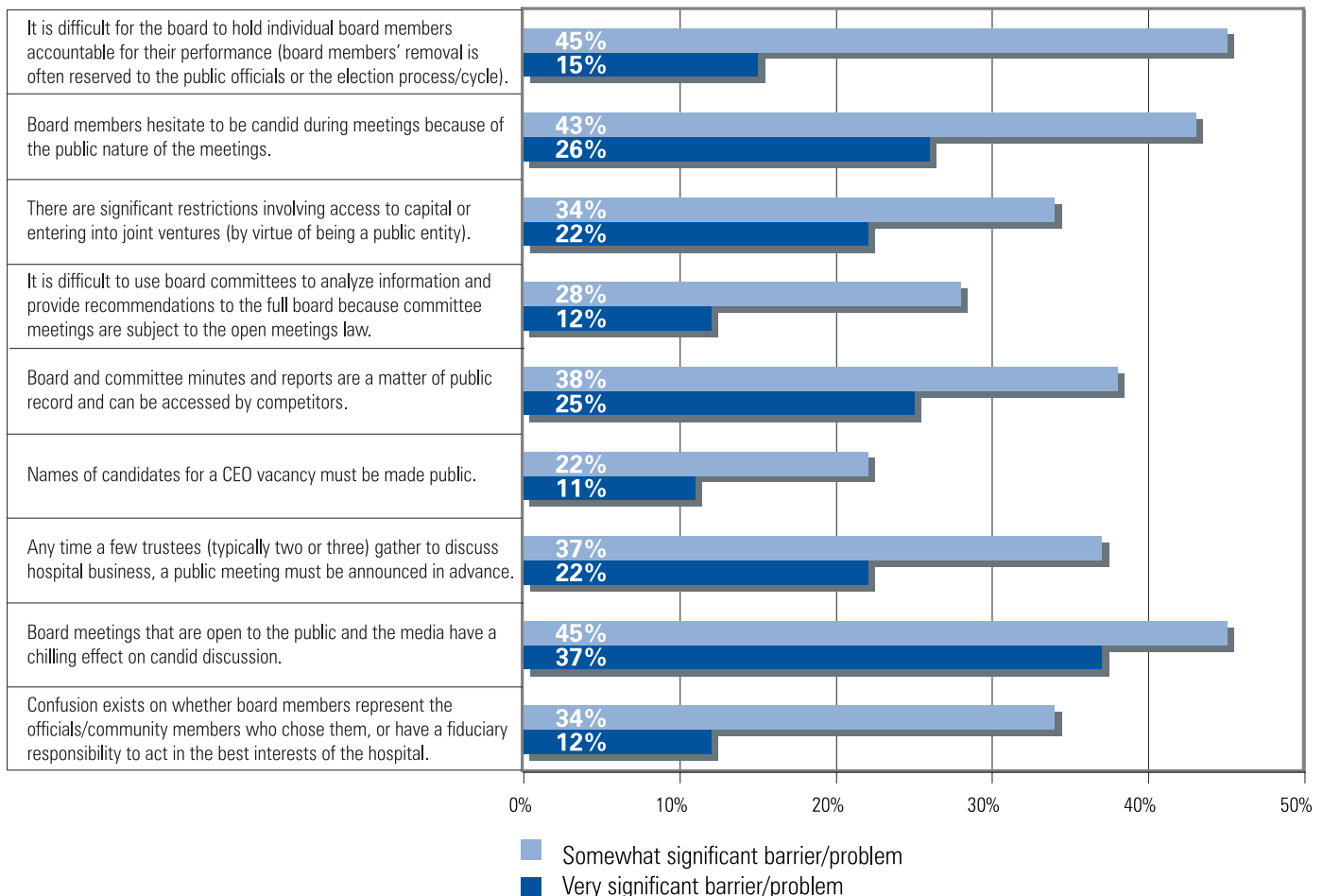
However, more than 45% of the respondent hospitals said their board had instituted policies and practices that are successfully addressing potential barriers to effective governance.

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

continued on page 3 →

Potential Problems and Barriers to Effective Governance of Public Hospitals



→ continued from page 2

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

continued on page 4 →

→ continued from page 3

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.

continued on page 5 →

→ continued from page 4

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

continued on page 6 →

The most difficult CEO searches to conduct are those for public hospitals, where candidate identification is required. 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.

— Roger A. Quick, president and CEO, Quick Leonard Kieffer

→ *continued from page 5*

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.

continued on page 7 →

→ continued from page 6

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.

For More Information:

Darlene M. Ebert
Darlene.ebert@dhha.org

Larry S. Gage
lgage@pogolaw.com

Martha C. Hauser
MarthaH@wittkiewer.com

Robert Heckert
rheckert@dchosp.org

Patrick M. Hermanson
path@portmed.org

Richard Irwin
RichardIrwin@HealthCentral.org

William Mahoney
wmahoney@lcmc.com

Roger A. Quick
RQuick@qlksearch.com

Sharon Tanner
stanner@albemarlehealth.org