

EFFECTIVE BOARDS:

WORKING SMARTER TO MEET THE CHALLENGE

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If a truth serum were administered to the members of the nation's not-for-profit health care boards, most would probably admit that they are not performing their core responsibilities as well as they could be. They know what they are supposed to do; they just don't do it. • For example, during the past two years several high-profile hospitals and health systems have declared bankruptcy or been on the verge of financial collapse. In many of these cases, the board was a major contributor to the problem. The most shocking example was the meltdown of the Allegheny Health Education and Research Foundation (AHERF) in Pennsylvania. • Here is a picture of what really happens in the boardroom, and why.

Strategic Planning

Ideally, the board sets the direction for the organization. This includes crafting a mission and developing a vision of what the system or hospital will look like in three to five years. That type of strategic thinking requires a complete analysis of the current situation, knowledge of all the available options, and an understanding of the likely ramifications of various strategies.

Trustees are often more comfortable tackling issues that are familiar to them (e.g., new buildings and other capital expenditures), preferring them to difficult strategic challenges and opportunities. That's why they often leave the planning process and final decisions to management and/or consultants.

The problem with this approach is that the board may end up endorsing strategies and their associated risks and consequences that they only vaguely understand. It's hard to believe that the board of Catholic Healthcare West, for example, would have supported the breathtaking expansion of its system over the last

five years if it had seen the potential for an operating deficit that reached \$225 million in 1999.

Quality of Patient Care and Services

The recent Institute of Medicine (IOM) report stating that as many as 98,000 people may die annually from medical errors has intensified the need for trustees to oversee the quality of patient care. Since trustees are rarely knowledgeable about clinical care, they must depend on the medical staff or other health professionals to interpret medical terminology and clinical data used in quality reports. Even if a trustee asks an informed question, physicians are reluctant to take the legal risk of being totally open and honest about their colleagues' performance.

In addition, measuring quality outcomes is an emerging science. There are no universally accepted standards, even within the medical community, defining the best quality indicators. That's why quality reports are often superficially discussed or just rubber-stamped by boards.

SMDC BALANCED SCORECARD—CORPORATE LEVEL							
FINANCIAL		CUSTOMER		OPERATIONAL		PEOPLE	
Indicator	Target	Indicator	Target	Indicator	Target	Indicator	Target
Acute market share	X	Acute patient satisfaction	X excellent	Integrate clinical services	X services integrated	Employee survey	Baseline established
Ambulatory market share	X	Ambulatory patient satisfaction	X excellent	Implement clinical pathways	A minimum of X clinical pathways implemented	Prioritize areas and implement employee mission/values program	Completion of prioritization and implementation of outcomes-based program
Operating margin	X					Physician survey	Baseline established
Excess margin	X					Prioritize areas and implement mission/values program for physicians	Completion of prioritization and implementation of outcomes-based program
Days cash on hand	X						
Return on investment	X						
Days in accounts receivable	X						

KEY:
 All service lines will address
 X =confidential information

Source: St. Mary's Duluth Clinic Health System, Duluth, Minnesota

Kevin Fickenscher, M.D., senior vice president at CareInsite, San Francisco, says, “In my experience, most health system boards have not treated quality as a priority agenda item; they have not ensured that sufficient resources are invested in quality-focused information systems; and they have not mandated an adequate level of education for lay board members on quality matters. The real tragedy is that many of the medical errors that result in harm to patients could be eliminated if adequate resources were devoted to the problem. And it’s the board that has the obligation and authority to make those resource allocation decisions.”

Financial Oversight

As fiduciaries, trustees must ensure the financial health of their organizations. Unfortunately, reimbursement changes are more numerous than the IRS’s personal income tax code. The shift from fee-for-service to managed care reimbursement adds to the challenges facing trustees. Even experienced administrators have difficulty understanding capitation and risk contracting. A trustee of a large, regional health system recently admitted to a new board member that it had taken him three years to interpret financial reports.

Trustees are further hindered because financial reports presented by management are often too detailed and filled with accounting jargon. Without a thorough understanding of the organization’s financial situation, board decisions about capital expenditures are often based more on the desire to stay competitive with the hospital next door than on the financial viability of the investment.

Executive Leadership/Management

One of the board’s key responsibilities is to select and evaluate the CEO. Too many boards, however, fail to provide substantive, regular feedback on the CEO’s performance. In addition, many trustees have been selected by the CEO and feel they are being disloyal if they challenge the chief executive during meetings or when it’s time for a performance review. “I’ve seen boards wrapped around the finger of the CEO far too many times in my career,” says Jordan Hadelman, chairman, Witt/Kieffer, Ford, Hadelman, Lloyd, a national health care executive search firm based in Oak Brook, Ill. “It’s never a healthy situation for one person to have that much power in any organization. Just look at what happened at AHERF.”

Because many trustees run successful businesses themselves, they may have strong opinions about the hospital or system’s operations. One health system CEO reported seeing trustees schedule meetings with nurses to discuss ways of improving a particular hospital floor’s quality of care. This level of involvement leads to staff confusion about whose directions to follow and undermines management’s ability to implement decisions consistently.

Community/Stakeholder Relationships

The boards of not-for-profit health care organizations are responsible for ensuring that the health needs of their communities are met. Currently, the homogeneous composition of many boards hinders their ability to truly understand the needs of all key stakeholders. This is especially true in systems that span large geographic areas. Although constituency or representational governance is destructive to systems thinking, boards of local hospitals in multi-tiered systems are increasingly dissatisfied, feeling “ disenfranchised ” by the parent board. In fact, it is becoming more common

for these smaller institutions to take on the challenge and cost of “seceding” from the larger system.

Regarding board composition, the percentage of female board and committee members is still embarrassingly small, even though national studies have documented that women are responsible for a majority of health care decisions in their families. A 1999 survey conducted by The Governance Institute, La Jolla, Calif., showed that, on average, only 23 percent of system board members are female.

Additionally, although physicians are key stakeholders in health care organizations, many systems and hospitals do not include enough physicians on the board. According to The Governance Institute, 24 percent of the system boards surveyed reported having no physician

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board members, and only 35 percent reported having one to three.

Boards have a responsibility to maintain positive working relationships with physicians. Yet in many organizations, trustees have become inappropriately embroiled in the tensions between physicians and management. At one Midwest integrated delivery system, trustees actively encouraged disgruntled physicians to bypass the administration and contact the board directly about their concerns. This behavior further distanced the administration, the board, and the physicians, making it difficult for them to work together. In this case, the disgruntled physicians eventually won a vote of “no confidence” in the administration, and the board ended up asking for the CEO’s resignation in an attempt to bring some peace to the organization and avoid further bad publicity.

Governance Effectiveness

Creating integrated delivery systems has often led to multiple community boards. When this happens, there are too many organizational layers for efficient decisionmaking. Some integrated delivery systems have ended up with as many as 17 or more different boards, all rightfully confused about their roles, responsibilities, and authority.

The most common complaint about governance is “There’s never enough time.” Actually, there’s plenty of time, it’s just not used efficiently. Too much meeting time is spent on operational, not strategic issues. Meetings are not well run, and communication between management and governance is insufficient. In addition, those serving in governance are stretched too thin. At one Florida health system, some trustees served on 14 boards and committees.

Few boards provide enough information in their orientation and education sessions to enable members to be knowledgeable contributors. The typical system trustee spends only 16 hours a year in formal educational activities.

Although the JCAHO requires board evaluations, many are superficial, and few action plans are created based on the results. In fact, we have found that many trustees never see the results of self-assessments, much less discuss how the board can improve. So what’s the answer?

Participative Strategic Planning

At Trinity Health System in Steubenville, Ohio, a highly participative strategic planning process provided a rare opportunity to

accomplish governance improvement goals. Recently, all trustees participated in individual and group sessions about critical strategic issues and their vision for the system. Once a plan had been drafted, the trustees reconvened to provide feedback to the 11-member work team (which included three trustees) that drafted and revised the vision, goals, and objectives for the system.

Fred Brower, Trinity's president and CEO, says, "Involving trustees in our planning process led to a plan that truly addresses the needs of the community we serve. This method of planning also helped educate our board members on health care trends and modeled the type of strategic discussions our board should engage in on a continuous basis. Our trustees enabled us to develop a stronger plan because of their perspectives and expertise."

Sharing data gathered during the environmental assessment phase of strategic planning was an effective education method for the board at Southern Vermont Health Services Corporation in Brattleboro. Internal and external environment information was presented in executive-level summaries. Chairman Pete Sherlock says, "As a [non-health care professional] board member, it's difficult to stay on top of all the industry trends. Reading the strategic planning preparation package was a great way to get updated on the relevant data and its implications for our community. As a result, our board was better informed and able to select the best strategies for our system."

Joint Educational Events

Periodic educational events and retreats are another effective method for engaging trustees in strategic-level conversations with all key stakeholders. St. Joseph Health System in Bryan, Texas, uses din-

ner meetings and weekend retreats, among other venues, to bring its board members, physicians, and senior managers together. Once a year they invite an external speaker to describe national trends and then facilitate action planning to address the most critical issues. The president and CEO, Sister Gretchen Kunz, and the board chair, Bill Magee, both agree that these annual gatherings have significantly improved trustees' ability to contribute to strategic discussions during board meetings and to make better decisions.

Dashboard Reports

Boards should insist that dashboard-style reports on all key measures (e.g., clinical quality, financial results, and customer satisfaction) are included in each board preparation package (see "The Data Game," in the April 1997 issue*). These reports can summarize a huge amount of very complex information and display it graphically in an easy-to-understand format. The reports should show trends over time and actual performance versus established targets or budgets. The hospital or system's results should also be compared to regional and national benchmarks.

St. Mary's Duluth Clinic Health System (SMDC) in Minnesota has pioneered the use of the "Balanced Scorecard" in its system governance and management (see sample of SMDC's FY2000 Balanced Scorecard Summary). "Basically, the Balanced Scorecard provides a framework to translate SMDC's mission and strategy into operational terms," says CEO Peter Person, M.D.

"The system's vision and goals, along with measurement indicators and targets, are summarized on one page for our board's review. This has enabled me to help our board see the big picture and not get lost in the details. In addition, we have more detailed summary and ser-

CORONARY BYPASS SURGERY REPORT CARD SMDC Health System

HOSPITAL	CITY	NO. OF MEDICARE CASES*	IN-HOSPITAL MORTALITY	MORTALITY AFTER ONE MONTH	MORTALITY AFTER 6 MONTHS
St. Marys Medical Center	Duluth	630	*****	*****	*****
St. Lukes Hospital	Duluth	119	***	***	***
Abbott-Northwestern	Minneapolis	1,645	***	***	****
Fairview University	Minneapolis	237	***	***	***
St. Marys Hospital	Rochester	1,520	***	***	****
Fairview Southdale	Edina	321	***	***	*****

*Mortality reflects a 1-5 star rating system assigned by HealthCare Report Cards.com (with 5 being the best) as compared with other private, not-for-profit subscriber hospitals.

Source: St. Marys Duluth Clinic Health System, Duluth, MN

vice line scorecards for management purposes.”

The SMDC scorecard system also generates report cards on its specific clinical services based on data from Health Care Report Cards.com. (see the sample report card), a Web site subscriber service.

Sister Kathleen Hofer, SMDC’s board chair, likes the score card and report cards “because the information is presented at an executive level, and the board discussions are more likely to be strategic in nature. Trustees can then provide an appropriate level of oversight to management, instead of becoming mired in operational details.” Sometimes an objective opinion on a complex issue such as finance can be particularly helpful.

Independent Reviews

Trustees at West Virginia (Morgantown) University Hospital in 1990 hired an independent analyst to ensure that their investments were being managed effectively. Since then, the investments’ performance has been significantly better than national benchmarks. As a result of that experience, the board decided to have internal and external auditors report directly to the board on a regular basis.

Physician Involvement and Integration

About two years ago, the board of a Midwest health system found itself in an awkward situation. The relationships among the physicians, senior management, and trustees were very tense because the physicians wanted to be much more involved in managing and governing the system. After many meetings between a special task force and the medical staff, a physician/system-relationship plan was approved. Some of the key components of the plan were increasing the number of physicians serving on the system board and committees from four to 14 and agreeing on a code of conduct that outlined acceptable behavior for physicians, trustees, and senior management.

The CEO and board chair recently stated that, as a result of these and other modifications, the relationships among the three groups have improved significantly. In addition, new physician trustees help non-medical field trustees interpret quality information, and those trustees assist physicians in understanding financial data.

Senior Management Selection and Evaluation

Another concern is the relationship between the board and the CEO, especially when it comes to performance review. Barbara Runyen of Executive Coaching Partners, LLC, Chicago, says, “In my career as a health care executive and now as a partner in an executive coaching firm, I have found that CEOs who are abruptly removed from their positions often complain that there was a lack of clarity from the board about expectations and lack of open and honest dialogue around key business performance issues.” Once the board has articulated its expectations, it is then the CEO’s job to ensure that he or she communicates these to the rest of the senior management team.

Organizational Restructuring

In addition to evaluating the CEO’s performance, many health system boards have recently decided to look closely at their own effectiveness. Fifty-four percent of systems responding to the 1999 Governance Institute survey indicated that they had conducted a comprehensive assessment of their governance structures, includ-

ing regional and subsidiary boards. These systems often began by determining whether their governance structure was helping or hindering the achievement of the system’s vision. Some of the changes commonly made based on these assessments included decreasing the number of boards and committees and clarifying roles, responsibilities, and authority among governing entities.

When an East Coast system decided to change its organizational structure, it implemented what was called “the rule of three.” In other words, no one person could serve on any more than three governance entities (boards or committees). This rule significantly decreased the amount of time that each individual spent in meetings, so the board and committee members had more time to devote to being effective contributors. The rule also required that non-board members serve on board committees, thereby increasing the pool of available trustee talent.

From Trustee Selection to Evaluation

Improving trustee selection and health system orientation gets a board off to a good start. A large Catholic system, for example, instituted term limits for both board members and officers. Because no one can serve for more than three, three-year terms, the system is continually searching for new board and committee members.

To be sure that it selects the right members, the board now insists that new trustees be clear on their motives for serving. People who are looking for a social experience, are on power trips, or are seeking personal gain are screened out. Trustees are actively sought who will increase the diversity of board perspectives. The system has set targets for the percentage of board and committee members who should be female and those who should be physicians.

As a part of the selection process, potential board members are given a written document outlining their job descriptions and the system’s expectations. If the individual agrees to serve, he or she must sign the document which includes a promise to spend at least 40 hours a year in educational sessions. He or she also agrees to annual individual and board self-evaluations. In this way, the system ensures continual reassessment of its governance effectiveness.

Final Thoughts

Just because it is difficult does not mean that the concept of not-for-profit governance is unattainable or hopeless. Community residents are still the right people to identify community needs and to protect the community’s health care assets. The challenge, then, is for trustees and management to acknowledge that the barriers to effective governance are real, and that they are the ones who must do something to make things better. Governance, management, and physician leaders have no alternative but to roll up their sleeves and make effective not-for-profit governance a reality. **T**

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