THE GOVERNANCE INSTITUTE

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THE GOVERNANCE EVOLUTION:

MEETING NEW INDUSTRY DEMANDS

Executive Briefing:
Top Trends and Issues for Boards to Consider from the 2017 Biennial Survey of Hospitals and Healthcare Systems

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The Governance Institute provides trusted, independent information, resources, tools, and solutions 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.

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MEETING NEW INDUSTRY DEMANDS

Despite the current uncertainty regarding federal legislation, the large majority of this uncertainty is surrounding the insurance market, and there remains widespread agreement that the payment and delivery models will continue the need to evolve further and faster away from fee-for-service. Board structure and culture will need to also evolve further and faster in order to make this transformation a reality. This executive briefing highlights key trends from The Governance Institute's 2017 biennial survey analysis.

This year's analysis continues to show governance evolution in several areas, indicating that boards are still moving towards a value-based business model, although more slowly than we would like to see. While we hope to see the pace of change in this regard increase in future surveys, this report shows a few indicators in the right direction, including more system-level control of key issues such as community benefit goals and measurement, a continuing increase in the number of respondents participating in an ACO or clinically integrated network, and an increase in physicians involved at the governance level.

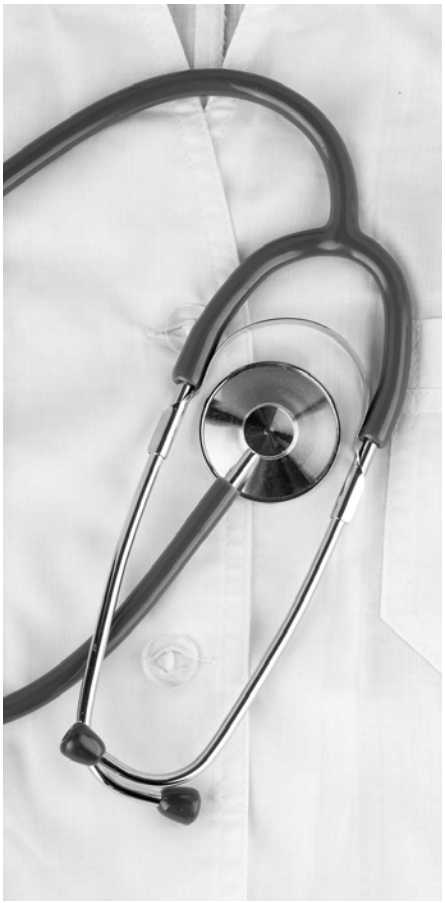
> ***"There remains widespread agreement that the payment and delivery models will continue the need to evolve further and faster away from fee-for-service.***

Areas of continued opportunity for boards to consider regarding structure and culture, in order to meet the demands of a value-based healthcare payment landscape:

- Spend more time during board meetings on strategic-level discussions rather than hearing reports from management.
- Add new expertise to the board to prepare for and/or succeed with population health management and value-based payment models.
- Improve board culture to achieve highest governance potential and move their organizations more quickly towards transformation.

BOARD COMPOSITION

The average number of board members decreased slightly since 2015—12.9 vs. 13.6—and the median went from 13 to 12. There has been only a slight shift in board composition from 2015 to this year; the most significant being a slight decrease in the number of independent board members, and a slight increase in medical staff physicians.



Nurse representation on the board remains startlingly low (out of an average board size of 12.9 members, 0.05 members are nurses, including the CNO), considering the key role nurses play in patient quality of care, experience, and customer loyalty.

Again, board diversity has not increased significantly. Most boards (98%) have at least one female board member, but only 52% have ethnic minorities represented on the board.

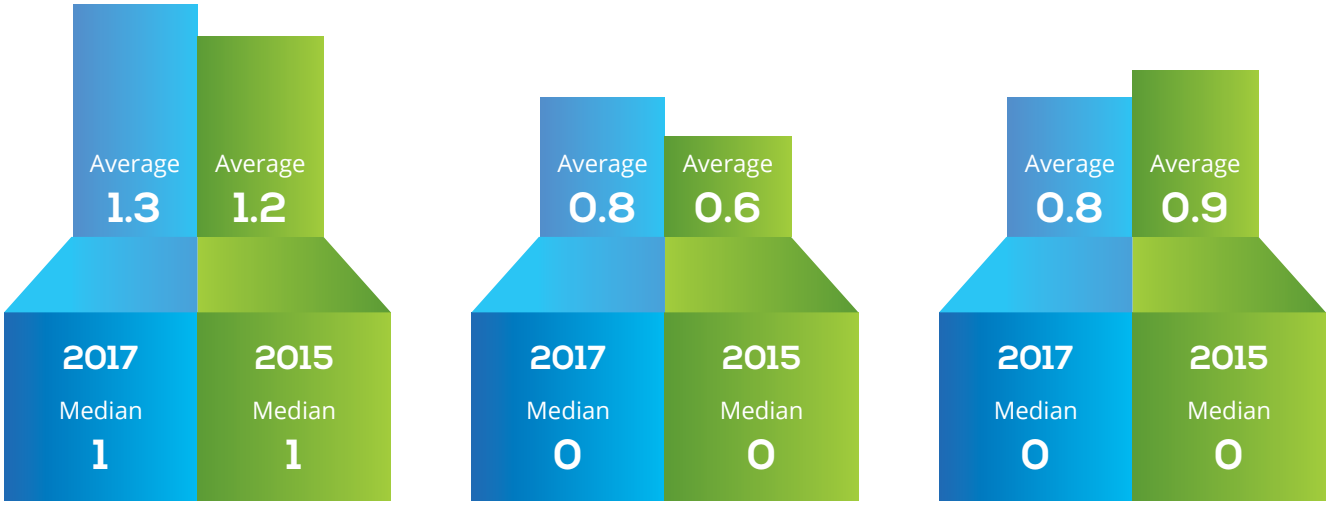
4.0%
of boards have nurse representation

37%
of boards have 0 voting physicians on the board

52%
of boards have ethnic minorities

> *Board diversity has not increased significantly.*

Physicians on the Board
2017 vs. 2015



On the medical staff but not employed by the organization

On the medical staff and employed by the organization (including CMO)

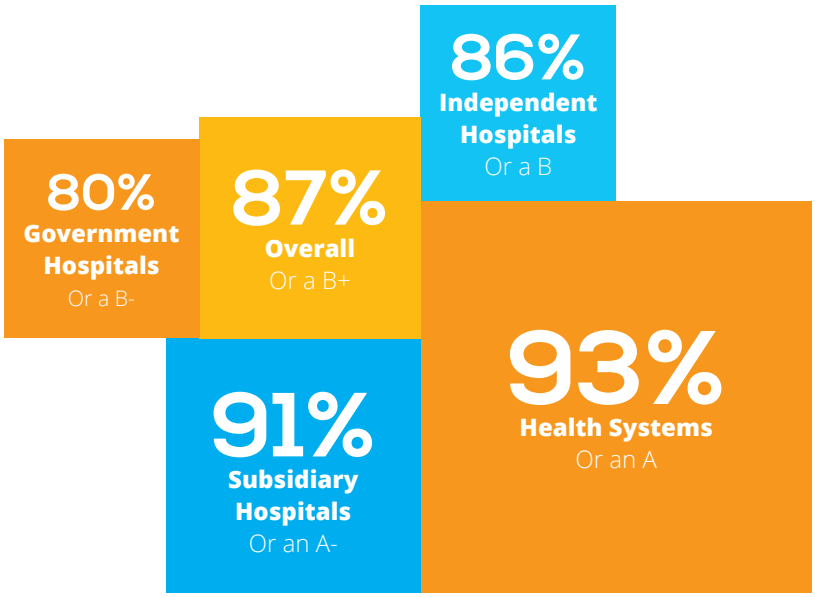
Not on the medical staff; not employed by the hospital ("outside")

Board meeting content: 66% of board meeting time is devoted to hearing reports from management and committees and reviewing financial and quality/safety reports. Only 24% is spent on discussing strategic issues/policy; and 12% to board education.

Committees: The average number of committees overall remains stable at seven. The compliance committee shows the most dramatic increase in prevalence (48% this year vs. 28% in 2015). This year we added a population health/community health improvement committee to the survey (separate from community benefit) to discern to what degree organizations are treating this as a priority at the board level. Eighteen percent (18%) of respondents overall have this committee; 9% of health systems and 20% of subsidiary hospitals have such a committee.

More boards have a quality committee (77% vs. 74% in 2015), with larger increases among subsidiary and government-sponsored hospitals. The executive committee is more likely to have full decision-making authority between board meetings (40% vs. 36% in 2015).

Board member compensation: Overall, board member compensation remains stable (12% compensate the board chair, and 11% compensate other board members). Also, the level of compensation remains low (less than $5,000).



Board Culture

Board education: 27% of respondents spend $30,000 or more annually for board education (down from 31% in 2015). Health systems generally spend more for board education than other types of organizations. This year, the data analysis showed that for boards spending $30,000 or greater on board education, there is a greater tendency to indicate strong agreement to the questions in the board culture section of the survey.

Accountable care organizations: More than half (55%) of the respondents are participating in an ACO model of some type (up from 47% in 2015). The majority of ACOs are health system owned (44%); the second largest percentage overall is a joint venture between two or more entities (18%).

Board culture: We asked respondents to state how strongly they agreed with a list of 13 board culture-related statements (See graphic below.) Each individual statement regarding board culture is important, but not indicative of a healthy culture by themselves. As such, we looked at these statements taken together as a whole to use as a reliable indicator of a healthy board culture. To determine the degree of healthy board culture overall (all statements combined), we calculated an overall average "letter grade" for each type of organization, combining all board culture statements ("strongly agree" and "agree") into one score (showing there is room for improvement).

Each individual statement regarding board culture is important, but not indicative of a healthy culture by themselves. As such, we looked at these statements taken together as a whole to use as a reliable indicator of a healthy board culture. Only 31 respondents (6.7%) reported that they strongly agree with all 13 statements.

We consider a healthy board culture to be a strong agreement with *all* of the following statements:

The board is focused on the organization's mission and fundamental purpose, and develops the strategic plan/makes strategic decisions in accordance with this mission and purpose.

The board engages in robust debate/discussions before making major decisions.

The board is effective at setting appropriate short- and long-term goals for management and physician leaders in accordance with the strategic plan.

The board has an effective system in place to measure whether strategic goals will be met.

The board effectively holds management and physician leaders accountable to accomplish strategic goals.

The board ensures appropriate physician/clinician involvement in governance.

The board engages in constructive dialogue with management.

There is solid agreement among board members and the CEO on the distinctions between the board chair's and CEO's roles.

The working relationship between the board and the CEO is consistently excellent.

Board members are well prepared to address agenda items at board and committee meetings.

The board assures itself of the reasonableness of any reliance it makes on the advice of advisors/consultants.

Individual board members share with the rest of the board information that could reasonably be determined to be of relevance to board duties.

Board members apply a level of diligence and attentiveness that is commensurate with the significance of the subject matter or circumstance.

Only 61% of system respondents said that the association of responsibility and authority is widely understood and accepted by both local and system-level leaders.

Actions taken in population health management since 2015

60% of respondents have added population health goals to the strategic plan since 2015

45% have not made any changes to board structure

Actions taken to succeed with value-based payments since 2015

56% have added value-based payment goals to strategic and financial plans

49% have not made any changes to the board or management team to succeed with value-based payments

System–subsidiary governance structure: Systems are more evenly split this year regarding governance structure. About one-third have one system board with fiduciary oversight for the entire system; another third has a system board and subsidiary boards with fiduciary duties; and the final third has a system board and subsidiary advisory boards. Only 61% of system respondents said that the association of responsibility and authority is widely understood and accepted by both local and system-level leaders (down significantly from 86% in 2015).

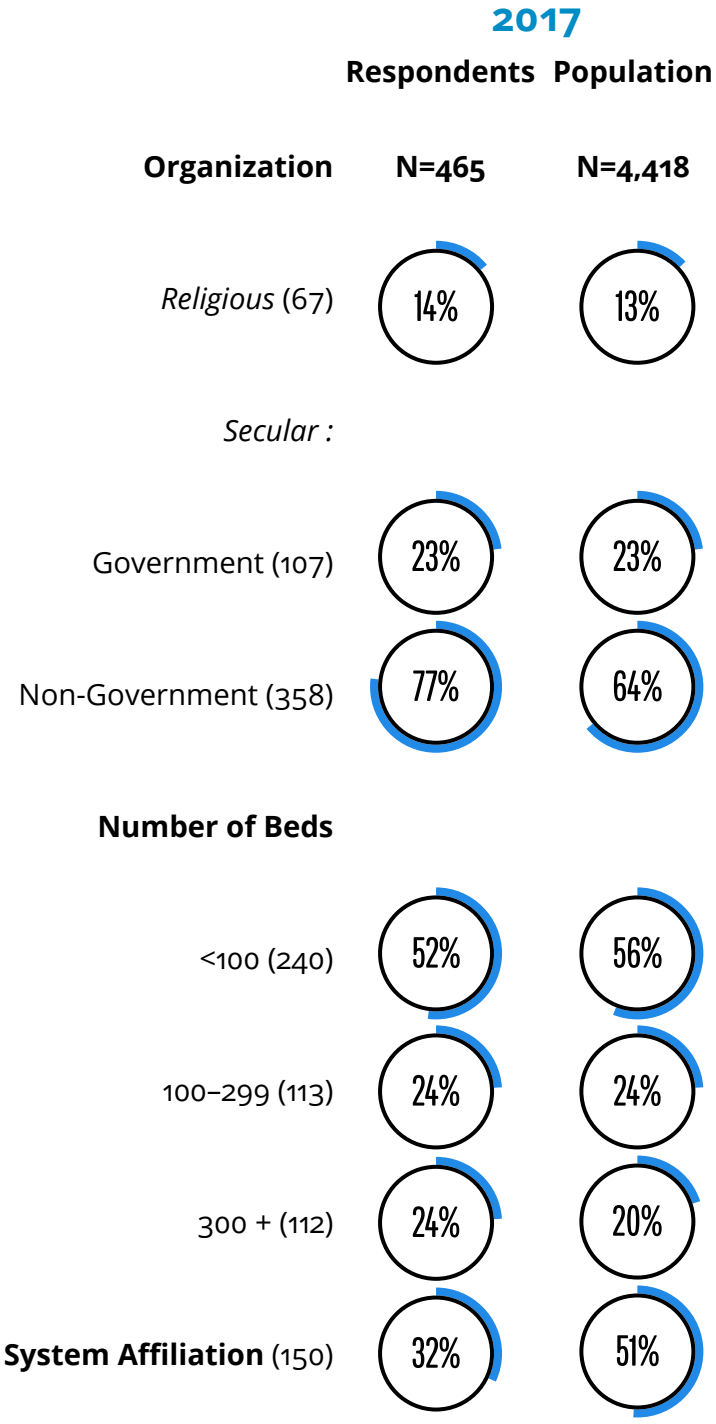
We also ask subsidiary boards to tell us whether they retain or share responsibility with the system board for certain board-level issues, or if their system board retains sole responsibility. The most significant findings from this year's survey include:

- While there is an increase in systems retaining responsibility for determining subsidiary capital and operating budgets, there is also an increase in subsidiary boards retaining responsibility (less "shared" responsibility).
- There is greater shared responsibility regarding setting quality and safety goals, and a corresponding decrease in subsidiary boards having sole responsibility for this.
- More systems are getting involved in appointing/removing and evaluating the subsidiary chief executive.
- There is polarization regarding electing/appointing subsidiary board members: this year, more subsidiary boards retain sole responsibility and conversely, more systems retain responsibility, while there is significantly less shared responsibility.
- Community benefit is a key area where we are seeing systems more involved at the subsidiary level, with more systems retaining responsibility for calculating and measuring subsidiary community benefit, and also setting community benefit goals for subsidiaries.
- More systems are establishing board education and orientation programs for their subsidiaries.

WHO RESPONDED?
2017 SURVEY RESPONSES

All U.S. not-for-profit acute care hospitals and health systems, including government-sponsored organizations (but not federal, state, and public health hospitals), received a copy of the survey—a total of 4,418:

- 465 responses (10.5%).
- 427 respondents had a fiduciary board.
- The 465 respondents represent a total of 904 hospitals, or 20.5% of the total hospital survey population.



CONCLUDING REMARKS

We consider the governance imperatives for today's boards to be:

Diversity, in both background/expertise as well as ethnic and gender diversity. The role of the board is changing, and issues facing healthcare organizations are more strategic in nature, and we expect this trend to continue. Thus, having the right expertise on the board is ever more paramount. Nurses play a huge role in patient outcomes and experience. They hold the keys to uncovering systemic issues affecting quality and patient safety. These have major strategic and governance implications and the nurse perspective is essential in the boardroom. Ethnic and gender diversity is even more important as well, as healthcare organizations continue their journey in managing population health and finding that addressing social determinants of health is a key factor in successful population health and community benefit programs.

Effective board meetings that focus on **strategic-level discussions**. Listening to reports from management is an ineffective use of valuable board meeting time. Board members should read reports prior to meetings, and management should be present to answer questions and provide interpretations of reports as needed, but the majority of board meeting time should be opened up to deep, root-cause, generative discussions of a strategic nature on mission-critical issues that require board action.

For systems, **clarity of roles and responsibilities** at the system vs. local level is critical. We expect to see more systems reporting in the future that allocation of responsibilities across the system is widely understood and accepted by leaders and boards at all levels of the system (and more importantly, that the allocation of such responsibilities fits appropriately within the structure of the system). The larger the organization becomes the more unwieldy it can be, and thus a streamlined leadership and governance structure with very clear delineation of roles is essential for highest efficiency.

A strong **board culture** is the foundation upon which boards can begin to build nimble and responsive organizations. A large majority of respondents should be able to indicate strong agreement with all aspects of board culture included in this survey. When that is the case, those boards will succeed in transforming their organizations to the value-based business model, and actually change the curve in healthcare spending against outcomes.

As a nation, we are still struggling to come to terms with the fact that our healthcare system underperforms and still costs much more than other countries. This issue exacerbates the increasing divide between the poor, the wealthy, and the struggling middle class as wages remain stagnant and families are scraping by as healthcare costs continue to increase. Hospital and health system boards are at the top of the care provider leadership hierarchy, and therefore positioned to lead the charge in turning the industry around. Over the past several years, research and pilot programs have revealed areas of opportunity to increase high-value care and access and eliminate low-value care and waste. We argue that all types of organizations, big and small, independent or part of a system, urban or rural, have options and opportunities to transform. As fee-for-service gives way to payment for outcomes, there may be a sense of urgency to compete and capture market share, but we believe there is equal need for working together and sharing best practices. We know what needs to be done. **Now is the time to act.**