The ADVISORS' CORNER Anthology

TWENTY INSIGHTFUL ARTICLES
FROM THE *BOARDROOM PRESS* NEWSLETTER

VOLUME ONE • APRIL 2006–APRIL 2010

The Governance Institute®

The essential resource for governance knowledge and solutions®

9685 Via Excelencia • Suite 100 • San Diego, CA 92126
Toll Free (877) 712-8778 • **Fax** (858) 909-0813
GovernanceInstitute.com

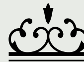
The Governance Institute®

The essential resource for governance knowledge and solutions®

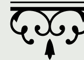
9685 Via Excelencia • Suite 100 • San Diego, CA 92126

Toll Free (877) 712-8778 • **Fax** (858) 909-0813

GovernanceInstitute.com



Charles M. Ewell, Ph.D.	Founder
Jona Raasch	Chief Executive Officer
Mike Wirth	President
James A. Rice, Ph.D., FACHE	Vice Chairman
Cynthia Ballow	Vice President, Operations
Kathryn C. Peisert	Managing Editor
Glenn Kramer	Creative Director
Kayla Cook	Assistant Editor



The Governance Institute is a division of National Research Corporation. Leading in the field of healthcare governance since 1986, The Governance Institute provides education and information services to hospital and health system boards of directors across the country. For more information about our services, please call toll free at (877) 712-8778, or visit our Web site at GovernanceInstitute.com.

The Governance Institute endeavors to ensure the accuracy of the information it provides to its members. This publication contains data obtained from multiple sources, and The Governance Institute cannot guarantee the accuracy of the information or its analysis in all cases. The Governance Institute is not involved in representation of clinical, legal, accounting, or other professional services. Its publications should not be construed as professional advice based on any specific set of facts or circumstances. Ideas or opinions expressed remain the responsibility of the named author(s). In regards to matters that involve clinical practice and direct patient treatment, members are advised to consult with their medical staffs and senior management, or other appropriate professionals, prior to implementing any changes based on this publication. The Governance Institute is not responsible for any claims or losses that may arise from any errors or omissions in our publications whether caused by The Governance Institute or its sources.

© 2011 The Governance Institute. All rights reserved. Reproduction of this publication in whole or part is expressly forbidden without prior written consent.

The ADVISORS' CORNER *Anthology*

TWENTY INSIGHTFUL ARTICLES
FROM THE *BOARDROOM PRESS* NEWSLETTER

VOLUME ONE • APRIL 2006–APRIL 2010

The Advisor's Corner is a regular column in BoardRoom Press, The Governance Institute's bimonthly newsletter. Written by our Governance Advisors, the column provides practical insights and guidance to Governance Institute members by addressing governance issues faced by boards of tax-exempt hospitals and health systems. Topics range from choosing directors with the "right stuff," to physician participation on the board, to addressing the implications of health reform. This volume contains 20 Advisors' Corner articles published since April 2006, organized by subject heading as a handy reference guide for readers.

About the Governance Advisors

Barry S. Bader[1]

Edward A. Kazemek

Pamela R. Knecht

Barry Bader, president of Bader & Associates, is a consultant, speaker, and retreat facilitator specializing in hospital and health system governance, the board's role in quality, and the relationship of hospitals, physicians, and senior management. He is an advocate for governance accountability, transparency, education, and engagement, and helps clients to build a strong partnership among the board, senior management, and clinical leadership. Since founding Bader & Associates in 1980, Mr. Bader has conducted board retreats and consulted on governance evaluation, restructuring, and improvement initiatives for boards throughout the U.S. and Canada.

As chairman and CEO of **ACCORD** LIMITED, Ed Kazemek has overall responsibility for the development and operations of the firm. He works closely with other ACCORD consultants to identify creative solutions to the issues and problems facing clients. Ed's areas of specialization include governance assessment/restructuring, board development, strategic planning, organizational analysis and development, change management, merger/collaborative arrangements, and facilitating integration and effective management in complex organizations.

Pamela R. Knecht, president of **ACCORD** LIMITED, has provided consulting services to a wide range of industries and organizations over her 29-year career. During the last 16 years, she has focused on assisting boards and CEOs of not-for-profit hospitals, health systems, and associations across the country with governance assessment, restructuring, and development; strategic planning; organizational diagnosis and change management; team effectiveness; and physician collaboration.

Continued

1 As of April 2011, Barry Bader is no longer affiliated with The Governance Institute. He was a contributing author to the articles in this collection.

Don Seymour

Don Seymour is president of Don Seymour & Associates, executive editor of Futurescan™, an American College of Healthcare Executives faculty member, past chair of the American Association of Healthcare Consultants, and recipient of the American Hospital Association/Society for Healthcare Strategy & Market Development Award for Individual Professional Excellence. Mr. Seymour has advised boards, CEOs, and physician leaders for over 25 years. A frequent author, speaker, and retreat facilitator on governance, strategy, and medical staff issues, he works exclusively with hospitals, healthcare systems, and physicians throughout the United States.

Roger W. Witalis, FACHE

Roger Witalis brings to his clients over 35 years of experience serving many of the leading healthcare systems, medical centers, hospitals, physician organizations, and professional associations throughout the United States. Roger is a founding member of the Governance Advisors, the consulting resource of The Governance Institute (TGI). He has been actively engaged with TGI as speaker, researcher, editor, author, facilitator, and advisor to a wide range of TGI members.

Acknowledgements

Eric D. Lister, M.D., managing director, Ki Associates, served as a governance advisor for roughly one year between August 2008 and April 2009. He was a contributing author on three of the articles in this volume.

About The Governance Institute

The Governance Institute provides trusted, independent information and resources to board members, healthcare executives, and physician leaders in support of their efforts to lead and govern their organizations.

The Governance Institute is a membership organization serving not-for-profit hospital and health system boards of directors, executives, and physician leadership. Membership services are provided through research and publications, conferences, and advisory services. In addition to its membership services, The Governance Institute conducts research studies, tracks healthcare industry trends, and showcases governance practices of leading healthcare boards across the country.

Table of Contents

STRUCTURE AND PRACTICE

1 Building the Governance "Playbook"

2 Choosing Directors with the "Right Stuff"

3 Board Member Terms: To Limit or Not?

4 "Drill Baby, Drill" Is Not Appropriate Boardroom Practice

6 Successful Board Retreats

7 Building the Board Chairperson–CEO Relationship

POLICY

8 Should the Full Board Approve the CEO's Compensation?

9 Public Transparency: Should You Be Proactive or Reactive?

10 Who Is an Independent Director?

12 Disruptive Board Members

PHYSICIANS

13 Physician Participation on the Hospital Board: A Moving Target

16 Physicians on the Board: Conflict Over Conflicts

18 Physician Engagement Models Fill the Knowledge Gap

QUALITY

19 Differentiating Board and Committee Work on Quality

20 The Board Quality Committee Goes to Work

STRATEGIC PLANNING

22 Strategic Planning: Work for the Full Board or a Committee?

23 Healthcare Policy: Seven Questions Boards Must Ask

25 Hospitals 2020—Specialized, Integrated, & Connected

SYSTEMS

27 The System–Subsidiary Relationship in Hospital Governance

29 System Affiliation Discussions Require Carefully Structured Process

Building the Governance "Playbook"

June 2006 • Roger W. Witalis, FACHE

Although I am not a dedicated sports fan, I do look forward each spring to the NCAA basketball playoffs. This past year the University of Florida was crowned champion for the first time in school history. What this team demonstrated to all their defeated opponents and the sports world in general was the value of "team discipline." There is no question that each member of the Florida team possessed incredible talent. Beyond competence, this team knew what it was doing as a unit. It passed, it assisted, it rebounded, and it scored like a highly tuned machine. What it had was a well designed and executed playbook, crafted by a dedicated and disciplined coach to inspire, lead, teach, direct, and focus his players to victory. So what does this have to do with governance? Everything.

The governing boards of our hospitals and health systems are filled with competent players (trustees). Unfortunately, like the other teams in the NCAA, too many boards lack an inspiring coach and disciplined playbook. By inspiring coach I mean chairperson, the person most responsible for the board working as a team. By disciplined playbook I mean an orientation manual that orients, directs, and coaches. Not the traditional encyclopedia, the size of a phonebook that no one reads or uses, but a document that becomes dog-eared, wrinkled, carried to meetings, and is constantly referenced and updated. So what should be included in the governance playbook? The following outline suggested by Governance Advisor Barry Bader is a great starting point:

About the Hospital or Health System

A. Brief organizational history (2–3 pages)
B. Summary of industry trends and marketplace challenges
C. Statement of mission, vision, and core values
D. Organization charts:
   - Corporate/Legal
   - Governance

E. Executive staff structure, officer biographies, and photos
F. Medical staff structure, officer biographies, and photos
G. Strategic plan summary (key initiatives)
H. Financial summary to include key indicators and ratios
I. Position descriptions for the board to include governing philosophy, the board member, and the board chairperson
J. Roster of board members, including brief biographies and current photos
K. Committee charters detailing purpose, specific responsibilities, roster of members, chairpersons
L. Schedule of all board meetings, committee meetings, outside education opportunities, and retreats for the coming year
M. Board policies to include:
   - Conflict of interest
   - Meeting protocols
   - Code of ethics
   - Public accountability

N. Articles of incorporation & bylaws

The core of the playbook should stand the test of time. However, with each new year, the schedules change, some of the players change, the market changes, and so does the industry as a whole. The document should be dynamic, flexible in form to be added to and edited. Every member of the team (board) should have his/her personal copy with the latest revisions. The current document should also be posted on the organization's Web site to demonstrate transparency and accountability to the organization as a whole.

Choosing Directors with the "Right Stuff"

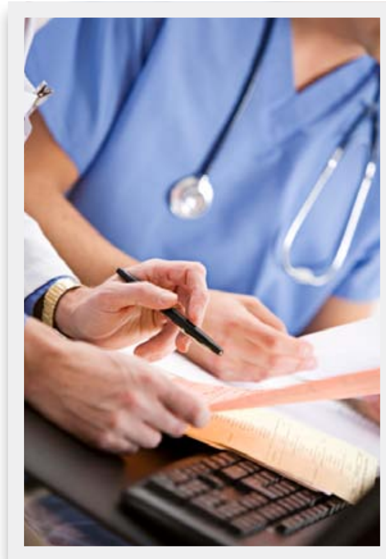
June 2007 • Barry S. Bader, Edward A. Kazemek, Pamela R. Knecht, and Roger W. Witalis, FACHE

Studies have shown that individuals who play action video games make better pilots and surgeons. Are there characteristics that predict which individuals have the "right stuff" to succeed as directors of non-profit healthcare boards?

The question is important as boards take succession planning more seriously and follow various best practices. Many have adopted guidelines describing the areas of knowledge, skills, and personal characteristics they seek from new directors. Many governance committees maintain a prospect list of potential future trustees rather than waiting until a vacancy occurs to think about a replacement.

Here are some of the characteristics that our experience suggests could portend a potential director's effectiveness:

1. Willingness to devote the time required. It's so obvious yet it's often overlooked in the zeal to recruit a talented individual. Articulate expectations and ask for a commitment up front. Make it clear how many meetings a director must attend, the committee service required, and the fact that an orientation and annual board retreat are mandatory, not optional. If directors are expected to support philanthropy, don't keep it a secret.
2. Professional competence in the board's key areas of responsibility. Board members who aren't healthcare professionals can learn about the industry and the organization's mission, but there is no substitute for first-hand professional accomplishment in key governance responsibilities. For example, a board should have one or more members who, as executives or directors in other organizations, are familiar with selection, evaluation, and compensation of senior executives, so they know how to perform the same function for the hospital or health system CEO.
3. Successors for committee chairs. Every major board committee needs one or two individuals who have the competence to assume the committee chairmanship at any time. Look for new directors who keep the pipeline flowing.
4. A passion for the organization and its mission. Passion is vital to effective governance. Without it, board members are less likely to exhibit the courage and diligence required when the going gets rough.



Assess whether the individual's values and life experiences suggest that he or she is likely to develop a deep sense of commitment for the organization. Pay particular attention to the candidate's stated reasons for wanting to serve on the board and avoid those individuals who view board membership as an opportunity to secure business from the organization or fellow board members.
5. Understand the difference between governance and management. Boards set big goals and make major policies and decisions. They think more about the future than the present. They think strategically and know how to oversee operations without usurping management's authority. They spend time understanding stakeholders' needs and assessing the organization's mission effectiveness. Medical staff members who are directors must understand they have a fiduciary rather than a representational responsibility. To assess an individual's governance "IQ," look beyond the resumé to performance. Ask CEOs or fellow members on other boards how this individual performed. Did she function at 30,000 feet or 300 feet? Were his relationships with the CEO and other directors collegial or abrasive? Would you put this individual on another board if you had the chance?
6. Help the board understand its community and customers. Diversity has become such a buzzword that it's lost its meaning. Why is having a mix of gender, ethnicity, geography, or other demographic factors important? Credibility is a partial answer—a board that doesn't look like its community may be suspect to its stakeholders. However, a board could be both talented and mirror its community like a digital photo and yet perform dreadfully if its members lack genuine understanding of community needs. A sensitivity to the perspectives of stakeholders—minority groups, the elderly of all races and walks of life, the uninsured, the business community, the medical staff, and so on—is a starting point. A board really needs individuals who ask the right questions and frame policies and strategies that truly serve stakeholders' needs.
7. Balance the board's group dynamics. To function as an effective team, a board needs a mixture of interpersonal working styles. A few contrarians to challenge the prevailing wisdom can be helpful, but a board full of contrarians will drive capable management out the door screaming. At the other extreme, a board full of polite listeners may lack the leadership to raise candid questions or face confrontation when necessary. Seek a healthy mix of leadership styles when recruiting new directors.

One final thought: student pilots fly simulators before they get jets. Budding surgeons practice under a resident's watchful gaze. Consider making all new directors' terms one year—and then assess the director's "fitness" before granting a full term.

Board Member Terms: To Limit or Not?

August 2007 • Barry S. Bader, Edward A. Kazemek, Pamela R. Knecht, and Roger W. Witalis, FACHE

According to The Governance Institute's latest industry survey, the vast majority (90 percent) of hospital and health system boards have established terms for their board members, averaging around 3 years, with 58 percent limiting the number of terms their members can serve. These numbers have changed little over the past several years. Like the Democrats and Republicans in Congress who don't seem to agree on any significant issues, hospital and health system boards remain divided on whether term limits help or hurt effective governance, with little interest in hearing the other side's point of view.

The Debate

A proposal to limit (or to not limit) board member terms triggers heated debate among board members. The arguments usually go something like this:

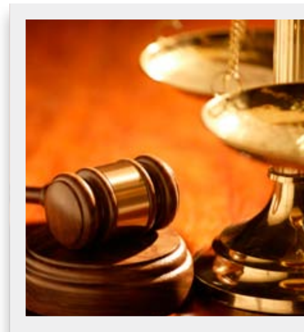
Tom: "I really believe term limits would be beneficial for our board. Limits would bring new blood into the boardroom—people with fresh perspectives and ideas who are not stuck in doing things as we've always done them."

Sarah: "That may be, but term limits would eventually force some of our best members off the board. We'd lose their accumulated knowledge and expertise and have to train new people constantly. I can't imagine a baseball team trading away a star pitcher they brought up through the minor leagues just when he starts winning 20 games a season. It just doesn't make sense to me."

Tom: "That could happen, but we could always bring that effective board member back on the board after a one year absence and keep the person engaged on a committee during that time. Besides, term limits also create opportunities to involve other interested community leaders who would love to serve but never get the chance."

Sarah: "In theory, you're right. But, as you know, we have had a difficult time finding qualified candidates when we've had turnover in the past. There's a real scarcity of committed and talented people out there, especially in a community the size of ours."

Tom: "We'd just have to look harder, seek more diversity on the board, and intensify our efforts to make board service a rewarding and enjoyable experience for people. I don't know how other boards do it, but, from what I hear, some hospitals actually have a waiting list of people who want to serve. Besides, term limits would help us get rid of some of the dead wood on our board and eliminate the problem we have of a few, long-standing members who tend to dominate our decisions because people defer to their longevity on the board."



Sarah: "We don't need term limits to get rid of members who don't perform or to modify the behavior of those who dominate our decision making. We just need to make board member evaluation a serious undertaking. And, have the guts to not renew a member's term or ask a member to step down if he or she hasn't performed or has been disruptive."

And so it goes, with neither side budging on their positions.

Best Practice?

Governance literature tends to reinforce the idea of fixed terms as a "best practice" for not-for-profit boards. And, it's true that most consultants recommend to their clients that they at least consider establishing term limits, even if they stretch them out to as many as 12 years of service. Too often, we have seen the negative consequences of boards that get stuck in their ways, resist changes that could benefit the institutions they govern, and drive away new members because of a power structure that keeps the "old guard" in place with little opportunity for newcomers to play a meaningful role.

Nevertheless, it is useful to keep an open mind on the issue of limiting board member terms. The 42 percent of hospital and health system boards that do not have term limits can't be viewed as ineffective simply because they have decided to not adopt this practice. There are situations where a board without term limits may be better off; e.g., the hospital is dealing with a major crisis that requires board attention; a complex merger is being negotiated with implementation anticipated to be difficult; after exhaustive attempts, a sufficient number of qualified, non-conflicted board candidates cannot be found; and others.

Being dogmatic about governance best practices, especially on an issue like term limits, misses the point. *Governance is a process that boards should constantly improve upon.* For those boards that do not have term limits, we recommend that you take the time every couple of years to discuss the issue with an open mind, weighing the pros and cons, and either reinforce the decision to not have limits or to adopt them. For those boards that may have adopted term limits because everyone else seemed to be doing it, go through the same process of evaluation to make sure that term limits are a true best practice for your board.For boards with and without term limits, it is equally important to establish specific selection criteria for board membership and to evaluate the board and its members on a regular basis to ensure the board has the right "mix" of people and that they are effective.

"Drill Baby, Drill" Is Not Appropriate Boardroom Practice

June 2009 • Barry S. Bader, Edward A. Kazemek, Pamela R. Knecht, Eric D. Lister, M.D., Don Seymour, and Roger W. Witalis, FACHE

Heightened external scrutiny is tempting some boards and governance experts to challenge prevailing notions about the difference between governance and management. The new thinking is that although boards need to be strategic and avoid micromanaging, getting into the micro level of board oversight and decision making to ensure management is truth-telling should be a permanent part of governance. A few members have asked our opinion about this.

To us, this sort of thinking sounds like turning back the clock 20 years. The impetus for boards getting into more details is understandable. Corporate investors and government regulators are skeptical that boards of public companies and not-for-profits are rooting out management malfeasance and protecting shareholders and the public, respectively. Cases in point include the boards of AIG, Enron, the United Way, the Smithsonian Institution, the Getty Trust, and the Red Cross. The Internal Revenue Service is demanding that hospitals provide unprecedented details on the new Form 990 about their community benefit, executive compensation, and board practices to prove they deserve their charitable exemption. Not-for-profits have been pilloried on the front pages of national newspapers like *The Wall Street Journal* and local papers like the *Hartford Courant*.

The heat is on, and boards can't sit in the clouds dreaming strategic thoughts while trusting management to mind the store. Although boards make their greatest contribution when they focus at a strategic level, they can't become rubber stamps when exercising their fiduciary responsibilities for oversight and decision making.

Tools for Disciplined Oversight

A variety of governance practices and tools (many available through The Governance Institute) help boards carry out fiduciary responsibilities efficiently and effectively, supporting but not usurping management's work. For example, recruitment of board members based on written criteria is critical. There is no substitute for governance temperament and subject area competencies such as executive leadership, financial management, audit, and clinical care. Long-range financial plans, strategic plans with measurable goals, and dashboards of critical indicators all enable a board to monitor performance and spot problems before they worsen. Tough questioning of independent reports from outside auditors, consultants, general counsels, executive compensation advisors, and others allows the board to meet the "reasonable businessperson" standard for the fulfillment of a board's fiduciary responsibilities.

Not-for-profit hospitals are not Wall Street institutions. The number of hospitals and health systems that have fallen from grace because of dishonest management and board ignorance pales in comparison to the number that faltered because of weak strategy or poor implementation.

When Is It Appropriate to Drill Down into Details?

At least four situations justify getting into what some might consider micro-details, but which in fact are appropriate governance activities:

1. **Red flags.** If a performance report indicates a significant, negative variance, trend, or faltering strategic initiative, the board should expect a detailed explanation and improvement plan from management. If the answer is not direct, fact-based, and convincing, the board has the right and responsibility to probe further. We're not talking here about boards nitpicking every measure or management decision, but rather, using board policies and headline measures such as patient satisfaction, operating margin, cash flow, market share, and community benefit to hold management accountable.
2. Managerial misconduct. If directors have cause to suspect management of misconduct or withholding access to information, the board is obligated to act. Lack of transparency cannot be tolerated. The former CEO of the Smithsonian Institution allegedly did not allow his chief financial officer or general counsel to speak to board members. That should have been a warning sign of an imperial CEO at best, and potential management misconduct at worst.
3. Certain charges of ethical violations. Normally, boards delegate investigations of alleged unethical conduct to the corporate compliance program or to a third-party such as the general counsel. However, certain circumstances call for direct board intervention. For example, when its high-profile basketball coach was accused of misconduct regarding one of his players, the board of Indiana University decided to lead the investigation itself.
4. Areas of explicit regulatory responsibility. The IRS clearly expects not-for-profit hospital boards to engage in diligent oversight of community benefit, financial assistance policies, external audit, corporate integrity, executive compensation, and the board's procedures concerning conflicts of interest. The full board can delegate detailed oversight of these matters to its committees, but committees should report fully and seek informed board approval.

Avoid the Slippery Slope

There's no question hospital and health system directors are better qualified, more informed, and more inquisitive than ever. Constructive skepticism and periodic contrarianism are healthy board behaviors—in moderation and at the right time. Executives and directors have to accept that active board engagement ultimately benefits the organization and need not destroy interpersonal collegiality.

When hospital boards slide down the slippery slope of focusing on micro-issues, they create a culture in which executives can

become risk-averse at the very time healthcare needs innovation. Even more dangerous is that a board obsessed with the micro will miss larger strategic and policy matters that ultimately will determine the organization's success: Do we have the critical mass to achieve excellence alone, or should we merge? Are we doing all we can to partner with physicians to manage for quality and efficiency? Are we directing our community benefits to get the best results? Such questions are the stuff of great governance discussions.

Not-for-profit hospitals are not Wall Street institutions. The number of hospitals and health systems that have fallen from grace because of dishonest management and board ignorance pales in comparison to the number that faltered because of weak strategy or poor implementation.

What most boards lack is not more detailed information, but rather, greater will to act on the information they already have or should get. More boards need to demand macro-level, comprehensive, dashboard-level measures in mission-critical areas. They need timely reports tracking major strategic initiatives against board-approved timelines and goals. They need the will to adopt clear policies on vexing issues such as physician competition, compensation, and recruitment—so they're not micro-managing every deal that management negotiates.

We have seen multiple examples of boards that watched passively as indicators went south or medical staff relations deteriorated—and did nothing until the only option was to fire the CEO.

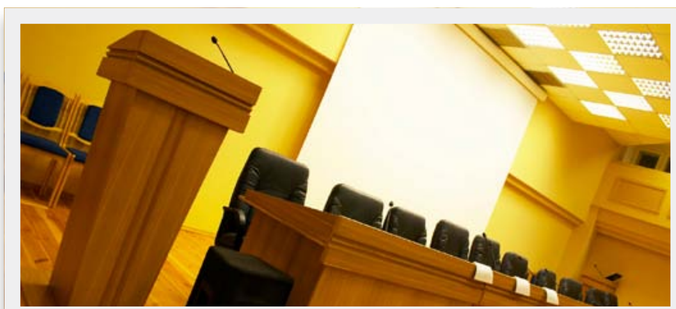
The best senior executives want to be empowered and then held accountable, not work for a board that is either disengaged on one extreme or constantly in the weeds on the other.

We're wary of blurring the line between governance and management—a line that has taken years for hospitals and health systems to establish. "Drill baby, drill" may work in the oil fields, but not in the boardroom.

Successful Board Retreats

August 2008 • Barry S. Bader, Edward A. Kazemek, Pamela R. Knecht, and Roger W. Witalis, FACHE

Board retreats provide a valuable opportunity for boards to deal with issues that cannot be fully addressed during regular meetings. The duration of most board meetings is 1 ½ to 2 ½ hours—barely enough time to cover the routine issues that need board discussion and action, and definitely not a sufficient amount of time (or the right setting) to deal with topics that need more reflection. And yet, the IRS, the Joint Commission, the Senate Finance Committee, attorneys general, bond rating agencies, and other legal, regulatory, and accreditation agencies are counting on boards to carefully consider critical strategic, quality, and financial decisions.



Retreats are the optimum forum for the intensive, candid discussions that boards need to provide effective oversight in today's environment of heightened scrutiny. A well-designed and facilitated retreat can help both the individual members and the board as a whole to have a clearer picture of the organization's strategic vision and a better understanding of their role in helping to realize that vision. Retreats can also strengthen the relationship between the board and CEO, build a more cohesive board, and energize board members.

Suggested Topics and Formats

The most effective board retreats are focused on the organization's strategic issues and/or the board's own performance. Typical board retreat topics and formats include:

Education and implications discussion: An internal or external expert makes a presentation on an important topic such as physician–hospital alignment strategies or the board's role in quality and safety improvement. The educational session should include at least 30 minutes of facilitated discussion regarding the implications of the information for the organization; total session time should be two to three hours.

Mission, values, vision, or strategic plan development: The board and perhaps other key stakeholders (such as physician leaders and senior managers) engage in discussion and preliminary decision making about the organization's future. They might revisit the mission and values to ensure they articulate the organization's fundamental purpose, identify the critical strategic issues facing the organization over the next three to five years, or develop a longer-term vision and/or shorter-term strategic goals. A strategic planning retreat can include an educational session on issues facing the organization. This retreat generally requires at least a full day and is most effective over 1 ½ or 2 days.

Board self-assessment and action planning: The Joint Commission *requires* that hospital and health system boards conduct a self-assessment every year. Once the board completes a written self-assessment, it should convene a retreat focused on improving its own performance. The retreat should begin with a presentation of governance best practices followed by a discussion of the gap between these practices and the board's performance results. Develop three to five goals for board development over the next year. This retreat requires a minimum of three hours—six hours is ideal.

Challenging issue forum: These retreats enable the board to discuss difficult topics in an open forum—topics such as employing physicians, developing stricter conflict-of-interest policies, the performance appraisal for an underperforming CEO, or clarifying the board–management relationship. The format will vary widely but requires at least half a day and most likely a full day.

Critical Success Factors

The following critical success factors for a board retreat were gleaned from the Governance Advisors' combined experience of designing and facilitating successful retreats:

- Custom-design the retreat based on interviews with the CEO, board chair(s), and perhaps a few other key board members.
- Focus on achieving three to five clearly stated objectives.
- Develop an agenda that allows sufficient time for each topic and carefully balances full-group versus small-group work.
- Send preparation materials to participants one week prior to the retreat.
- Err on the side of discussions (versus presentations).
- Select an objective, third-party facilitator who is skilled in group dynamics and knowledgeable about governance practices.
- Hold the retreat at an off-site location conducive to privacy, free-flowing conversation, creative thinking, and informal relationship building.
- Include plenty of time for informal socializing.
- Schedule the retreat a year in advance, so all can attend.
- Evaluate the retreat using a written instrument.
- The retreat should result in a written action plan that is monitored on a regular basis.

Building the Board Chairperson–CEO Relationship

April 2006 • Barry S. Bader, Edward A. Kazemek, and Roger W. Witalis, FACHE

George and Gracie. Martin and Lewis. John and Abigail Adams. Great two person teams are sometimes long-lasting, other times short-lived, but in their prime, they function seamlessly, and each brings out the other's strengths.

Similarly, the relationship between the board chair and the CEO can result in great team leadership—or it can lead to friction, misalignment, and loss of valuable board or executive talent if one of them departs in frustration. Building an effective relationship can't be reduced to one formula, but we have found these practices to be useful:

1. Choose a board chair with the "right stuff." Board chairs can literally make or break the effectiveness of the entire board, and thus the entire organization. Board chairs need leadership skills, communication skills, the courage to take a stand, and the respect of peers and the CEO. Great chairs are accessible, approachable, and patient with organizational process. An effec¬tive board chair needs the skills to play a variety of roles:
   - Role model: displaying integrity, trustworthiness, participa¬tion, and commitment to the mission
   - Change agent: engaging the board in visionary thinking and establishing a culture of free exchange and creativity
   - Facilitator: keeping meetings moving and ensuring that com¬mittees and management fulfill their assignments and keep the board up to date
   - Confidant and sounding board for the CEO: providing a safe zone for frank discussion, with nothing perceived as "taboo" or off limits
   - Politician: connecting with and being sensitive to the needs and opinions of key stakeholders
2. Develop a position description that describes the responsibili¬ties and desired attributes of a chairperson.
3. Establish appropriate term limits for the chairperson. Generally, board chairs should serve at least two years and in most cases no more than five years.
4. Adopt an explicit board policy on succession planning for the chairperson and other board leaders. Assign the responsibility to a nominating or governance committee. The committee develops a "pipeline" of potential future board and committee chairpersons, and encourages their development.
5. Choose a chair-elect at least a year before the current chair's final term is expected to expire. The chair-elect can prepare to assume the office, for example, through briefing sessions with the CEO and attending committee meetings and educational conferences. The chair-elect and CEO should clarify how their relationship will work and agree on what's important, how often to communicate, and how to set meeting agendas.

6. Nurture the chair–CEO relationship. Keep communication lines open and candid, with "no surprises." Some chairs and CEOs routinely speak weekly or several times a month—more often if hot issues arise.
7. Nurture the chair–board relationship. Chairs foster open communi¬cation with board members in various ways. Some make it a point to have lunch with every member at least once or twice a year.
8. Evaluate both the board chairperson and the CEO—and include as one element of each evaluation an assessment of the board–CEO relationship.

Above all, both the board chair and CEO should put "we" above "me" and work together in the best interests of good governance and the organization. A sense of humor and a dose of humility won't hurt either.

Should the Full Board Approve the CEO's Compensation?

October 2006 • Barry S. Bader, Edward A Kazemek, and Roger W. Witalis, FACHE

Should the full board know and approve the salaries of top executives, or may it delegate this responsibility to a committee?

The short answer is yes. A fiduciary board is responsible for and should know the compensation of its top executives. The board may delegate the details of compensation plans, salaries, incentive awards, and contract terms to an executive compensation committee, but it must ultimately oversee the committee's work and review/approve its recommendations.

For better or worse, executive pay has become a high visibility issue. In some places, newspapers publish hospital CEOs' salaries using publicly available data from a hospital's own Form 990. Senator Charles Grassley is examining healthcare organizations' executive pay practices, and recently criticized the independence of hospitals' board compensation committees, their lax oversight of personal entertainment expenses, and the use of supplemental executive retirement plans (SERPs).

With hospitals' charitable tax status under scrutiny, it's time for boards to open a window on the work of their executive compensation committees. In this context, we offer the following advice:

1. **Independent executive compensation committee.** This committee should be composed of only independent directors. This excludes the CEO and other C-suite members, medical staff members, and directors who do business with the organization.
2. **Engagement.** The committee is not a rubber stamp—it must be informed and engaged, raising tough questions and exercising rigorous oversight. The full board should approve the committee's charter. The committee should become literate in government requirements and compensation trends, including IRS Section 4958.
3. **Independent advice.** This committee should choose an independent compensation consulting firm to provide education, advice, and comparability.
4. **Compensation philosophy and plan.** This committee should recommend to the board a compensation philosophy and incentive plan that provides a framework for base pay and incentives for the CEO and other senior executives. Without this context to educate the board, salary figures are orphan data that leave the board ill-equipped to assess whether compensation is reasonable and competitive with the market among comparable organizations.
5. **Report to the board.** The committee should educate the board on its work by means of a thorough report, including the annual compensation awards in the context of the board-approved ranges in the compensation plan. Most boards look to the CEO to recommend incentive increases for members of the senior team consistent with the compensation plan.
6. **Board approval.** The full board should review and approve the committee's recommendations. Except in rare circumstances, the board should not rehash or redo the committee's work. The full board should also approve the terms of the CEO's contract.

For some boards, this is business as usual—for others, it will be a difficult change. Greater transparency opens a cloistered process to the risks of inappropriate tinkering and breaches of confidentiality. Board education, clear policies, and rigorous enforcement of confidentiality can mitigate the risks. Gradual implementation may be appropriate.

We recognize some will disagree with our recommendations, but we believe a board of directors deserves information that will in short order be in the public domain, available to the press, and accessible to regulators and legislators. In an age of accountability and transparency, the board needs to know.

Public Transparency: Should You Be Proactive or Reactive?

June 2008 • Barry S. Bader, Edward A. Kazemek, Pamela R. Knecht, and Roger W. Witalis, FACHE

"Why should we put all this information on our Web site when the local newspaper and public aren't asking us about it?" That was the pointed question raised by a hospital trustee at The Governance Institute's Leadership Conference in Phoenix in March.

The question arose at a presentation by one of the authors (Mr. Bader) on the increasing demands on not-for-profit hospitals and health systems—from IRS, Congress, state governments and others—to demonstrate that they continue to deserve their tax-exempt status and the public's trust.

Not-for-profits, Mr. Bader asserted, need to be more proactive in telling their communities about the organization's good works and independent board oversight. He quoted Sister Carol Keehan, president of the Catholic Health Association: "When I was CEO at Providence Hospital (Washington, DC), I was concerned about community benefit every day, but I wasn't concerned about counting it or publicizing it. I should have been."

Since writing The Governance Institute's white paper on institutional integrity in 2006, we have recommended that boards embrace the new era of public accountability and transparency. We believe hospitals should use a variety of media to communicate the community benefits they provide, quantitatively and with clear descriptions of their financial assistance policies and various programs of community health promotion, health education, and research. Hospitals must work to dispel the notion that community benefit means charity care and nothing more. Hospital Web sites are an important medium to present and explain the hospital's quality of care, patient safety, and patient satisfaction scores. Not-for-profit boards should consider having a public Web page on governance, including photos and names of board members and descriptions of how the board is organized to carry out key governance processes, including audit oversight, establishing executive compensation, and leading quality improvement.

And so, after hearing all of this, the trustee at the conference in Phoenix asked, "Why not wait until we're asked?"

The following week, this headline blasted across the front page of the *Wall Street Journal:* "Nonprofit Hospitals, Once for the Poor, Strike it Rich."[1] The article, from the nation's most respected and widely read business paper, slammed some highly-regarded health systems for their rising operating margins while providing (allegedly) less charity care than the value of their federal and state tax exemptions. The article wrongly equated charity care with community benefit. It ignored the importance of strong financial margins and balance sheets to generate capital to reinvest in new technology and facilities to meet community needs. Is there any doubt Congressional leaders will quote from this story at their next hearings on not-for-profit hospitals?

Days later, the *Boston Herald* reported that a state senator was proposing pay caps on hospital executives. He voiced outrage that 14 Boston-area CEOs earned upwards of a million dollars a year. The chairman of one medical center defended his executive's pay package, saying the hospital CEO's job is "equal to the responsibilities of any (corporate) CEO in town." Was anyone listening?

Why be proactive? Because stories like these are on the rise. One day it's CEO salaries, the next day it's medical errors or clinical outcomes or charity care or conflicts of interest. The new Form 990 will bring even more information about community benefit, executive compensation, and governance practices into the public domain, and Medicare has added patient satisfaction surveys to the growing number of quality indicators available online. About 30 states require that hospitals file community benefit reports and some are considering minimum standards.

Why be proactive? Because myths and misinformation persist about what being tax-exempt requires, and without education of the press, policymakers, and the public, not-for-profit organizations will be held to arbitrary standards not based in law or regulations.

Finally, being proactive makes sense because many not-for-profits have great stories to tell. They conduct business with integrity and a profound sense of serving the community. Going public demonstrates that "we've got nothing to hide," and we are proud of who we are and what we do.

Being more transparent with the public has another benefit. It gives the board a powerful reason to exercise ongoing oversight of institutional integrity. We advise boards to consider these agenda and action items:

- Establish a board policy on public transparency.
- Review the Form 990 with the board annually, including how the information is prepared and what the information means, and determine if the form along with an explanation should be posted on the hospital's Web site.
- Establish community benefit goals, approve a community benefit plan, and monitor performance at least annually; consider forming a community benefit committee.
- Review the information that is publicly available about the organization's clinical quality, patient safety, and patient satisfaction, and decide if relying on such sites (such as Hospital Compare) is sufficient or if the hospital should make its own quality report to the community.
- Ask legal counsel or a governance consultant to audit the board's conflict-of-interest policies and procedures to ensure they meet new expectations for board independence.
- Consider whether the organization's Web site should include information on governance.
- Consider using The Governance Institute's "Institutional Integrity Self-Assessment" instrument.

When transparency becomes a core corporate value, everyone benefits.

1 John Carreyrou and Barbara Martinez, "Nonprofit Hospitals, Once for the Poor, Strike it Rich," *The Wall Street Journal*, April 4, 2008.

Who Is an Independent Director?

December 2009 • Barry S. Bader, Edward A. Kazemek, Pamela R. Knecht, Don Seymour, and Roger W. Witalis, FACHE

Independence is a duty of the highest order for the director of a not-for-profit organization. All directors are expected to make objective decisions based on the best interests of the organization, and not for any personal or professional gain.

Broadly speaking, independence requires a director to have no material economic or other relationships with the corporation that a reasonable person might construe as interfering with the director's ability to carry out his or her fiduciary duties. Recent developments are leading to new and different definitions of "independence" for different purposes, however, and this may have an effect on who should or should not serve on boards and their committees.

New IRS definition on Form 990

The question, "Who is an independent director?" has received renewed interest because of recent revisions to the IRS Form 990. The IRS requires filing organizations to determine and state on the new Form 990 how many of their board members are "independent." It applies the following general definition:

> A trustee is not an "independent trustee" if, at any time during the fiscal year, the trustee: (a) received compensation as an officer or employee from the corporation or a related organization; (b) received compensation or other payments as an independent contractor of $10,000 or more not including expense reimbursement or payment for services as a director; or (c) became involved or had a family member who became involved in a "reportable transaction" with the corporation, whether directly or indirectly through affiliation with another organization.

Generally speaking, reportable transactions include: (1) loans or grants to the director (or the director's family members or entities in which the director or family members have an ownership interest, collectively "related persons"); (2) compensation to a family member of $10,000 or more; or (3) a business transaction with the director or related persons that exceeds the greater of $10,000 or 1 percent of the organization's annual revenues, or multiple transactions that exceed in the aggregate $100,000 during the fiscal year.

For example, a director who received more than $10,000 for consulting services or whose solely owned company sold more than $100,000 of goods and services to the hospital would not be counted as independent on the Form 990. **However, even if a director has transactions with the filing organization that are disclosed on the organization's 990, and as a result is not counted as one of the "independent" directors on the Form 990, there is no prohibition on that individual serving on the board, so long as these transactions are disclosed and any potential conflicts of interest are appropriately addressed under the organization's conflict-of-interest policy.**

Do Physician Directors Meet the Definition of "Independence" on the New Form 990?

The basic rule is this: as long as the physician is not being compensated by the organization as an employee (in any amount) or as an independent contractor (more than $10,000), and there is no reportable direct or indirect business transaction between the physician and the organization, then the physician director can be counted as independent on the Form 990.

Thus, a physician employed by the hospital, or a solely owned medical group, whom the hospital pays more than $10,000 a year would not meet the test of independence. Neither would a physician who is paid more than $10,000 to serve as the medical director of a clinical department.

Determining whether a physician is indirectly engaged in a reportable business transaction with the organization through a family member or their medical practice can be more complex, says Ralph DeJong of McDermott Will & Emery. For example, what if a physician on the board earns no compensation from the hospital, but has a partner in a two-person practice who serves as the hospital's chief of medicine for a stipend of more than $10,000 a year? What if a physician's spouse is paid more than $10,000 a year to provide on-call coverage in the emergency department? Arguably, these are reportable transactions. Even though they do not involve the physician directors directly, these doctors would not be defined as "independent" on the Form 990.

The IRS definition does not explicitly address private practitioners who receive no direct compensation from the hospital, but who generate significant fees from treating patients in hospital facilities. Using a strict reading of the new Form 990 definition, these physicians would be defined as independent, says DeJong, if the only relationships with the hospital are serving as a director and being on the voluntary medical staff.

However, another IRS definition clouds the picture, says DeJong. To satisfy the "community benefit standard for tax exemption," a hospital must show that it or its parent organization is controlled by a majority of independent persons representative of the community. **Historically, says DeJong, the IRS has not treated physicians (on the voluntary medical staff) as independent community representatives for purposes of the community benefit standard.** He adds, "This is a confusing area of the law, and the IRS has yet to definitively state whether its new definition of independent director for Form 990 purposes may also be used for purposes of applying the community benefit test."

Douglas K. Anning, who co-chairs the non-profit organizations practice at Polsinelli Shughart PC in Kansas City, MO, notes, "The advice I'm giving to clients is to strictly comply with the Form 990 definition but not go overboard. A private practice physician who earns no compensation from the hospital would be independent for purposes of the 990."

What about hospitals that want to be stricter and define any active member of the medical staff as "not independent" (but still eligible to serve on the board)?

"That's okay," says Anning, particularly for determining who can sit on board

committees overseeing executive compensation, external audit, and corporate compliance. In its 1997 training materials, Anning notes, the "IRS has said medical staff members may not serve on the compensation committee." However, even hospitals that adopt a tougher committee standard may still count the private practitioner who draws no compensation as independent on the Form 990.

Our Advice

As governance advisors, we do not offer legal advice; boards should consult their general counsel to develop policies and practices on independence. That said, we recommend five guidelines:

1. Update the board on the new Form 990 requirements, which address independence, executive compensation, community benefit, and various governance policies and practices.
2. Comply with the IRS definition of independence when filing the Form 990, but remember that independence means more—it takes into account financial and non-financial relationships that could lead a reasonable person to question an individual's objectivity and loyalty to the organization. The gold standard for independence should be that the board is beyond reproach, in fact and appearance.
3. Adopt a more stringent definition of independence for the board's committees overseeing executive compensation, physician compensation, audit, and corporate compliance. Physicians on the active medical staff should not serve on these committees even if they are considered independent on the Form 990. Consider requiring that the board chair be an independent trustee.
4. Continue to include physicians as board members, so long as they satisfy the same qualifications as any other board member. However, to meet the intent of the IRS community benefit standard, ensure that the board is composed of a majority of outside, community members, and a minority of "inside" trustees, which would include the CEO, other employees, and physicians on the active staff.
5. Take this opportunity to rethink the appropriate degree of physician participation on the board, the method of selecting physician members, and the criteria for choosing physician board members. For example, some hospitals that have barred employed physicians from serving on the board now employ a growing portion of their medical staffs. They find themselves in the anomalous situation that while private practitioners may serve on the board, employed physicians—arguably the most aligned physicians in the organization—may not. Physician involvement in governance is a larger topic than independence, and we'll explore this issue in an upcoming Advisors' Corner.

continued...

Disruptive Board Members

February 2007 • Barry S. Bader, Edward A Kazemek, and Roger W. Witalis, FACHE

"How do you deal with a board member who dominates most discussions—just never stops talking?" "What do you do when a board member regularly ignores the agenda and forces discussion on extraneous issues?" "What can you do with a board member who can be quite offensive in the way he speaks to or attacks some of the other members?" "What should we do about board members who miss more meetings than they attend; don't come prepared; or arrive late and leave early?"

These are some of the most common questions we get from board chairs and CEOs that we meet in our work. The board members who exhibit these behaviors are a real challenge for the board and the chairperson. They can and often do have a negative impact on the board's overall effectiveness and efficiency. Far too many board members just grin and bear it or vent their frustrations in private after the board meeting.

The first thing to remember is any behavior that interferes significantly with the effective and efficient process of governance should be considered "disruptive" and treated as a matter requiring immediate attention. However, it is also advisable to spend a little time analyzing possible causes for the undesirable behavior of some board members before taking action. It's useful to keep in mind that it is rare for a board member to come to a meeting with a personal goal to disrupt the meeting.

For instance, the domineering board member may feel very passionate about his/her ideas and want to make sure others accept his/her perspectives. The member who strays from the agenda may feel that certain issues can't wait until a future meeting or isn't aware that there are procedures for adding items to the agenda ahead of time. The member who has an off-putting or aggressive communication style may be exhibiting normal behavior expected in his/her work environment and feel that being forceful and direct is what board members are supposed to do. Those who are chronic absentees, don't prepare, or come late and leave early may be overloaded with other responsibilities and haven't faced the fact that they can't meet the demands of being a board member.

Attempting to understand the reasons behind some board members' behavior usually goes a long way toward figuring out how to modify the behavior. Figuring out how best to deal with disruptive behavior usually falls on the shoulders of the board chair or the chair of the governance committee, with appropriate support from the CEO and other board members. Providing one-on-one, honest, timely, and respectful feedback to a "disruptive" board member (sometimes more than once) is the most impactful approach to bring about the desired change. Of course, this is easier said than done. Therefore, it's useful to put some "preventive measures" in place to reduce the number of times these uncomfortable conversations have to take place.

Preventive Measures

1. Engage the full board in the development of a "code of conduct" for board member behavior and participation in meetings. Encourage everyone to enforce the code's guidelines during meetings and, periodically, check in at the end of board meetings on how well the guidelines are being followed.
2. During the recruitment process, make sure that board member candidates understand and agree to the board's code of conduct.
3. Incorporate the code-of-conduct guidelines into the annual board self-assessment discussion to hold the board accountable for following them. Also, consider some form of individual board member evaluation as part of the board self-assessment and use that information to counsel disruptive members. This can dramatically reduce disruptive behavior going forward.
4. Educate board members on constructive ways to raise issues, monitor processes, influence the board agenda, and question policies vs. personalities.
5. Distribute the meeting agenda at least a week before the meeting and make sure it spells out clearly the subjects to be covered and the time allotted for each item. Leave some time for discussion on other issues/concerns on the minds of board members.

Finally, on those rare occasions when nothing seems to work in modifying the disruptive behavior of a board member, ask the individual to leave the board. This may seem harsh, but remember—the overall effectiveness and efficiency of the board comes first.

Physician Participation on the Hospital Board: A Moving Target

April 2010 • Barry S. Bader, Edward A. Kazemek, Pamela R. Knecht, Don Seymour, and Roger W. Witalis, FACHE

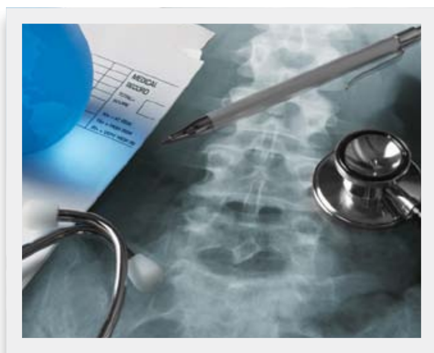
Most hospitals and healthcare systems recognize the value physicians bring to the governing body, by enhancing the board's knowledge of clinical matters and by fostering communications and trust with the medical staff. In turn, many medical staffs believe it is essential for boards to include physicians who can ensure the board is aware of and responsive to patient care and medical staff issues.

However, as hospitals seek greater integration with physicians in order to manage costs and quality, medical staffs are resisting what they see as potential threats to patient care, professional autonomy, and their economic welfare. Several factors are provoking questions about the role, proportion, and selection of physicians on hospital governing boards.

Declining Importance of Formal Medical Staff

A medical staff's primary role is to engage physician leaders in oversight and improvement of clinical quality, patient safety, and credentialing. The medical staff organization's elected chief of staff and medical executive committee are supposed to provide leadership and promote communication among the hospital administration, board, and physicians.

In reality, many medical staffs are a loose confederation of physicians who are variously dependent on, interdependent with, or barely affected by what the hospital does. Some are actually competitors or are affiliated with competitors in key clinical services. Most physicians have little interest in medical staff leadership and serve their time out of obligation. Medical staffs can be reluctant to take adverse action against peers unless the danger to patient care is compelling. Decisions are often slowed by Balkan-like structures burdened by too many committees, departments, and specialty sections, and by poorly organized or attended meetings. Formal communications from the hospital and the staff's own leaders are routinely ignored.



Attorney and Governance Institute faculty member Brian Peters recently called the traditional medical staff "…outdated and fundamentally dysfunctional…" (open letter to The Joint Commission, October 2009). In short, the typical medical staff is the antithesis of a highly effective organization.

Thus, it's hardly surprising that as hospitals seek partners to manage costs and quality and to grow services, the traditional medical staff organization is becoming less relevant. Key physician leaders are increasingly likely to be employed by (or otherwise economically aligned with) the hospital, and are not necessarily the staff's elected leaders. Hospitals seeking policy advice and recommendations on clinical matters increasingly look to full-time and part-time chief medical officers, chief quality officers, clinical department chairpersons, service-line chiefs, physician cabinets, medical quality councils, and medical group governing bodies, all populated by employed and other aligned physicians.

The Governance Institute's 2009 biennial survey[1] suggests a decline in importance of formal medical staff leaders in some hospitals. The hospital's chief of staff is now a voting member of just 37.5 percent of boards (compared with 43 percent in 2007), and is a non-voting board member on 13 percent of boards (up from 11 percent in 2007). Conversely, the chief of staff is a not a board member but regularly attends meetings for 36.8 percent of boards (up 1 percent since 2007), and is a non-member who does not attend board meetings for 12.7 percent of boards (up 2.4 percent since 2007).

Employed physicians are beginning to crack the boardroom door despite concerns about their independence from management. According to the survey, the typical, non-government hospital or health system board has between 14 and 17 board members, of whom about two are physicians *not* employed by the organization, and 0.4 of whom *are* physician employees. (The survey broke down employed and non-employed physician board members for the first time in 2009.)

Hospital–Physician Competition

Hospitals are in competition increasingly with physician-owned or co-owned outpatient facilities and specialty hospitals. Some physicians on the medical staff treat a sizable number of financially lucrative patients in these facilities while relying on the hospital for emergencies and sicker or poorer patients. In some cases, physician competitors may dominate a major specialty or subspecialty.

The uptick in physician competition introduces the anomalous situation of a physician competitor being elected as a medical staff officer, a member of the board, or even the chief of staff, who then holds an *ex officio*, voting board seat. If that doesn't sound problematic, think of Microsoft not only allowing its top software designers to enter into business ventures with Google, but also giving designers with split loyalties a vote on the Microsoft board! Healthcare is the only major industry we know of that allows such conduct—but its roots lie deep in traditional medical staff self-governance and the protection of the physician–patient relationship, and these principles are not easily abandoned.

New Joint Commission Standards

As Paul M. Schyve, M.D., senior vice president of The Joint Commission wrote in a white paper for The Governance Institute last year, "The governing body, the chief executive and other senior managers, and the leaders of the medical staff must collaborate to achieve [the hospital's] goals,"[2] including patient safety, financial sustainability, community service, and ethical behavior. The Joint Commission does not prescribe that any number or

1 Governance Structure and Practices: Results, Analysis, and Evaluation, 2009 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute.

2 Paul M. Schyve, M.D., Leadership in Healthcare Organizations: A Guide to Joint Commission Leadership Standards (white paper), The Governance Institute, 2009.

percentage of board members must be elected by or from the medical staff, but clearly, the presence of physician board members can contribute to a culture of collaboration.

The Joint Commission has been laboring since 2007 on revised medical staff standards. One area of contention is whether the board can look to the medical executive committee as the clear, ultimate authority of the medical staff, or whether the general medical staff electorate is entitled to circumvent its leadership and go directly to the board. This controversy illustrates many doctors' fear that hospital-employed and other economically aligned physicians will gain control of the MEC and can take actions that disadvantage private practitioners. The same concern is likely to arise if a board considers reducing the medical staff's position on the board.

IRS Perspective on Physician Board Members

As we wrote in the December 2009 advisors' column in *Boardroom Press*, the Internal Revenue Service is increasingly interested in the independence of the not-for-profit hospital board. Clearly, when physicians are employed by a hospital, are active practitioners on the medical staff, or both, reasonable questions arise about their independence. IRS policy is somewhat ambiguous, however. Employed and most other compensated physicians are not considered independent; private practitioners are counted as independent on the Form 990 but are not so considered when evaluating an organization's tax-exempt status.

Guidance for Boards

Amidst these shifting sands, we do not believe a single set of guidelines regarding physician membership on the board can apply to all hospitals and healthcare systems. We also believe that any changes to a board's current policies and practices with regard to physicians on the board should be made after a genuine consultative process with medical staff leaders and communication with the broader medical staff. Much effort has gone into improving hospital–medical staff communications and relationships; hasty changes can quickly undo trust and reignite latent suspicions.

Framing the right questions is a precursor to a constructive dialogue. The wrong questions can mire leaders in the past; the right questions can point them toward developing the medical staff and hospital of the future.

We recommend a new set of questions for discussion among board, senior management, and physician leaders, beginning with the following:

Old question 1: Should the elected chief of staff, chief-elect, and/or past chief be *ex officio*, voting board members, in order to represent the medical staff and the MEC?

New question: What is the organizational structure that will best enable the medical staff, board, and senior management to collaboratively pursue the hospital's goals—and how should the leaders in this structure have access to the board?

For example, who should constitute the primary medical leadership body that is accountable to the board? Is it the medical executive committee, or full- or part-time clinical department chairs and service line chiefs, or a "physician leadership cabinet" of some sort, chosen based on objective competencies and including both employed and private, aligned, and active physicians? If the MEC is to remain the primary leadership entity, how will its leaders be chosen and held accountable for performance? If the hospital owns a physician group, will it have a governing council, and if so, what is its role and relationship to the MEC or physician cabinet?

For many hospitals, these are vision questions as they transition from largely volunteer medical staffs to employing some, most, or all their physicians and physician leaders. Although some hospitals will continue to rely primarily on private practitioners, many will have a pluralistic and hopefully symbiotic relationship between and among private practice, employed, and other economically aligned physicians. The right structure should facilitate achievement of the hospital's vision with its physician partners.

The discussion of leadership structures must precede questions about voting physician board members because the formal medical staff's role is changing. As governance advisors, we cannot endorse *ex officio*, voting seats for the chief of the medical staff or for any stakeholder group. However, if physicians enjoy this prerogative today, it should not be withdrawn cavalierly, without careful consideration of the other structures through which physicians are involved in leadership decisions affecting clinical quality and their practices.

Although some hospitals will continue to rely primarily on private practitioners, many will have a pluralistic and hopefully symbiotic relationship between and among private practice, employed, and other economically aligned physicians. The right structure should facilitate achievement of the hospital's vision with its physician partners.

Old question 2: Should a minimum number of physicians serve on the board?

***New question: What role are physician members of the board expected to play, and therefore, how many individuals are needed to fill that role*?**

This question must precede any determination of how many physicians are needed. On most boards, a physician's primary contribution is to provide clinical expertise and real-world insights to help the board discharge its oversight and decision making with regard to clinical quality and patient safety, as well as matters of finance, strategy, community service, and ethics.

However, are physicians also expected to "represent" the views of the general medical staff? No. We believe physician board members who serve on the active staff can facilitate communications and working relationships amongst leadership groups, but board service must not constitute "formal medical staff representation." We would strike the phase "represent the medical staff" from the lexicon.

Every voting board member, no matter how selected, must fulfill the fiduciary duty of loyalty and act objectively and independently to protect and promote the hospital's mission. There is a place for recognition of stakeholder views, not but representation in the boardroom.

Old question 3: Should the medical staff be able to elect or nominate physicians to serve on the board?

New question: What are the qualifications for physicians to be elected to the board, and conversely, are there any characteristics that would disqualify a physician from board membership?

We believe that physician board members should—like any other board member—be fully committed to the hospital's success and performance of their fiduciary duties, demonstrate integrity, think strategically, and be able to work collaboratively with others. They should be able to put in the time required to do the job. On a self-perpetuating board, the same criteria-based competencies used by the board or governance committee for lay members should apply to physicians.

The board also should adopt "disabling guidelines" that bar or allow removal of trustees who are direct competitors to the hospital or who violate confidentiality.

Should employed and other economically aligned physicians be allowed to serve on the board? We do not think that employment by or alignment with the hospital or a related organization should automatically bar an otherwise qualified physician from board membership. However, employed physicians and other active medical staff members should *not* be considered independent for purposes of populating the committees responsible for executive compensation, audit, and corporate compliance. Also, care should be taken to ensure that a majority or, better yet, two-thirds of the board members meet the IRS' definition of independence for tax-exemption purposes. Additionally, the nomination process for board members should be in the hands of independent directors, but there is no reason why a governance committee cannot welcome and give significant weight to input from the medical executive committee or from other formal or informal physician leadership groups.

We also think that more hospital boards should look for physicians who are not members of the active staff, such as retired physicians, corporate medical directors, and physician leaders from health systems in other communities. They bring both expertise and independence.

The Bottom Line

At the end of the day, a board's membership should include independent, creative, strategic thinkers who bring a broad mix of relevant skills to the table. It is difficult to imagine those skills excluding medicine. It is also difficult to imagine that employed and other economically aligned physicians who are becoming the core clinical leaders of the medical staff would be barred from the boardroom while non-aligned private practitioners remain because they are elected to office. Employed physicians do have a conflict of interest that must be disclosed and addressed in accordance with the organization's conflict-of-interest guidelines, but they also have skills and insights that are valuable to the board. Physicians should be evaluated according to the same criteria for judging independence, competence, and overall fitness to serve as any other trustee. Some physicians will make the cut; others won't.

Addressing matters of physician membership on the board may not be comfortable. The timing must be right (are reasonable leaders and a trusting relationship in place?). However, waiting too long can be dangerous, inviting the elevation of competitive or combative physicians to leadership positions. The time to raise difficult questions about physicians on the board is *before* serious problems arise.

Physicians on the Board: Conflict Over Conflicts

February 2008 • Barry S. Bader, Edward A. Kazemek, Pamela R. Knecht, and Roger W. Witalis, FACHE

The vast majority of not-for-profit hospitals and health systems allow physicians to serve as fiduciary board members with vote (with the exception of many government-sponsored organizations). The reasons are compelling. Research has shown that having physicians on the board enhances the quality of board decisions and correlates with improved overall organizational performance, in terms of clinical quality, operational, and financial performance. Furthermore, the symbolic value of physicians playing a meaningful role in policy and strategic matters has evolved into a prerequisite for productive physician relations.

New Pressures

Hospital boards are under intense pressure from numerous sources, including the IRS, Congress, state attorneys general, and the news media to name a few, to demonstrate that their decisions are controlled by independent community directors, not by insiders or others with significant conflicts of interest.

The pressures for board independence and transparency are colliding with the enormous increase in competition hospitals are experiencing from members of their own medical staffs, as well as an increase in "aligned physicians" who, as hospital employees or joint venture partners, may share the hospital's goals but can't be considered independent, outside directors. As a result, it is becoming a challenge to find physicians who are free of material conflicts of interest with the hospital. Hence, many boards are beginning to raise questions about the wisdom of having active members of the medical staff serve as voting board members.

Important Concepts

There are a number of important concepts to consider when evaluating any person's fitness to serve on a not-for-profit board and on certain board committees such as audit and executive compensation. These concepts apply to all board and committee candidates, including physicians.

"Insiders." The IRS considers employees and most active members of the medical staff to be "insiders" and it limits the number of insiders serving on the board to no more than 49 percent. This is a non-negotiable IRS position that boards must keep in mind when selecting board members. This becomes even more important when considering who can serve on certain board committees. The IRS Section 4958 Rebuttable Presumption of Reasonableness criteria with regard to oversight of executive compensation require that the board members who serve on the committee handling this function (usually a compensation committee) are independent, which generally excludes insiders. Therefore, most hospitals that have elected to comply with the IRS criteria do not allow physicians to serve on the compensation committee.

"Independence." An independent board member has no direct or indirect, *material* conflict of interest with the corporation, or has a conflict of such insignificance (*de minimis*) that it would not be perceived to exert an influence on the director's judgment. Both *de minimis* and material conflicts must be defined precisely and in quantifiable terms. Sarbanes-Oxley governance requirements (which have been embraced by a majority of not-for-profit hospital and health system boards) call for a majority of the board and all of the audit and executive compensation committee members to be independent. This concept applies to all board members equally.

"Disabling Guidelines." These guidelines describe conflicts that are so significant that an individual should not be elected to the board, or should be asked to resign if they occur during a director's term (e.g., investing in a direct competitor, repeated failure to disclose a conflict of interest, intentional violation of the organization's code of conduct, and others). This concept applies to all board members but raises serious questions about the appropriateness of physicians serving on the board who are engaged in significant competition with the organization.

Current Practices Stimulate Conflicts

In light of the concepts described above, some governance practices used today reveal a fair amount of confusion and/or lack of attention when it comes to physicians serving on the board. When a board attempts to modify these practices, physicians often react negatively and resist the changes. Some current practices that can result in conflicts with physicians include:

- Most hospital boards have not developed detailed definitions for "independence" and "disabling guidelines," and allow physicians who are engaged in direct, material competition with the hospital to serve on the board (sometimes even in board leadership positions).
- Some boards ignore or are unaware of the fact that physicians are insiders and allow them to serve on the executive compensation committee.
- Many boards consider physicians who have clinical privileges but no direct financial relationship with the hospital to be "independent," but in reality, any physician director who also practices in the hospital is subject to influence daily from partners

and peers whose economic livelihood is affected by hospital decisions and may be able to exert undue influence over those decisions. To call an active medical staff member "independent" strains credibility. This is especially important when considering committee appointments or eligibility for a board leadership position since many boards require that board officers qualify as independent members.

- Many boards allow employed physicians to serve as voting members with little thought given to fact that these physicians are severely limited in the roles they can play on the board and that non-employed physicians do not always view them as effective representatives for their issues and needs.
- A large number of boards continue to designate the elected president (and sometimes the president-elect and past president) of the medical staff as an *ex officio*, voting board member, or allow the medical staff to elect board members directly as their representatives, despite the trend to move away from these practices to ensure the board's control over selecting its own members.

For Consideration

Addressing matters related to physician board membership is politically sensitive and "one size doesn't fit all." However, our research and experience suggests that boards should engage in education and dialogue with their physician leaders about changing requirements and consider changes in how physicians are chosen to serve on the board and/or select committees. Specifically, we recommend consideration of these practices:

- Develop comprehensive policies concerning physicians' engagement in leadership roles and decision making, including service on the board and in medical staff positions, seeking physician input throughout the process.
- As a matter of policy, do not allow physicians (or non-physicians) who are engaged in a form of competition that endangers the hospital's mission to serve on the board or any of its committees.
- Determine whether employed physicians should be allowed to serve as voting board members, including a clear rationale.
- Do not permit medical staff members and other "non-independent" directors to serve on the executive compensation committee.
- Designate any physicians who serve in an *ex officio* capacity to be non-voting, so they have a voice but are not placed in a conflict-of-interest position.
- Above all, continue to allow physicians to serve on the board. The benefits far outweigh the challenges.

Physician Engagement Models Fill the Knowledge Gap

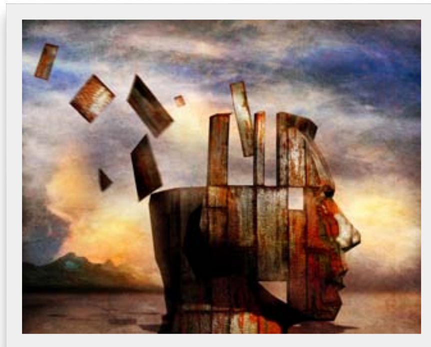
April 2008 • Barry S. Bader, Edward A. Kazemek, Pamela R. Knecht, and Roger W. Witalis, FACHE

In our previous column, we discussed the subject of physicians serving on the governing board. Our conclusion was that physicians should serve as directors/trustees for practical and symbolic reasons, as the benefits far outweigh the challenges. However, we advised that boards need to be sensitive to the risk of material conflicts of interest presented by any voting member, especially physicians.

In addition to the boardroom serving as a forum for open and meaningful physician engagement, what other venues are being created to serve this purpose? Below are two examples.

Scripps Health: Physician Leadership Cabinet

In 2000, the CEO of Scripps Health faced votes of no confidence from five of the system's six medical staffs and was asked to resign. Physicians, feeling alienated from the system, took their patients to competing facilities, resulting in a $23 million operating loss for Scripps Health. Chris Van Gorder, FACHE was promoted from COO to become the new CEO and was charged with turning the situation around. As CEO, Van Gorder's first step was to help Scripps doctors and administration work together as a team, with the doctors as an integral part of the decision-making process. Van Gorder, along with CMO Brent Eastman, M.D., established Scripps Physician Leadership Cabinet (PLC). The PLC consists of the chiefs of staff, the chiefs of staff elect, the CEOs of each hospital and, on a rotating basis, one of the hospitals' chief nursing officers. This forum is designed to:



- Identify and address physician concerns
- Tackle process and structural issues
- Promote quality and medical excellence
- Share information between medical staffs and administration
- Provide physician input on significant health system issues

In addition to contributing to the system's return to profitability, the PLC serves a critical role in strategic and operational decision making. Van Gorder adds, "To this date we have never rejected a decision coming out of the PLC. Its informal power has created one of the most powerful bodies ever seen at Scripps. Some organizations don't like giving physicians this type of power. I don't think we could function without it."

Cottage Health System: Medical Advisory Panel

During its 2002 board retreat, the Cottage Health System board reviewed a series of alternative construction proposals, which were intended to meet seismic standards and prepare Cottage Hospital for the long-term future. Cost and financing of this nearly total replacement facility ranged from frightening to fantasy depending on various configurations and sizes of major programs and service lines. Since administration was already in "hot water" with the medical staff over its definition of program priorities, the board chair wisely recommended that the medical staff come up with its own set of priorities and present them at next year's retreat. System CEO Ron Werft appointed co-chairs of a Medical Advisory Panel (MAP), designed to engage physicians in serious and meaningful program planning. The co-chairs selected 15 additional members to include a mix of physicians and surgeons, specialists, and internists; a balance of private practice, clinic, and hospital-based physicians; and those who are well respected by their peers.

For about a year, the MAP met on a weekly basis, listening to presentations from the leaders of all major departments and service lines. Each presentation was evaluated using a sophisticated scoring/rating tool, which was crucial to making objective priority decisions. The CEO and administration were invited to educate the MAP on financial concepts, nursing challenges, the impacts of information technology, and other subjects.

The MAP report, describing its recommended priorities and lessons learned during the process, was presented to the full board in September 2003 (without prior administration review). It was unanimously approved.

Robert Reid, M.D., VPMA and a MAP participant, offers the following benefits of MAP beyond its report and recommendations:

- Physicians became owners of the process.
- Physicians developed a shared vision of the hospital's future.
- Physicians realized they could really make a difference and be heard.
- By actively engaging physicians in the process, administration strengthened its position with the board.
- By filling the knowledge gap, initial physician skepticism gave way to enforcement of administration.
- A new pool of physician leaders was created.

Because of its overwhelming value to the health system, MAP has been mandated to continue into the future.

Scripps and Cottage are but two examples of many. Multiple new models for physician engagement are emerging, each tailored to engaging physicians in a forum compatible with local needs and physician culture. Many center around quality as a common goal; some emphasize employed and other closely aligned physicians as opposed to formal medical leaders; and all require a change in the traditional board and management culture to empower physicians with a real role in decision making.

Differentiating Board and Committee Work on Quality

October 2007 • Barry S. Bader, Edward A. Kazemek, Pamela R. Knecht, and Roger W. Witalis, FACHE

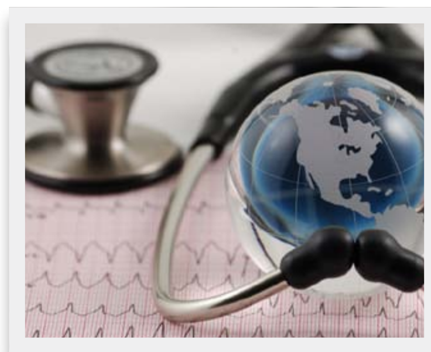
Medicare's recent announcement that it will no longer reimburse hospitals for the treatment of preventable errors, injuries, and infections that occur in their facilities strengthens the business case for quality investments and underscores the need for strong governing board engagement in quality oversight. Studies by The Governance Institute have confirmed that the board makes a difference—hospitals whose boards spend at least 25 percent of meeting time discussing quality are more likely to have higher scores on quality indicators.

Many boards have found a quality committee to be an effective venue for in-depth oversight of clinical outcomes, quality improvement projects, medical staff peer-review activities, patient safety improvement initiatives, sentinel events, "culture of safety" surveys, and customer satisfaction studies. However, such boards with effective board quality committees are asking, "What should we discuss at the full board level that isn't overly detailed or repetitive of the committee's work?"

One answer won't fit all situations, so the identification of the full board's quality agenda must begin with recognizing that quality oversight can be delegated but not abrogated to the board quality committee. The full board should be educated in its responsibilities, and fully review and understand the committee charter it approves. The board quality committee charter should identify the specific reports the committee will review, include the frequency with which the committee will conduct its reviews, and articulate the committee's responsibility for making reports to the full board. The board may want to ask the quality committee, as well as other board committees, to set several goals for high-priority issues such as reducing drug errors or understanding the role of organizational culture. These goals should be the committee's focus in the coming year.

Education First

The full board should be educated about the hospital's quality improvement methodology and its initiatives to reduce medical errors and adopt best practices. The board should also be conversant with national initiatives such as pay-for-performance, IHI's 5 Million Lives Campaign to protect patients from harm, and transparent public reporting of quality indicators, accreditation reports, and patient satisfaction surveys. Physician leadership is critical to successful improvement efforts, so the board may also want education on best practices for developing physician quality leaders.



Information is Key

A well-designed quality dashboard report should give the full board a comprehensive picture of the organization's performance compared to its own goals and benchmarks against the country's top hospitals. A good dashboard is the catalyst for boards to establish improvement goals, raise tough questions about negative variances, and exercise accountability for results. Without good information, the board is like a treasure seeker without a map.

The full board should receive a summary of the quality committee's work at each meeting, in writing and in a brief verbal report from the committee chair. Periodically, the chair or vice president for medical affairs may lead a board discussion on a particular aspect of the committee's work.

Written reports can get a bit dry, but several techniques can enliven the discussion, bring quality issues home, and make the issues more relevant. For example, IHI recommends presenting a recent, serious medical error or near miss, including why it happened and what steps have been taken to prevent a recurrence. Another technique is to conduct a chart audit for harm, in which a number of patient records are reviewed to identify previously undiscovered errors and identify trends. By "bringing the patient into the boardroom," quality and safety issues come alive.

Quality committee members sometimes accompany management on patient safety rounds. This may also be worthwhile for other board members as a learning exercise and a means to demonstrate the board's commitment to the staff.

The Board's Main Job

All the foregoing activities are prerequisites to perhaps the most important roles the full board has with regard to quality: establishing quality and patient safety goals and ensuring sufficient resources are invested in the measurement and improvement of clinical quality, patient safety, and customer satisfaction. Just as the board determines the hospital's targets for its bond ratings, operating margin, and return on investment in new programs, so too should the board determine the organization's quality goals. Some boards are aiming for "no preventable errors within five years" or winning the Malcolm Baldridge National Quality Award. Such measurable, aspirational goals serve as a powerful driver of transformation, because it visibly demonstrates leadership commitment.

Quality is not free—it takes investment in training, credentialing and hiring, information technology, and state-of-the-art equipment. It takes sufficient staff to carry out measurement and improvement activities. Boards should know how their CEOs and chief medical officers are personally involved and how the organization's quality infrastructure is working. In addition, the board should align its commitment to quality with its compensation program for executives, incorporating quality goals in the executive incentive plan.

Boards that take a greater role in quality find that not only do organizational results improve, but also that senior management appreciates their support and the board itself derives greater satisfaction from its work.

The Board Quality Committee Goes to Work

August 2009 • Barry S. Bader, Edward A. Kazemek, Pamela R. Knecht, Eric D. Lister, M.D., Don Seymour, and Roger W. Witalis, FACHE

A decade ago, it was unusual for boards to have standing committees focused on quality and safety. With leadership from The Governance Institute, the National Quality Forum (NQF), and the Institute for Healthcare Improvement, what was once rare has become commonplace.

We believe that a robust board quality committee is essential, if the governing body is to play its appropriate role in guiding and overseeing a hospital's quality program. Findings from analyses done in 2008 and 2009[1] in fact substantiate this belief: having a standing board quality committee correlates with better performance on quality measures. Previous columns have addressed the distinction between committee work and that which needs to be done by the board as a whole, and the importance of role clarity between system and subsidiary boards. This column is designed to offer the quality committee a blueprint for effectiveness.

Start with the Right People

Many quality committees are too large, including everyone from the management team who "touches" quality. This is a mistake. It may be helpful to think about composition of the finance committee as a template for the quality committee. The committee should be led by a board member (preferably a non-physician board member) with an interest and background in quality, and include a number of other trustees. It should be staffed by those who direct the hospital's quality efforts, including the VPMA or CMO, physicians representing the work of the medical staff, as well as the management personnel who direct efforts related to quality, risk management, patient satisfaction, and patient complaints.

Set the Right Goals

On an annual basis, the committee should request an updated and comprehensive quality plan from management, a plan created with input from staff as well as physicians. In the review and modification of this plan, the board quality committee has the prerogative—and in fact the responsibility—to frame serious goals that embody the board's commitment. Complacency, modest ambitions, and defensiveness must be challenged. The plan needs to include an overview of how staff and physicians will work to advance quality, what data will be gathered and how it will be analyzed, and what reports the quality committee will see. Again, think about finance. The board should be knowledgeable and informed in both areas but the entire board does not have to be as steeped in the details as the committee.

Select the Right Clinical Measures

There are more quality measures available than any committee could possibly track. The committee needs, through its annual planning ritual, to identify a set of measures that it will track regularly, changing these measures as necessary over time. Some unstructured discussion is necessary as well, allowing unanticipated problems and new ideas to surface.

The measures selected should include some from each of the following categories:

- Publicly reported measures (such as CMS "core measures"), allowing ready comparison with other institutions.
- *Trends* in complications, length of stay, readmission, resource utilization, and so forth (trends allow comparison with your own previous performance, enabling the organization to set goals towards "zero" or "perfect" care).
- Measures addressing safety and efficacy of new or high-risk procedures.
- Measures addressing effectiveness in treating your most commonly seen conditions and procedures.
- Measures tracking performance on national initiatives (such as IHI programs).
- Measures tracking your performance on initiatives launched in response to some particular local finding or experience.
- Summary results of peer review activity.
- A log of critical incidents (lawsuits, unanticipated deaths, occurrences reported to regulators or licensing boards, etc.) and staff's analyses of these incidents.
- Measures of culture (see below).

Focus on Culture

Through its Safe Practices Guidelines, NQF sets, as its first recommendation, the development of a culture of safety. This tenet is at the top of the list for a reason. The challenge, of course, is that culture is hard to quantify. There are a number of surveys, including one available free of charge from AHRQ, that attempt to quantify culture. Other proxies for culture include physician engagement, employee satisfaction, retention rates, patient satisfaction, and the results of focus groups with staff or patients.

Accent the Quality/Operations Interface

The way work is done in a hospital connects in a direct way with its quality and safety results. Are processes efficient or chaotic? Is communication crisp or sloppy? Are methodologies like Lean and Six Sigma employed regularly? In reviewing the analyses and action plans brought forward by physician leaders and management, the committee must assure that activities on the quality front are thoroughly integrated with operational process improvements.

1 See Joanna Jiang, Carlin Lockee, Karma Bass, and Irene Fraser, "Board Engagement in Quality: Findings of a Survey of Hospital and System Leaders," *Journal of Healthcare Management,* Vol. 53, No. 2, March/April 2008 (AHRQ analyzed data from The Governance Institute's 2006 quality survey and reported the findings in this article); and Joanna Jiang, Carlin Lockee, and Irene Fraser, "How Hospital Governing Boards Enhance Quality Oversight: An Application of the Agency Theory Perspective," conference paper, International Conference of Academy of Innovation and Entrepreneurship, Beijing, July 2009.

Drive the Integration of Quality and Finance

All too often, quality and safety work takes place in one "silo," with financial matters overseen completely separately. This process risks sacrificing effectiveness for efficiency. Periodic contact between committee chairs is useful to highlight areas where quality impacts cost (lack of payment for avoidable errors) and cost impacts quality (resources needed to advance quality activities). We suggest that all capital allocation processes include the calculation of a "quality and safety ROI" as a way of integrating these two perspectives.

Tap the Voice of the Patient

It is important for the committee to spend some time looking past the metrics to touch the human experience of being a patient, whether by inviting patients to the committee to describe their experiences, by studying focus group results, or by viewing videos of focus groups. This activity informs and enriches all of the work described above.

Conclusions

The board quality committee has critical work to do—setting organizational goals, monitoring performance, overseeing management's action plans, and selecting a set of critical issues to bring to the entire board. The committee's culture must be one of robust engagement, marked by high standards and a willingness to ask the hard questions. The use of dashboards, a commitment to transparency, and attention to the voice of the patient are essential. This work allows board members a deep sense of pride and purpose, as they drive institutional success in the area fundamental to every hospital's identity—it's care of patients.

Strategic Planning: Work for the Full Board or a Committee?

April 2007 • Barry S. Bader, Edward A. Kazemek, Pamela R. Knecht, and Roger W. Witalis, FACHE

In light of the growing pressure on boards for greater accountability, many boards want a bigger hand in making major strategic decisions.

But three things challenge them:

- Lack of time for the full board to be engaged
- The perception that trustees have insufficient knowledge about the healthcare business and local market to make a valuable contribution
- The difficulty of distinguishing "strategic" versus "operational" issues

Consequently, almost half of boards across the country (44 percent according to results from *Raising the Bar,* The Governance Institute's 2005 Biennial Survey of Hospitals & Healthcare Systems) have opted to charge a committee with developing a strategic plan for the full board's approval. Boards have the legal right to delegate this authority to a committee. In fact, many would argue that using a committee for this purpose is comparable to using a finance committee to review the annual budget and capital plan on behalf of the full board.

However, it may be time to revisit the assumption that a standing strategic planning committee (SPC) is the best method for engaging the board in strategy. While some boards may find an SPC useful, there can be a "dark side" to relying on a committee to do the board's strategy work. All too often, it is *only* the members of the SPC who fully understand the strategic challenges and opportunities facing the organization over the next five to ten years. The rest of the board members may not have been included in the educational sessions on national healthcare trends, in-depth conversations about current and potential competitors, and discussions of alternative strategies for the organization's future.

For example, a board member recently confided that because she had not served on the SPC, she did not feel confident that she could fully explain to the broader community the rationale for the new strategic plan that she and her colleagues had approved. She was concerned that she might not be adequately fulfilling her fiduciary duty to make wise decisions about community resources.

At its very core, a board's fiduciary duty of oversight includes establishing the mission, core values, and vision for the organization and then approving goals and objectives to ensure that the mission is accomplished. The board's legal responsibilities also include the duties of obedience and loyalty to that mission, and the duty of care—having knowledge of all reasonably available and pertinent information before taking action.

It follows that the full board—not just a subset of its members—should be actively engaged in the strategic planning process that determines the mission, vision, and strategic goals based on a thorough understanding of internal and external environmental trends. That does not mean that all board members must sit through dozens of meetings. Many boards create an *ad hoc* task force of board members, administration, and physician leaders to help guide the process and ensure appropriate involvement. The task force ensures that the full board:

- Debates and approves the mission and core values
- Attends educational sessions about national, regional, and local healthcare trends
- Understands internal performance data, external competitive threats, and community health needs
- "Frames" the critical issues to be addressed in the strategic plan
- Helps develop the longer-term vision and shorter-term goals
- Allocates resources to ensure achievement of the strategic plan
- Ensures that accountability for results is clear and implementation is monitored

Additional task forces can also explore strategies for hot topics such as physician joint ventures, geographical expansion, and wellness initiatives. These content-specific task forces may operate as part of the formal strategic planning process, or on an as-needed basis. The full board should then devote a portion of its meetings to discussion of the strategic issues researched by the task forces.

Since one of the board's most profound responsibilities is to set strategic direction, it seems contradictory to delegate that role to one small group. After all, this is the job that the community expects to be done by all (not just some) of the board members to whom they have entrusted the community's healthcare assets.

Healthcare Policy: Seven Questions Boards Must Ask

February 2010 • Barry S. Bader, Edward A. Kazemek, Pamela R. Knecht, Don Seymour, and Roger W. Witalis, FACHE

As the great Congressional debates over healthcare reform pass into history, access to care and cost both continue as unresolved problems. As a result, hospitals and physicians are left with enormous challenges in their mutual quest to provide high-quality patient care.

Policy Implications

The dust is settling and the clear message from policymakers to healthcare providers is this: ***take care of more people with more complications and demands, and do it with fewer resources.*** From the hospital standpoint there are three major implications:

1. **Problems accessing care.** There is a national shortage of primary care physicians (PCPs) and many people (though they may have newly available health insurance as a result of policy changes) still won't have access to a PCP. Massachusetts, which has more practicing physicians than any state in the U.S. except the District of Columbia, saw wait times for PCP appointments increase significantly after it passed universal coverage legislation in 2006. Consequently, emergency department costs and visits both rose appreciably.
2. **Splitting one check.** Policymakers will be tossing the hot potato of cost containment into the laps of providers in the form of at-risk reimbursement (e.g., bundled payments, pay-for-performance, Accountable Care Organizations, and/or capitation) tied to quality and cost outcomes. Massachusetts is currently considering a statewide move in this direction, replacing fee-for-service with mandatory, global payments[1] to contain the escalating costs of universal coverage. Doctors and hospitals will essentially get one check and they will have to figure out how to divide it among the various providers.
3. **Flat or declining payment.** Average payment per increment of service will, at best, stay the same when adjusted for inflation. The "tax the rich, feed the poor" scenario (i.e., increasing income taxes and taxing "Cadillac health plans" in order to cover the cost of the uninsured) won't generate enough revenue to sustain current reimbursement levels (Massachusetts increased state taxes more than 20 percent and still faces a deficit). The potential for cost savings from Medicare and Medicaid remain elusive.

Seven Questions Boards Must Ask

There are seven specific issues hospital boards should pay particular attention to.

1. What are our core mission and our core business, respectively?

That's right, they might not be the same. Explicitly or implicitly, most community hospitals have a *core mission* to take care of the sick, injured, and frail members of their service area, whether their needs are acute or chronic, while also providing wellness and prevention services. But the *core business* for most hospitals is the provision of acute care services: inpatient, ambulatory, and emergent/urgent. This is a unique service to the community and also where the hospital generates most of its revenue. Boards should assess their ability to continue providing other, non-acute care services; especially if another organization might do a better job and/or if the service takes resources away from the core business.

"'We will do everything for everybody' has never been a viable value proposition for any successful business…yet that's the value proposition…of general hospitals…."[2] The notion of being all things to all people is well intended, speaks to the mission of most non-profit hospitals, and poses a significant dilemma for boards in a time of increasingly limited resources. In the past, a hospital service could be justified because it was "good for the community." Hospitals have been saying they can't do everything—but they will have to be far more disciplined about this in the future. Increasingly, hospital boards will need to debate these fundamental questions:

- What is the highest and best use of the organization's limited resources?
- What changes, if any, need to be made to our mission and vision so they reflect our core business?

2. Are our clinical outcomes as good as they could/should be?

As payment is tied to quality, clinical outcomes—which have always been important indicators of patient care—will take on economic importance as well. Boards can continue their quest for quality improvement by asking the following questions:

- What do our metrics tell us about the quality of care in our hospital?
- Are we using the right metrics?
- What systems and processes does the hospital have in place to ensure continuous quality improvement?

3. Are we doing all we can to optimize the bottom line?

Profitability in most hospitals is driven by a small number of services. Hospitals need to assess their portfolios to identify "cash cows" and determine if they have sufficient resources (physicians, facilities, equipment, and staff) for continued success. Hospitals should also look at the expense side of the ledger and identify opportunities to cut costs. Lower costs and higher quality often go together when savings are driven by evidence-based process improvements, not by indiscriminate budget cuts. Questions for further discussion include:

- How will the "rising stars" in our current portfolio become the "cash cows" of 2015?
- What do our comparative cost profiles indicate about opportunities to reduce expenses?

4. Do we have a five-year capital plan, and do we actively use it as a strategic management tool?

Every hospital should have a five-year "sources and uses of capital" statement in place as a component of its strategic plan and the board should participate in at least annual reviews of these projections. During these reviews boards should start with three questions:

- What are the underlying assumptions and do they take into account the vagaries of future revenue streams and the probability of increased expenses?

1 Steve Leblanc, "Mass. weighs 'global' health care payment system," Associated Press, July 16, 2009.

2 Clayton M. Christensen, et al., The Innovator's Prescription: A Disruptive Solution for Healthcare, McGraw-Hill, 2008.

- What is the contingency plan to cut "uses" if the "sources" don't materialize?
- Does the capital plan support our core mission and core business?

5. What is our vision and plan for integration with physicians?

Integration goes beyond alignment and employment to create one cohesive organization focused on patient care, quality improvement, and economic efficiency. Many hospitals and their physicians have begun the heroic journey towards integration. The easy part is changing the structure; the heroic part is changing from a culture that encourages and rewards individual efforts to one that supports and rewards a systemic approach to patient care. Two structural approaches provide vehicles for facilitating an integrated approach: the formation of a multi-specialty group (MSG) and/or the creation of an Accountable Care Organization (ACO). Both are designed to improve patient care while simultaneously enhancing provider ability to succeed financially under at-risk contracts. Boards should be engaged in discussing the pros and cons of the following questions:

- Should our employed physician group begin the transition to becoming an MSG?
- Should our hospital, employed physicians, and independent physicians participate in an ACO?

6. How severe is our PCP shortage and what are we going to do about it?

Hint: simply trying to recruit more PCPs or making them work harder won't work; there are too few of them nationally and only 24 hours in a day.

While there are no easy solutions to the shortage of PCPs there are some steps that innovative organizations are taking. Board questions include:

- What does our physician development plan tell us about the severity of this challenge over the next five years?
- Will the highly touted medical home model of practice help to eliminate the shortage?
- What approach are we taking to differentiating ourselves in recruitment of PCPs?
- What approach are we taking to recruitment of mid-level practitioners to supplement the work of PCPs?
- Should we establish an urgent care center, fast track in the ED, and/or a retail clinic?

7. Can we continue to go it alone or do we need to join/form a larger hospital system?

The policy challenges are daunting and many hospitals may not be satisfied with the answers they give themselves for the previous six questions. What then? For some the answer is turning to a larger system; for others it may be forming a system; for still others it may be adding to an existing system. Among other potential benefits, hospital systems may provide clinical scale (i.e., larger volumes and therefore the ability for greater specialization), economic scale, the ability to negotiate better contracts, and diversification of risk. But the benefits can be elusive and all come at the price of autonomy. As they start down this road, hospital boards should ask themselves at least three questions:

- What are the principles driving this potential relationship—what are we trying to accomplish?
- What are we willing to give up in order to develop the relationship?
- Assuming we joined with others, how would our answers to the previous six questions change?

Conclusion

The issues of policy change are complex and, of course, we are not clairvoyant. We encourage hospital boards to use this article as a jumping- off point for discussion about policy changes and their implications for hospital governance.

Hospitals 2020—Specialized, Integrated, & Connected

October 2009 • **Barry S. Bader, Edward A. Kazemek, Pamela R. Knecht, Don Seymour, and Roger W. Witalis, FACHE**

A "hospital" in 2020 will be a very different organization from today. Hospitals that still exist will have examined the value they provide to their community and redefined their core competencies, causing them to become more specialized, integrated, and connected.

Core Competence

A core competence is analogous to the roots of a tree; it feeds the trunk, branches, and leaves.[1] Historically, the true core competence of hospitals has been centralization and coordination of the diagnosis and treatment of acutely ill patients. This competence was beneficial to society. Hospitals provided great community value by serving as a central meeting point for physicians and others to physically gather in proximity to patients and proceed through an iterative process of patient diagnosis/treatment.

Specialized, Integrated, & Connected

Over the course of the last decade—thanks largely to clinical advances and information technology breakthroughs—the core competence of the hospital has been increasingly disrupted. Primary care physicians don't come to hospitals, surgeons rely on PACS systems accessed from remote locations (including iPhones), and some types of surgeries are performed robotically. Medicine is more precise and physical presence less paramount.[2] The pace of this disruption will increase over the next five to ten years.

Specialized

The core business for most community hospitals is the organization and delivery of acute care services (i.e., care of the sick and injured). Most hospitals attempt to provide wellness, prevention, chronic disease management, and other beneficial services to their communities.

1 C. K. Prahalad and Gary Hamel, "The Core Competence of the Corporation," Harvard Business Review, May/June 1990, p.81.

2 Policy wonks, payers, and others are piggybacking on these two megatrends to put even more pressure on hospitals to redefine their core competence. But hospital leaders should focus, first, on the two major drivers of disruption (clinical and technological advances).

Until very recently, hospitals could afford the luxury of diversifying outside acute care services. Challenges, which were rare, to diversification were addressed with two simple admonitions:

- These services are good for the community.
- If we didn't provide these services, we wouldn't be fulfilling our mission has a full-service hospital.

Given the pressure hospitals will be under in the foreseeable future, the full-service mission will face serious challenges. "Doing good" is important and should be respected as a fiduciary obligation the hospital has to the community it serves. However, it is insufficient justification for diversion of a hospital's resources from its core business. Rather than asking, "Is this good for the community," the question will become, "What is the highest and best use of the hospital's limited resources to meet the community's needs?"

Over the course of the next decade, diagnosis and treatment will become more precise—and standardized—making it possible to evaluate and compare both clinical outcomes and costs. In the 1990s, the term Center of Excellence (COE) was so overused it became meaningless. Today it is increasingly meaningful in, for example, cardiovascular, orthopedic, stroke, and urologic patient care. In 2020 the COEs that exist will have the clinical and financial documentation to back the claim. To accomplish this they will have redefined their core competence. If you establish a brand that guarantees excellence, you'd better be doing more than organizing and coordinating care because you have, at least implicitly, provided a guaranteed result.

Integrated

As hospitals become more specialized they will also become more integrated horizontally (i.e., hospital to hospital) and vertically (e.g., with physicians). The motivations for horizontal integration will remain what they have been for the last fifteen years: capital access, physician recruitment, payer contracting, reduction of operating costs, market share defense, and/or service line enhancement.[3] There will be a renewed emphasis on hub and spoke models that support specialization. We fully expect the recent uptick in consolidations to continue, but most of the transactions that are going to take place will have been completed by 2015—probably sooner. Note: everyone won't join a system. Some strong, freestanding hospitals will still remain, even in 2020.

The case for hospital–physician alignment has been well established.[4] It is likely that nearly all physicians in 2020 will practice in a single- or multi-specialty group that may or may not be corporately tied to a hospital. The tightest alignment (therefore having the strongest core competence, therefore being the most competitive) will be in vertically integrated provider organizations (advance thinkers have already stopped calling them "hospitals"). Regardless of the structure, hospitals in 2020 will be more closely integrated with physicians in order to improve quality, manage costs, and respond to patient, government, and payer demands for accountability.

Connected

Hospitals in 2020 will be full participants in the digital exchange of all patient related information (i.e., clinical, financial, and demographic). They will participate in a secure, interoperable IT network that is accessible to

3 Don Seymour, "Mergers, Acquisitions & Partnerships—Lessons from the 1990s," Healthcare Executive, July/August 2009, pp. 56–59.

4 Barry S. Bader, Edward A. Kazemek, and Pamela R. Knecht, Aligning Hospitals and Physicians: Formulating Strategy in a Changing Environment (white paper), The Governance Institute, Fall 2008.

patients, physicians, other providers and payers. The transition will be difficult and some won't survive the journey. Those that do will be able to provide more value to the communities they serve. Just as the hospital was the central point for coordination of patient care from 1945–2005, the EMR will be the point of coordination in 2020 and beyond.

Boardroom Implications

We hope the premises and hypotheses in this article will provide the foundation for a great leadership discussion about the future mission and vision of hospitals and health systems. We suggest starting with the following questions:

1. What is our core competence today (hint: no more than three components)?
2. How will trends in clinical practice, IT, public policy, and payment support or disrupt us over the next 10 years?
3. What will be the highest and best use of the hospital's limited resources to meet the community's needs? How is that different from what we do today?
4. Perhaps your board sees things differently. If your board and management don't agree with this 2020 vision for the future of hospitals, what is your alternative view for the future of the healthcare industry and, most importantly, your hospital/health system?

The System–Subsidiary Relationship in Hospital Governance

October 2008 • Barry S. Bader, Edward A. Kazemek, Pamela R. Knecht, Eric D. Lister, M.D., Don Seymour, and Roger W. Witalis, FACHE

In health systems of all sizes, the relationship between system and subsidiary boards suffers from inadequate clarity, coordination, and consistency. Roles and responsibilities are not differentiated. Subsidiary boards often lack a full understanding of their fiduciary duties. Even when clear "on paper," reporting relationships are likely to be inconsistent, and more attention needs to be paid to creating a true sense of "systemness."

Suggestions for Establishing Appropriate System–Subsidiary Relationships

The following five actions lead to optimal performance. A commitment to optimal governance within a health system involves taking on this entire package of tasks. Local input is critical, but the work involved needs to be driven by the system board and CEO.

1. **Structure Building through Clear and Interrelated Bylaws**

Bylaws and board policies for the health system should explicitly reference each assignment to subsidiary boards, the tasks delegated to these boards, and the oversight mechanisms that relate to each of these tasks. All subsidiary boards should have the same set of bylaws and policies and these should parallel the bylaws of the system board in structure and content.

Bylaws need to be explicit about the authority vested in each body, the degree of autonomy delegated to the subsidiary board in each area of authority, as well as the mechanisms by which policies flow "downstream" to the subsidiary boards, and reports flow "upstream."

2. **Consistency through Standardization**

Health systems should move toward standardization of the following:

- **Hospital bylaws:** See above. Attention to standardization should be particularly rigorous in areas where subsidiaries have discretion and authority (e.g., quality, credentialing, provider discipline, and so forth).
- **Medical staff bylaws:** There is a world of difference between "average" medical staff bylaws and great ones. Excellent bylaws institute a rigor to the credentialing and peer review functions that are essential to maintaining standards and advancing the system brand. While the ability of each medical staff to generate its own bylaws makes system standardization difficult, this should be the unwavering goal.
- **Board agendas:** A standardized template for all subsidiary board meetings will assure regular and appropriate attention to all critical areas and will streamline upstream reporting.
- **Board committee structures:** The system board will have committees that are not necessary for subsidiaries (i.e., audit) but unless there is a clear rationale for variation, all subsidiaries within a system should have parallel committees with similar charters and operating processes.
- **Compliance and risk management policies and processes:** These should be identical across all entities in the system unless there are specific reasons for variation.
- **Board support:** The administrator or administrative assistant coordinating the system board should have dotted-line authority over his/her counterpart at each subsidiary in order to assure coordination and consistency.
- **Board minutes:** Minutes should have an identical structure across all boards, highlighting issues at the system/subsidiary interface. All of this has efficiency, effectiveness, and compliance ramifications.
- **Board self-evaluation:** This JCAHO requirement can be a meaningless ritual or a meaningful piece of self-reflection. Be consistent within the system as to the process and format of the evaluations; allow some room for customization to address local issues.
- **Quality and safety:** The system quality plan and dashboard need to be carefully developed and, in turn, drive the form and structure of each subsidiary plan and dashboard. Again, allow room for customization to study local issues. The system quality committee needs to at least review summaries of each subsidiary quality committee.

- **Board nominating process; inclusion and exclusion criteria:** Consider system philosophy, values, and strategy when creating the nominating pathway for subsidiary boards. The nominating committee of the system board should be attentive to the opportunity to use appointment to a subsidiary board as a training ground and proving ground for potential system trustees.
- **Board contribution to local CEO evaluation:** The evaluation remains a management prerogative of the system CEO, but local board input is a regulatory requirement and a wise political move. The process for obtaining subsidiary board input should be clear and consistent across institutions.

3. **Governance Education**

While education on finance may be more germane for members of the system board, a clear understanding of business realities is useful for all board members. Creating a system educational calendar and agenda allows for consistent levels of knowledge and capacity across the system. Topics that should appear regularly on this agenda include, but are not limited to, the business of medicine, trends in service delivery, quality and safety, community health and well being,

legal issues for trustees, philanthropy, and provider relations.

4. **Engaging in a System Perspective**

One of the critical advantages of being a system involves the mobilization of talent, energy, and creativity to transfer ideas and support programs across an extended geography.

To the extent that system boards understand the concerns and resources of subsidiary organizations, their attention to strategy will be enhanced. If subsidiary boards keep "the big picture" in mind they will be potential advocates, particularly with respect to the use of political influence and philanthropy.

5. **Mobilizing for Philanthropy**

Much has been written today about the need for philanthropic dollars to supplement operating income. Health systems have a unique story to tell the donor community, yet often squander the opportunity to capitalize on that story by failing to create a plan that spans the communities involved in the system. Develop a comprehensive message that taps donors for both local projects of immediate relevance and, simultaneously, system-wide projects of overarching, long-term significance. This requires a unified plan that has components for each locality represented by a subsidiary institution.

System Affiliation Discussions Require Carefully Structured Process

December 2006 • Barry S. Bader, Edward A. Kazemek, and Roger W. Witalis, FACHE

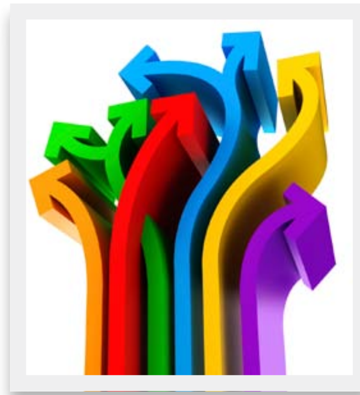
The Governance Institute has fielded a number of inquiries lately from freestanding hospitals thinking about joining a multi-hospital system and asking how to engage the board in these discussions.

A potential transfer of ownership to a system parent and the resulting loss of full autonomy involve the quintessential governance duties of care, loyalty, and obedience to charitable purpose. The transferring hospital board must be satisfied the transaction is fiscally sound and in the best, long-term interests of the hospital's primary stakeholders—patients and the community. Thus, the board's fiduciary responsibility suggests it should be involved early on, but in reality, that's not so easy.

Deals usually are born between a few top leaders who see that a system affiliation could enhance each organization's financial stability, access to capital, market share, operating efficiency, clinical quality, or patient access. Timing must be just right. The impending retirement of a hospital CEO, the need for capital to finance a major hospital expansion, or financial losses that create a CEO vacancy can briefly open a window.

However, leaders can become so focused on the potential bounties that they lose real world perspective. Potential partners must be candid from the outset about the deal-breakers that doom transactions. They include:

- How much autonomy the hospital must relinquish to the parent board (specifically, whether the system's reserved powers will include total or limited control over operating entities' budgets, strategic plans, CEO selection and evaluation, and local board composition)
- New management structure (and the fate of the hospital CEO and senior management team)
- New governance structure (and what happens to current hospital board)
- The desire to maintain treasured hospital programs and services (that are duplicative or losing money) after the deal



Such complexities are best resolved by small groups working out of the limelight. In the hospital arena, physicians, employees, the foundation, senior management, and others may fear loss of influence, jobs, and control. Religious sponsors may be concerned over maintaining their values and religious identity under new owners. Government owned entities answer to elected officials with political agendas. The saying "loose lips sink ships" applies: premature disclosure of discussions can jeopardize a strategic partnership by unleashing a host of negative forces.

As a result, we recommend the parties carefully structure a process to get tough issues on the table early and progress from small work groups to larger forums. Initial meetings between the two CEOs might be followed by bringing in the board chairs and then forming a small, confidential transaction committee to agree on the key principles of the partnership, draft a vision statement, and address potential deal breakers. The parties would sign a confidentiality agreement. Flexibility, candor, and subject matter experts in finance, law, human resources, and governance, are critical. An experienced facilitator is often of great help.

At an appropriate point, the full leadership of both parties should be educated and agree to a non-binding letter of intent, leading to a due diligence phase. Eventually the hospital board, and where appropriate the system board, should be educated and asked to approve the transaction. Strict time frames are important. When discussions drag on without resolution, morale suffers, anxieties spread, and opposing interests dig in.

Many of these concepts are also applicable to mergers and acquisitions. Making 1+1 = 3 requires creativity, vision, expertise, patience, and attention to detail. A carefully structured process that confronts reality and engages the best thinking of the board and senior management has the best chance of producing a masterpiece.