BoardRoom Press

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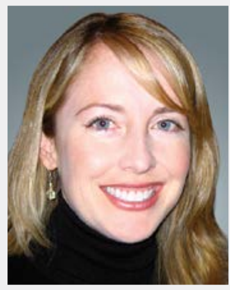
The Leadership Troika: Defining Roles in Creating and Sustaining Change

Improve the Patient Experience—Ask a Nurse to Join the Board

ADVISORS' CORNER

Designing an Effective Committee Structure within Healthcare Systems

Getting beyond the Low-Hanging Fruit



At a recent conference, Dr. Don Berwick called for healthcare providers to unite and prioritize shared values in order to move toward a model based on cooperation and prevention. "We have to make an empty bed more valuable than a full one," he said. "We need a new way to think all together. And I call it Era Three. It has to have a values framework; there is no technical route that doesn't go through reconsidering our values."

How do we get to "Era Three"? We need to get beyond the "low-hanging fruit" and dig deeper foundations into true and permanent changes in care delivery. It won't be easy.

This year, The Governance Institute spent time with the incredible team at Carilion Clinic in Roanoke, VA for an in-depth case study on their transformation to a physician-led clinic model. Melina Perdue, Executive Vice President, described a potential future state at Carilion. "We are creating a partnership with our patients, which will then reduce, at some point in time, the number of inpatient beds we need. It will increase the needs for ambulatory services—home care, hospice, more access to things that don't involve the hospital. There's a lot we're doing now that we don't get paid for, but it's the right thing to do for the patient. But we have to be sustainable. I think it's hard to turn that boat when the payment structure doesn't change."

As healthcare leaders, we must find a way to fund these critical care delivery transformations, even if payers aren't there yet. It will involve a degree of faith and trust that the payers will catch up soon and fast—and more work engaging payers in the value of such efforts. When Berwick was at CMS, he requested a cover sheet for projects that answered the most essential questions—that providers and payers alike can align behind: Will this help people, improve care and health? Will it help the poor? Will this reduce costs?

We hope this issue of *BoardRoom Press,* and our ongoing work to develop independent, educational resources focused on high-performing governance, will help board members, executive leaders, and physicians develop strategic initiatives to get beyond the low-hanging fruit.

Kathryn C. Peisert, *Managing Editor*

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UCHealth Hospitals Use IT Strategically

BY KEVIN UNGER, PH.D., FACHE, POUDRE VALLEY HOSPITAL AND MEDICAL CENTER OF THE ROCKIES

As a healthcare leader, one of my greatest challenges is determining the best way to leverage emerging technologies to advance my organization's mission while balancing other priorities, such as preparing for value-based care and adopting new governance structures.

Key Board Takeaways

Healthcare boards should consider the following advice as they implement IT projects to meet their organization's strategic objectives:

- Involve key clinical and operational leaders early on in IT initiatives.
- Engage physicians to vet the data and lend credibility to the project.
- Develop an effective communication plan to alleviate the change fatigue that can accompany IT rollouts.
- Use scorecards to track performance and prioritize initiatives across the organization.

Since 2005, I have served as President and CEO of Poudre Valley Hospital, one of only 10 hospitals in the country to earn Magnet® designation four times. The hospital, based in Fort Collins, Colorado, has more than 2,000 healthcare professionals who provide primary and specialty care. With the formation of UCHealth in 2013, I also became President and CEO of Medical Center of the Rockies, a 166-bed Magnet®-designated hospital in Loveland, Colorado, that offers a range of services, including heart and trauma care.

Kevin Unger, Ph.D., FACHE
President and CEO,
Poudre Valley Hospital and Medical Center of the Rockies

One of our new health system's first initiatives was getting our five hospitals and more than 200 physician offices on a common electronic health record (EHR). With that project completed, our intent is to use our EHR as a platform for more advanced population health management.

Currently, we are exploring methods to utilize our existing enterprise data warehouse for analytics and risk stratification of patient populations. When needed, we augment our in-house technology solutions with third-party tools to get the most value from clinical data throughout the system.

In addition, we are leveraging our patient portal, called My Health Connection, to improve communication with patients, and we are piloting virtual visits. Patients with low-acuity complaints have the option to choose a virtual visit through the portal, select their payment option, and then connect to an emergency medicine physician. By offering this service, we will provide a more convenient access point for patients, especially those who may be located in remote areas of Northern Colorado.

Staying Focused on Quality

Before UCHealth formed, Medical Center of the Rockies and Poudre Valley Hospital were part of Poudre Valley Health System, which was awarded the Malcolm Baldrige National Quality Award in 2008.

Today, our growing IT infrastructure is central to our ongoing efforts to improve our quality outcomes. For example, our medical and quality leaders are developing protocols that utilize clinical educators to reach at-risk populations, such as those with diabetes. In addition, leaders at UCHealth directed a systemwide antisepsis initiative, which reduced overall mortality. Thanks to technology, we can use simulations to train frontline staff to identify risk factors for sepsis in patients. We also are using analytics to reduce hospital-acquired conditions, including urinary tract infections and central line-associated bloodstream infections, throughout the system.

Strong board leadership has been essential to our quality efforts. Over the past few years, we changed our governance structure from local governing boards to a more centralized structure. Today, local advisory boards for each facility report up to the UCHealth board, although they still provide insight into strategy, capital planning, and major purchases.

The UCHealth board maintains a clinical services and quality committee. In addition, the local advisory boards have quality committees that monitor quality scores and sentinel events on a monthly basis. We also utilize physician quality committees throughout the organization to track key metrics.

Having this extensive committee infrastructure has helped us maintain our high standards for quality since winning the Baldridge Award. In fact, we continually achieve the top 10th percentile for patient outcomes, and we credit our IT efforts and our governance for part of that success.

Vetting New Technology

Like other healthcare organizations, our health system continues to make significant investments in IT. We added IT program managers who are focused specifically on population health management and ambulatory EHRs. They also develop patient registries to help us keep track of at-risk patients in outpatient settings. We hired more analysts and developers to support enhancements of our patient portal as well.

To make sure we are making technology investments that align to our overall strategic goals, our senior executives are involved in IT governance at every level. The IT goals that we set cascade from the overall organizational strategic plan, and we

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Healthcare Facility and Service Decisions in a Self-Serve Environment

BY KENNETH KAUFMAN, KAUFMAN, HALL & ASSOCIATES, LLC

Healthcare's changing business model is taking its toll on hospitals and health systems nationwide. The way patients traditionally have accessed healthcare—chiefly through physician offices, urgent care, and emergency rooms—is giving way to mobile telehealth, retail clinics, and other non-traditional access points.

For many consumers, these non-acute offerings eliminate the inconvenience associated with waiting for and traveling to appointments at distant offices and facilities.

Loss of low-intensity services is a real risk for legacy providers, as new models begin to disrupt lucrative hospital services, such as diagnostic testing. For example, through small facilities that are open Monday through Saturday at a minimum from 7 a.m.–7 p.m., Smart Choice MRI is impinging on hospital imaging business in Wisconsin and the Chicago-land area.[1] The firm offers the consumer a no-wait appointment for an MRI scan, the results of which are available to the consumer in less than an hour and at a cost of no more than $600. Scans are read by subspecialty board-certified radiologists at the Cleveland Clinic.

Seventy to 80 percent of patients are self-referrals. These are people whose physicians ordered an MRI and who actively pursued a non-traditional facility. They are shopping for the test, working around the typical gatekeeper model that is the basis of hospital traffic.

In this challenging environment, senior executives and directors of U.S. hospitals and systems should use two lenses to make their facility and service decisions.

1. Consumer Needs and Expectations

A much deeper level of understanding of the consumer is required of healthcare leaders for effective decision making with facilities and services going forward. To serve activated consumers, providers must understand consumer preferences and needs—particularly unmet needs in the increasing set of "shoppable" services. Fulfilling those needs and expectations will drive provider and venue choices, and influence customer loyalty under all payment arrangements.[2]

Organizations that excel will likely be well-capitalized health systems that offer access to health maintenance and healthcare services across the entire continuum.[3] Their providers will be accessible at a variety of convenient locations, with extended hours, and online through email and video chats. Price and quality information will be readily available.

The online and in-person experience for the consumer will be like that of the most innovative retailers. Communication between consumers and providers will be continual and multichannel rather than episodic and limited to in-person visits and occasional phone calls, and services will be organized and easy to navigate. The entire enterprise will be highly integrated through two items: information technology that allows seamless coordination of care from any entry point and a deep understanding of services that consumers need and want informed by a wide array of data analytics.

Many healthcare providers likely need to develop virtual offerings. At its most basic, online and mobile interaction can be used to schedule appointments, send/receive reminders, communicate test results, and exchange messages with providers. However, virtual care has a large potential to complement or replace traditional in-person healthcare services. Some providers will opt to partner with others for the provision of virtual services, and some will want to develop their own.

Key Board Takeaways

Hospital and system leadership teams nationwide need to move rapidly to make strategic decisions related to the services offered by their organizations and the locations in which each service will be provided. Inpatient facilities will need to be reconfigured, outpatient care likely will involve retail clinics as well as other new models, and virtual care options will be expected by increasingly activated consumers. These decisions are unfamiliar and extremely complex, and they carry millions of dollars in risk. Two lenses will help leaders make high-quality facility and service decisions:

- Consumer needs and expectations: by understanding new and changing customer expectations, organizations can identify and appropriately meet unmet needs.
- Risks and rewards: through use of an integrated plan, leaders can prioritize clinical, infrastructure, and technological initiatives required for their reconfigured delivery system, thereby balancing risks and returns.

Making facility and service decisions carefully and correctly is the new strategic imperative for a successful provider organization.

On the bricks-and-mortar front, community-based healthcare sites could be limited in size and offer a single service, such as urgent care or physical therapy. For example, SCL Health and Dignity Health have opened "microhospitals" that offer comprehensive emergency services, but typically have fewer than a dozen beds.[4] Community sites could also be larger, offering multiple services such as specialty care, surgery, and diagnostics at various degrees of comprehensiveness.

Healthcare boards and executives will need to find ways to translate the strong relationships their organizations currently have with patients into new levels of service for today's demanding consumers.

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1 Kenneth Kaufman, "A Clear and Present Disruption," Kaufman Hall Blog from the Chair, May 16, 2016.

2 David Crosswhite and Paul Crnkovich, "Understanding the Consumer Patient," Kaufman Hall ebriefing, April 2016.

3 Kenneth Kaufman, *Fast and Furious: Observations on Healthcare's Transformation,* Kaufman, Hall & Associates, LLC, 2015.

4 Michelle Andrews, "Sometimes Tiny Is Just the Right Size: 'Microhospitals' Filling Some ER Needs," *Kaiser Health News,* July 19, 2016.

The Leadership Troika: Defining Roles in Creating and Sustaining Change: The Board, Executive Staff, and Management

BY ROGER A. GERARD, PH.D., SLOAN & GERARD CONSULTING, AND DAVID A. SHORE, PH.D., HARVARD UNIVERSITY, TIANJIN UNIVERSITY OF FINANCE AND ECONOMICS (CHINA), AND UNIVERSITY OF MONTERREY (MEXICO), BUSINESS SCHOOL

The strategic planning process is about identifying, executing, and sustaining changes in the organization that make it more purposeful and effective in accomplishing its mission and vision.

Key Board Takeaways

As the board works with the executive team and management to create and sustain change in the organization, it should consider the following:

- Differentiating the roles and responsibilities of the board, executives, and managers is critical in properly aligning the work of the organization, and attending to performance management.
- In many organizations, despite efforts to clarify roles and responsibilities, confusion still occurs.
- Having clarity of role and purpose will set the stage for rich dialogue, and increase the probabilities that leaders will move forward effectively together.
- Not everything can be nailed down into clear, unambiguous roles and assignments. Take your best effort and work with it, knowing that there will never be a perfect order.
- Training and abundant conversation about expectations, responsibilities, authorities, and accountabilities will be required.
- It will be necessary to nourish the cultural values of respect and teamwork among the various layers of leadership to ensure alignment of purpose, roles, and responsibilities. Role alignment and clarity requires trust and a culture of performance excellence.

In previous articles, we focused on the planning process itself, and on the dynamics experienced by healthcare leadership as the organization makes necessary changes.[1] While most before us have treated this as delineation between board members and executives, this article specifically emphasizes the differing roles played by the board and its members, the executive team, and *management* as strategy creates reality.

Why Differentiating Roles Is Important (Stratifying Leaders for Optimal Performance)

Much has been written about organizational change in healthcare, the board and executive roles in strategic deployment and change, and management responsibility for success in the deployment process. Usually, the work spotlights one layer of management (board, executives, or managers) including specific focus on roles and responsibilities of that individual layer of management, without delineating the differences in responsibility from one layer to another. Often, managers are left out of the picture entirely, despite the fact that they are in the middle of where the "real" daily work of the organization is done. Sometimes, conflicting opinions are expressed. According to Ellis Carter, "One of the fastest ways to destroy a non-profit is for board members and staff members to start confusing their roles and stepping on one another's toes."[2] On the other hand, Stephanie Myrie writes, "Sometimes the lines are blurry, requiring flexibility and dialogue."[3] Further, there are circumstances when it is not only important but necessary for boards to get involved with management in management concerns.[4] Certainly, such diverse opinions can cause confusion among board members and executives trying to understand what is expected of them.

Leadership takes many forms, and in strategy deployment, each layer of leadership has specific and somewhat different duties and responsibilities. Much "lip service" has been given to clear role delineation between board members and layers of management, but in practice, board members still impinge on executive and management work, executives still work to manipulate board decisions and actions, and managers attempt to navigate the turbulence that results. While roles may overlap at times and in certain circumstances, understanding the differences in each role offers a platform for achievement otherwise unavailable. Clarity and focus of responsibilities, authorities, and accountabilities offer benefits that foster alignment of intention and purpose, reduction of confusion and collisions in agenda, and minimization of misunderstandings about who is doing what when. Examples include board members misusing their board status to dictate operational decisions and actions, executives undertaking substantial initiatives that have not been strategically vetted by the board, managers focusing on parochial responsibilities at the expense of larger system priorities, and the list goes on.

The Purpose of Each Role (The Leadership Troika)

Organizational purpose is generally organized around several clear categories: governance, strategy and innovation, policy, fiduciary responsibility, quality, communications, resource management, and performance management. For each, there are three differing roles to play, which, together, form a leadership troika as follows:

- **The board/board member role**: Typically, the board is responsible for the overall mission, vision, values, strategy, fiscal and fiduciary oversight, boundary setting, and hiring and evaluation of the CEO. Each board member contributes their experience, wisdom, and

1 See Roger Gerard and David Shore, "Aligning Strategic Planning with Cultural Change Imperatives," Governance Notes, The Governance Institute, June 2015; and Roger Gerard and David Shore, "Leading Operational Change at the Board Level: Navigating the First Mile," *BoardRoom Press,* The Governance Institute, February 2016.

2 Ellis Carter, "Board Member vs. Executive Director Roles," Charity Lawyer Blog, September 16, 2015.

3 Stephanie Myrie, "Effective Board Chair–Executive Director Relationships: Not About Roles!," *Nonprofit Quarterly,* December 21, 2006.

4 Michael Peregrine, "Respecting the Line Between Governance and Management," E-Briefings, The Governance Institute, May 2009.

perspectives to the formation and direction-setting process, and weighs in on critical strategic decisions affecting the future of the organization. Board members, as leaders responsible for oversight, typically work to improve the organization, via strategy, and the performance planning and data available to communicate what needs to change. *As leaders, their primary focus is to bring about change.*

- **The executive role**: Executives are responsible for system/organizational execution of strategy, prioritization and allocation of resources, and the aspirational leadership of management and staff. As leaders, they execute strategy via tactics that guide overall operational priorities and initiatives. They work freely within the boundaries set by the board, and are accountable for overall organizational performance, in terms of clinical/technical quality, managerial competence and performance, employee engagement, and financial performance. *As leaders, they, like board members, are primarily focused on bringing about change.*
- **The manager role**: Managers typically are charged with the tactical/operational execution of organizational strategy, stewardship of resources, hiring and management of daily work by staff, and performance management of those staff. Unlike board members and executives, inherently, *managers exist to stabilize the organization*, via the use of policy, resources, training, and daily management. Managers as leaders are responsible for ensuring action at the staff level to make things happen, deliver services, and ensure the customer/patient is well cared for within the strategic intentions of the board.

To the extent that these differing roles are organized to work together, with common intention and purpose, the organizational payoff will be an effective execution of overall strategy and direction. However, to the extent that roles are unclear, ambiguous, and structurally in collision, the organization's performance will suffer in significant ways. It is imperative that steps are taken to clarify who is responsible for what, and to ensure that differing layers of leadership do not "muddy the waters" by interfering with other layers. Each layer has its job, and must be left free to do that job. (See **Exhibit 1**, which shows one organization's effort to clarify roles and responsibilities, so that all involved know their job. The actual document contains a more complete list of responsibilities, with more detailed delineation of roles for each, but this example shows the general framework for the conversations that took place among stakeholders. All board members and executives were involved in the crafting of the final documents, in a facilitated group dialogic process led by one of the authors.)

To the extent that the differing roles of the board, executives, and managers are organized to work together, with common intention and purpose, the organizational payoff will be an effective execution of overall strategy and direction. However, to the extent that roles are unclear, ambiguous, and structurally in collision, the organization's performance will suffer in significant ways.

How These Roles Work Together (Getting the Job Done)

As roles differentiate, it is critical that board and executive leadership carefully consider how these roles should work together to create effective overall governance. A smoothly

Exhibit 1: Board, Executive, and Manager Roles and Responsibilities*

	Board	Joint (Board/Executive)	Executive Staff	Management
Governance	• Board/committee structure/oversight • Ensure board development and succession planning for officers, members, and CEO	• Effective integration of board and management structures • Compliance with all bylaws requirements	• Management structure • Executive succession planning • Cross-functional integration and management	• Take action on decisions made at board and executive structural levels
Strategy and Innovation	• Establish and approve mission, vision, values, and goals • Strategy approval/oversight • Foster strategic innovation	• Participate in strategy planning process, including robust competitive analysis • Foster a climate for innovation	• Participate in strategic planning • Execute MVV (mission, vision, and values) strategy • Research new, innovative opportunities	• Manage strategic and tactical activities in business units • Collect data/progress reporting
Fiduciary Responsibilities	• Ensure board decisions are in the best interests of the community • Ensure budget approval and capital allocations process • All duties required in bylaws	• Overall financial vitality • Effective use of resources • Development and execution of compliance initiatives	• Ensure executive decisions are in the best interests of the organization • Budget development/audit • Corporate compliance • Investment/financial planning	• Effective cost management
Organizational Performance	• Hire and appraise/evaluate the CEO • Support the executive team • Oversight re: staff engagement	• Balanced scorecard (KPIs) at system level • Initiate and execute processes to ensure application of roles and responsibilities guidelines	• Establish business performance KPIs at entity and unit levels • Conduct regular performance audits and appraisals	• Manage daily work focused on KPIs/business results (quality, financial, engagement, and customer care)

*Adapted with permission from work done by Marshfield Clinic Health System, 2015.

operating organization is never an accident. It is the result of many conversations among stakeholders throughout the organization about "what matters most." When those conversations occur, the results create the framework for decision making and effective, efficient performance. This means having conversations and making decisions about:

- Attention to cascading authority and responsibility with clear assignment
- Creation and maintenance of a framework for performance monitoring and management
- Establishing a capacity for each level to assist other levels in accomplishing intentions, especially when the changing environment requires strategic and tactical change
- Building a developmental framework for cultivating competencies and skills over time
- Nourishing a culture of relational clarity, confidence, and predictability

These are not small conversations, and can sometimes be tedious, surfacing collisions in philosophy and individual intention/goals that are disruptive and unsettling. Often, such conversations require the help of trained facilitators who can keep conversations focused on what matters most, and ensure all voices are heard with respect and professional discipline. But the conversations are necessary if people are going to move forward together with common intention, and a common understanding of how things must work so that everyone stays in alignment.

A smoothly operating organization is never an accident. It is the result of many conversations among stakeholders throughout the organization about "what matters most." When those conversations occur, the results create the framework for decision making and effective, efficient performance.

Problems Can Occur Requiring the Disciplines of Reflection and Change

In many organizations, despite efforts to clarify roles and responsibilities, confusion still occurs; people collide in their efforts to move forward, and difficulties result that have an adverse impact on overall performance. Some of the issues include the following:

- Board members, especially those who have an appointment to the board in addition to their staff responsibilities (such as physicians in healthcare organizations), sometimes feel that they can enter the day-to-day work of the organization and affect that work by issuing advice or even directives with staff. This is disruptive behavior, and can even be abusive in the misapplication of authority, undermining the manager of the area they have entered. A board member should never feel free to assign staff to favored projects, or to interfere with the management of daily work. (For example, in one organization, a physician board member felt compelled to use his board "authority" to prevent the rightful discipline of his staff nurse by her manager, because "she was a good nurse," without truly understanding the actions that led to her need for discipline in the first place.)
- Executives, often with good intention, sometimes speak for board members, and misconstrue intentions for the sake of personal agendas or expediencies. (For example, an executive used the board strategy of financial improvement to suggest that necessary quality initiatives be curtailed in the face of needed cost improvements. These should never be traded off.)
- We often expect managers to be both leaders (changing things) and managers (stabilizing things). (For example, "We need to reduce costs, and therefore staffing, but do it without compromising quality or increasing overtime, regardless of patient load! And do it within the next two weeks!") This is schizophrenic at best and counter-productive and destructive at worst. Leaders change things, but managers stabilize things. The manager, by role, is "in the middle," dealing daily with the transition process described by Kurt Lewin in his three phases of change (unfreeze, *transition*, refreeze).[5]
- Leaders at all levels, in the name of politics or other urgencies, often fail to call out inappropriate behaviors of board members, executives, and/or managers. Such avoidance merely serves to teach people the wrong things about what is appropriate and what is not, and exacerbates the problems as things move forward. It is necessary that people have the courage to deal directly with the issues of governance and leadership. Failure to do so just makes things worse. Have the crucial conversation.

So, What Is the Solution to All of This?

Creating an effective decisional governance structure and process is time-consuming work that is mostly conversational and involves many stakeholders in the organization, at all levels. However, it is work that must be done if people are to be able

5 See Kurt Lewin, "Frontiers of Group Dynamics," *Human Relations,* Volume 1, 1947, pp. 5–41.

to work effectively together. Some advice below will get you started on the process:

- First, and most importantly, roles and responsibilities of each layer of leadership must be made clear, with defined boundaries. Doing so will result in clarified expectations, more certainty, and more predictability of leader behavior over time.
- People must recognize that, beyond certain limits, there must be some flexibility; not everything can be nailed down into clear, unambiguous roles and assignments. Take your best effort and work with it, knowing that there will never be a perfect order. The key is building strong relationships so that trust can evolve, and people can help one another without the need for power struggles and other concerns.
- Training and abundant conversation about expectations, responsibilities, authorities, and accountabilities will be required. This includes training current and new board members, executives, managers, and even some critical staff, so that everyone is on the same page, with the same understandings, and using the same language to describe how things work.
- Clear governance documents must be created that spell out processes for mediation of role conflict and collision. Collisions will occur and such documents help the conversation along, providing a frame of reference for people to use in building and rebuilding relationships over time. When the documents are found to be defective in some way, they are not cast in concrete, but can be changed as needed by further conversation among board members, executives, and managers. It is in dealing with exactly these kinds of issues that long-term trust is built among the different layers of leadership.
- Finally, it will be necessary to nourish the cultural values of respect and teamwork among the various layers of leadership to ensure alignment of purpose, roles, and responsibilities. If a history of misbehavior, misalignment of purpose, or role confusion has created distrust and cynicism (which it often does), time for conversation about that will be needed and should be facilitated by an experienced process facilitator.

Summary

Differentiating the roles and responsibilities of the board, executives, and managers is critical in properly aligning the work of the organization, and attending to performance management. Doing so creates clarity, creates predictability, and fosters a better understanding of how things must be done by diverse layers of management. Doing so recognizes that roles are necessarily different, but with some overlap. Moreover, it establishes a framework for trust, respect, and effective teamwork among leaders. Problems and collisions will still occur, and robust dialogue will be necessary to ensure successful resolution. However, having clarity of role and purpose will set the stage for that dialogue, and increase the probabilities that leaders will move forward effectively together.

The Governance Institute thanks Roger A. Gerard, Ph.D., Executive Coach and Management Consultant and Owner of Sloan & Gerard Consulting, and David A. Shore, Ph.D., former Associate Dean of the Harvard University School of Public Health, current faculty of Harvard University, Distinguished Professor of Innovation and Change at Tianjin University of Finance and Economics (China), and Adjunct Professor of Organizational Development and Change at the University of Monterrey (Mexico), for contributing this article. They can be reached at rgerard@athenet.net and dshore@fas.harvard.edu.

Improve the Patient Experience—Ask a Nurse to Join the Board

By Laurie Benson, Nurses on Boards Coalition, and Susan Hassmiller, RN, Ph.D., FAAN, Robert Wood Johnson Foundation

The Beryl Institute defines the patient experience as the sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care. By this definition, the nursing profession is uniquely positioned to provide healthcare leaders with deep insight, data, evidence, and understanding of the multifaceted determinants of the resulting patient experience.

By necessity, all healthcare leaders are considering new approaches to improve the patient experience, as it directly impacts quality of care and outcomes. Healthcare leaders have the privilege and responsibility to apply their best thinking, resources, and evidence to improve patients' experiences and outcomes by providing exceptional healthcare, a caring and compassionate experience, and the ability to successfully transition from the hospital into the community.

This article looks at the benefits of inviting nurses into the boardroom and the positive impact this will have on the organization's patient experience efforts.

Inviting Nurse Leaders to the Boardroom

There are pragmatic and altruistic reasons for inviting nurse leaders to the boardroom to garner the best possible outcomes in a proactive, innovative, consistent, and sustainable way. Given that nurses represent the greatest number of healthcare professionals, they should participate in the discussions where strategy and policy decisions are made that impact the patient experience.

From our own experience serving on boards, we know the impact of the nursing perspective in the boardroom. Nurses are adept and immersed in working in teams, seeing a path forward amidst complexity, and creating and implementing plans to achieve the best patient outcomes and to improve the patient experience. They are able to consider the implications of decisions on staff, patients and their families, the hospital, and the community.

According to The Governance Institute, successful board members have various skills and knowledge. They understand the organization's services and the needs of the community, possess a high level of integrity, are good listeners and collaborative and communicative leaders, build and maintain good relationships, ask questions, and are sensitive to cultural differences, among many other attributes. The best nurse leaders possess these competencies and use them daily.

One of the key characteristics of high-performing boards is diversity of people and ideas. Along with other healthcare professionals and board members, the dialogue becomes enhanced with the nursing profession's valuable perspective. But unfortunately, nurses fill less than 3 percent of healthcare board seats.[1] By bringing their vast experience, insight, and perspectives to the table, hospitals and health systems can add a diverse and patient-centered perspective.

Let us be clear: we believe inviting more nurse leaders to the boardroom will improve the board's effectiveness and efficiency in addressing the compelling business case to improve the patient experience in an integrated, systematic way throughout the organization. Our goal is not to benefit the nursing profession.

In the June issue of *Boardroom Press,* Michael R. Bleich, Ph.D., RN, FAAN, of NursDynamics wrote, "Nurses are critical to the success of any hospital or health system. To enhance governance dialogue around nursing, boards need to have a basic understanding of their education and roles."[2]

Having more nurse leaders serving on the board brings the relevant linkage to the education, skills, abilities, and roles of nurses practicing in the organization into discussions on an ongoing basis. This is especially important when considering the implications of board decisions related to the patient experience. The nurse leader is an expert at providing examples that increase board member understanding of the patient experience, often resulting in different discussions, actions, and outcomes. As the profession most trusted by the public, nurses bring credibility and evidence-based practice that contribute to robust discussions to make dramatic changes in outcomes and quality of care.

1 Lawrence D. Prybil, "Engaging Nurses in Governing Hospitals and Health Systems," *Journal of Nursing Care Quality*, 2009.

2 Michael Bleich, "What Healthcare Boards Need to Know About Nursing," *BoardRoom Press*, The Governance Institute, June 2016.

Key Board Takeaways

The patient experience directly impacts quality of care and patient outcomes, affecting the hospital's bottom line. Nurse leaders are uniquely positioned to offer strategic and policy advice to ensure an optimal patient experience. Nurses serving on boards are prepared to:

- Consider the implications of decisions on staff, patients and their families, the hospital, and the community.
- Leverage their experiences caring for patients to improve measures of patient experience and quality of care.

Healthcare executives should invite nurse leaders into increasingly strategic roles, including the boardroom, to improve the patient experience and the organization's bottom line.

How Might Nurse Leaders Impact the Patient Experience in the Boardroom?

With the HCAHPS scores now influencing Medicare reimbursement, healthcare leaders should note that nursing is directly involved with, and in some cases, drives activity in:

- Communication with nurses
- Responsiveness of hospital staff
- Pain management
- Communication about medicines
- Discharge information
- Care transition
- Cleanliness and quietness of hospital environment

Nurses have specific knowledge, training, experience, and direct influence in terms of the patient outcomes in each of these areas.

"Optimal patient experience cannot be reduced to checking off boxes. Patients and families have a right to expect that they will be treated with respect, that they will share responsibility for decisions about their care, that care will be safe and efficient, and that transitions in care will be well coordinated," says Katharyn May, Ph.D., RN, FAAN, Professor and former Dean of the University of Wisconsin-Madison, School of Nursing, former member of the University of Wisconsin Hospital Authority Board, and immediate

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UCHealth Hospitals Use IT Strategically

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try to use innovative solutions to achieve our objectives.

Preparing for New Payment Models

At UCHealth, physician leaders are essential to our IT initiatives. We rely on physicians to define and validate the data. Physicians also help identify the most relevant quality metrics to pursue for our value-based contracts.

Recently, our physicians have been exploring bundled payments for hip and knee replacements, although our hospitals have not been formally involved yet. However, we are using this as an opportunity to test our processes as if we were partners in bundled payments for orthopedic procedures. We expect our next foray will be piloting bundled payments for cardiac procedures.

Leading Change

Change management has been one of our greatest challenges related to these IT initiatives. Although change fatigue was a real issue during our first year as UCHealth, we eventually hit our rhythm. We credit constant, effective communication with helping our staff stay focused on what was important during this time.

We have been able to engage key leaders as change agents throughout the organization, which has helped us maintain our momentum during IT projects. Although it is important to be inclusive during decision making, leaders need to keep moving projects forward. Finding that balance between inclusiveness and efficiency is a significant challenge.

Another challenge is identifying best practices. UCHealth has been using analytics to determine where we excel and where our opportunities for improvement lie. We developed a systemwide balanced scorecard to monitor our performance on key metrics across facilities and at the departmental level. Until we had that scorecard, it was difficult to identify which areas had best practices that could be shared with others.

A common barrier to IT investments is that they can be expensive, but through our consolidation efforts and the cost savings based on economies of scale, we have managed to reduce or avoid any IT costs that each individual entity would have seen in the amount of $86 million in the first four years of UCHealth. While it is too early in the process to know for sure, we also anticipate lower costs of care as we enter into more telehealth and population health arrangements.

By leveraging IT strategically, we believe we can engage our physicians and staff in helping us continuously improve quality, prepare for new payment models, and better meet the needs of patients as well as payers.

The Governance Institute thanks Kevin Unger, Ph.D., FACHE, President and CEO of Poudre Valley Hospital and Medical Center of the Rockies, for contributing this article. He can be reached at kevin.unger@uchealth.org.

Healthcare Facility and Service Decisions…

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2. Risks and Rewards

Leadership teams must make strategic calculations of the risks and rewards related to facility and service offerings soon—determining the best combination of single-service outpatient sites, multi-service outpatient sites, inpatient sites, and virtual services.

With their deep roots in acute care, hospitals face a steep challenge with identifying appropriate care delivery channels. At the same time, leadership teams need to calibrate all these channels in the midst of constantly changing purchaser expectations, technological capabilities, and competitive pressures.

For organizations that get the right offerings in the right locations with the right timing, the potential rewards are great. Providers may be able to dramatically reduce fixed costs associated with their physical assets, make more productive use of clinicians' time, provide a greater level of convenience and lower prices for consumers, and position themselves for success in an environment of value-based payment, capitation, and consumer choice.

In past decades, changes occurred more slowly and each facility or service decision was additive and influenced another decision only marginally. In contrast, the nature and speed of current change in healthcare brings multiple new inputs, constraints, and interconnections.[5] Unfamiliar and extremely complex, these decisions now carry millions of dollars in risk.

Use of a planning process and an integrated strategic financial plan is a must, as is close oversight of the analyses and plan by the board.[6] This plan should provide rigorous and objective assessment of the organization's current situation and establish a future path that enables the organization to maintain a solid financial position. Importantly, the plan articulates a strategic vision, quantifies opportunities, and prioritizes the clinical, infrastructure, and technological initiatives required for an ambulatory- and consumer-centric delivery system.

Through the consumer needs and risk/reward lenses, hospital and system leadership teams can best investigate and experiment with new delivery models and channels, and move quickly to implement the most promising opportunities for their facilities and service offerings. This phase of change in healthcare will take commitment to an analytic decision-making process and a lot of courage.

The Governance Institute thanks Kenneth Kaufman, Chair, Kaufman, Hall & Associates, LLC, for contributing this article. He can be reached at kkaufman@kaufmanhall.com.

5 Ryan Gish, Mark Grube, Mark Muller, and Emily Pirch, *Integrated Strategic Direction Setting and Planning,* Elements of Governance, The Governance Institute, 2015.

6 Patrick Allen and Mark Grube, "Three Leadership Imperatives for Success with Value-Based Care," *BoardRoom Press,* The Governance Institute, August 2016.

Improve the Patient Experience…
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past chair of the Patient Safety and Quality Council. "Of course, all care providers are important in this, but when the main product line is nursing care, nurses drive patient satisfaction."

Nurses, along with other members of the healthcare team, are inextricably linked to these measures of the patient experience and quality of care. Their firsthand knowledge of factors affecting clinical outcomes and patient perceptions can shed light on root causes to discover and explore opportunities for improvement.

"We know the push for quality is stronger than ever," said David Knowlton, who served as President and CEO of the New Jersey Health Care Quality Institute until his retirement in 2015. "Any hospital that wants to avoid the Medicare penalties or—just as harmful—the bad publicity that can follow low quality ratings needs a nurse on its board."[3]

3 David Knowlton, "Hospitals Must Recruit Nurses to Their Leadership Boards," *RWJF Human Capital Blog*, 2014.

The nurse can provide exceptional care and show compassion to significantly impact how patients' perceive their experience. In fact, how patients feel about their experience plays a key role in their willingness to return to the hospital or health system for care and refer others there.

Embracing the Role of Nurses in the Boardroom

What might be possible at your organization if you invited nursing professionals into increasingly strategic roles, including the boardroom? We encourage boards to discuss at an upcoming meeting how they might enable nurse leaders to join the board in strategic discussions to improve the patient experience.

The board most likely will need to approach nurse leaders in the organization to invite them to serve on the board, since many nurses will not self-promote. But you can be certain, once asked, that nurse leaders will deliver in the boardroom, just as they deliver for the patients and families they feel privileged to serve every day.

Everyone Benefits

An added benefit of inviting nurses to join the board is that word will spread fast throughout the organization. When a nurse leader makes valuable contributions on the board, that individual will typically credit the entire board for their role in bringing about the significant improvements in the patient experience. Nevertheless, nurses at all levels will feel valued and empowered, which translates into increased engagement in improvement activities and stronger commitment to the organization. Ultimately, your patients will benefit.

The Governance Institute thanks Laurie Benson, Executive Director, Nurses on Boards Coalition, and Susan Hassmiller, RN, Ph.D., FAAN, Senior Advisor for Nursing, and Director, Future of Nursing: Campaign for Action, Robert Wood Johnson Foundation, for contributing this article. They can be reached at laurie.benson@ana.org and shassmi@rwjf.org.

Designing an Effective Committee Structure…
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board—either as a whole or through a dedicated board committee—should be actively involved in developing a local iteration of system strategy, one that takes into account the challenges and opportunities of the affiliate's service area.

Governance (or nominating) committees are relevant to each board that exists within the system, absent the unusual circumstance of a system where the parent board appoints members of all affiliate boards. Coordination among chairs of these committees ensures that all are working off of a shared list of "desired competencies."

Community benefit/outreach is a function that primarily lives at the local level. This involves deep connectivity with local civic leadership and community agencies that address the health and well-being of the populace. Many affiliate boards embrace this function as a "committee of a whole." Others delegate the work to a specific committee. So long as the work is done with diligence, either structure can work. Status reports from this work often roll up to a corporate officer directly reporting to the CEO, and are reported to the system board in that manner. It is unusual to have a *system* board committee tasked with this function.

Philanthropic efforts need to be strong at the local level. In some systems, this is managed by a unitary "foundation" that has local committees. Other systems use a committee structure, with a system board committee focused on businesses and foundations that cross the entire service area, and affiliate board committees focused on local geographies.

While structural clarity is essential, with clear charters and unambiguous domains of authority, communication is even more important.

Periodic "all boards" retreats—often focused on education or strategy discussions—allow everyone involved in system governance to experience a sense of joint purpose. Periodic meetings of all board chairs heighten alignment and cross-fertilization. Annual meetings of like-committee chairs (all quality and safety committee chairs, etc.) also allow coordination, cross-fertilization, and the rapid spread of lessons learned.

Finally, we find that two governance practices can profoundly mitigate tensions about "who is in charge," and resentment on the part of affiliate boards ("Do we really have a purpose anymore?"). The first of these techniques is to ensure *input* into decision making, rather than unilateral dissemination of conclusions. The second has to do with establishing a rhythm of "query and response," where the system board routinely asks for input from affiliate boards, rather than simply passing on information, and the same thing happens from affiliate boards to system boards. This rhythm ensures that all involved feel that they are part of a collaborative governance ecosystem, fulfilling mission and driving performance.

The Governance Institute thanks Eric D. Lister, M.D., Managing Director, Ki Associates, and Governance Institute Advisor, for contributing this article. He can be reached at elister@kiassoc.com.

Designing an Effective Committee Structure within Healthcare Systems

BY ERIC D. LISTER, M.D., KI ASSOCIATES

Consolidation continues relentlessly in American healthcare. Health insurance providers have already reached what one might call mature aggregation, with a small number of dominant national players and a modest number of regional powerhouses.

Among institutions offering clinical services, many ambulatory practices are aligning with insurers, others with providers outside the hospital space (DaVita, for instance). Hospitals as well—both not-for-profit and for-profit—continue to aggregate. The pace of system formation often pushes together governance structures in ways that are confused and confusing. Within any given health system, different "deals" made at different times or different types of affiliation agreements can result in puzzling inconsistencies.

One reaction to this confusion involves total governance centralization, with all fiduciary responsibility moving to one system (or "parent") board, leaving, if anything, only "advisory bodies" within each constituent member of the system. The existence of this option is relatively recent, consequent to a JCAHO ruling allowing the elimination of local boards; previously, separate governance structures were required for each licensed hospital. In some ways, this change parallels the migration from "holding company" models, marked by high levels of autonomy for each component of a system, to "operating company" models, marked by increasingly centralized and standardized operations.

While the strategy of complete governance centralization achieves simplicity and eliminates confusion, it does so at a high cost. This cost can be measured in a diminution of local "ownership" in the psychological sense. When local hospitals begin to be seen as anonymous commodities within their own communities, erosion of loyalty and philanthropy can be predicted. Market share is jeopardized. Recruitment and retention can be impacted. Rarely can these costs be entirely mitigated by identification with an overarching system brand.

For all of these reasons, the vast majority of health systems have elected to maintain governance structures that include both system and local—or affiliate—boards. When this is the case, questions inevitably emerge about committee structures, and how local and system committees should best relate to each other. Our work with numerous successful systems provides some guidance.

Key Board Takeaways

Below is a checklist for system committee structures:

- Does each committee have a clear charter?
- Are lines of connectivity between system and affiliate committees clear?
- Is the authority and responsibility of each committee explicit?
- Is there a unified rhythm of governance work across the system?
- Do board chairs and like-committee chairs meet regularly?
- Do system boards routinely solicit input from affiliate boards?
- Do affiliate boards routinely query system boards to ensure alignment?

Committee Structure Guidelines

This article suggests guidelines for fully integrated systems, wherein the system is the sole corporate member of all affiliates. In these circumstances, the need for all work to be directed by and report up to the system is explicit. Committee structure needs to reflect this reality. Let us look at each committee in turn.

Executive committees can exist—but need not exist—at the system level, and also at the affiliate level. Our experience suggests that large boards often profit from the existence of an executive committee, but smaller boards work well without them. When executive committees do exist, care needs to be exercised to ensure that they do not eclipse the entire board—a common phenomenon and serious risk.

Investment functions invariably live at the system level only, within a board committee of the system board. Appropriately knowledgeable members of affiliate boards often serve on this system committee.

Compliance and audit functions clearly need one (or two) committee(s) at the system board level. (We recommend a unitary committee, but dividing these tasks can certainly work.) There is little to be gained by replicating these committees on affiliate boards; management does this work at the affiliate level, rolling up to the system board committee.

The **executive compensation** committee is only needed at the system board level, as compensation of affiliate executives is a prerogative of system management. Affiliate boards should provide input to system management relative to the performance of local executives, but there is no need for affiliate committees.

Finance is interesting. In mature systems, we recommend a strategy equivalent to that described above—one system committee overseeing management activity across the system. However, in young systems, with affiliate boards still accustomed to exercising oversight around financial matters, there is often a strong desire to retain a board finance committee. Some young systems even delegate formal prerogatives to affiliate boards in the finance arena—voting on budgets, for instance. Where affiliates maintain finance committees, their prerogatives need to be explicit, without the intimation of authority that is in fact reserved to the sole corporate member. Critically, however, the affiliate committee's attention needs to be directed toward budgetary oversight (or approval, where designated) *within the context of the system's financial and capitol allocation plans.*

Quality and safety is an essential committee for affiliate boards. Even here, however, synchrony with system efforts is crucial. We recommend that an overarching plan for system performance, complete with goals and timelines, be generated by a system committee with input from all affiliates, and then approved by the system board—just as is the case with the operating budget. Affiliate quality and safety committees are then empowered to track local performance, focus on cultural determinants of success, and add metrics relating to unique local programs.

Setting overarching **strategy** is the responsibility of the system board, guided by the work of system management; sometimes it is set by that board as a whole, and other times it is first refined by a board committee. At the affiliate level, system strategy will be rolled out through management, but the affiliate

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