Governance Notes

Welcome to The Governance Institute's Governance Notes!

This newsletter is designed specifically for governance support professionals with information and expert opinions in the area of hospital and health system governance and updates on services and events at The Governance Institute. We hope you find it beneficial in helping you keep your board performing at its best. We welcome article submissions related to the board support role, ideas for future topics, and feedback on how we can better support you in achieving optimal board performance. Please contact us at kwagner@GovernanceInstitute.com.

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Competency-Based Board Recruitment: How to Get the Right People on the Board

By Marian C. Jennings, M. Jennings Consulting

Recent Governance Institute research showed a positive correlation between a hospital's or health system's quality scores and the board's use of competency-based criteria when selecting new members.[1] Numerous studies and blue ribbon panels have come to the same conclusion: hospital and health system boards should use a competency-based approach, not only to recruit new board members but also to assess, educate, and develop existing members—ultimately creating a board with the right blend of knowledge and expertise, experience, personal attributes, and diversity for the hospital or health system of the future.[2,3,4] This article focuses on practical approaches to attract board members who demonstrate the competencies your hospital or health system needs most.

What We Can Learn from *The Imitation Game*

While writing this article, I happened to see the film *The Imitation Game,* which dramatized how British intelligence during the Second World War broke the German's Enigma machine-generated naval codes. One scene showed the top-secret British Government Code and Cypher School recruiting new talent. Did they seek out people exceptionally fluent in German? Did they recruit only the most proficient mathematicians or cryptographers from Oxford or MIT? No, instead they ran a newspaper ad with a complex crossword puzzle and asked anyone who could solve the puzzle in less than six minutes to contact them. Yes, they required expertise in mathematics and cryptography, but the real competency they sought was "complex problem solving."

Fiction? Maybe. But this anecdote offers a powerful analogy for how to construct a competency-based board. Often, when we hear the word "competencies," we think first of expertise, knowledge, and perhaps experience. But this is a limited—and deficient—definition. Instead, we should think of competencies as comprising three broad, essential, and equally important categories: knowledge and expertise (sometimes called "hard skills"), personal experience,

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1. Larry Stepnick, *Making a Difference in the Boardroom: Updated Research Findings on Best Practices to Promote Quality at Top Hospitals and Health Systems* (white paper), The Governance Institute, Fall 2014.
2. Barry S. Bader, "Competency-Based Succession Planning," *Great Boards*, November 18, 2010 (available at www.greatboards.org/newsletter/2010/Succession_Planning_for_Board_Members.pdf).
3. Don Seymour and Larry Stepnick, *Governing the 21st Century Health System: Creating the Right Structures, Policies, and Processes to Meet Current and Future Challenges and Opportunities* (white paper), The Governance Institute, Fall 2013.
4. The American Hospital Association's Center for Healthcare Governance, *Competency-Based Governance, A Foundation for Board and Organizational Effectiveness,* February 2009 (available at www.americangovernance.com/resources/reports/brp/2009/brp-2009.pdf).

and attributes (sometimes called "core competencies," behaviors, or required competencies).

Many hospitals/systems already have a wealth of bankers or other experts in accounting/finance on the board. But perhaps you need someone who has successfully navigated an organization during a period of rapid industry change, or someone who is experienced in helping collaborative relationships/partnerships succeed, or an individual with experience in reliability science who has driven quality in a non-healthcare environment, or someone who is an effective team leader able to build consensus around complex issues and decisions.

In practical terms, then, what should your board do to foster the competency-based governance your organization needs for the long term? Below are four steps for building the right board for your organization's future.

Step 1: Articulate Desired Future Board Member Competencies

The first step is to identify a set of competencies that will be critical for the future success of your hospital or health system. It is important to a) use your strategic plan as the context to identify needed competencies and b) recognize the future roles and responsibilities of your board. For example, if the strategic plan calls for your organization to transform itself into a clinically integrated network with a diverse array of businesses focused on improving population health, you will require board members with different competencies than those you would need to implement a plan centered on "becoming a top 100 hospital."

Exhibit 1 on the next page presents a sample listing of future competencies as a starting point for you to develop a customized competency list. It is recommended that you:

- Review this list with your CEO and the nominating or governance committee to generate any potential additions.
- Review and discuss your revised list with all board members at a regular meeting to identify any missing competencies. None should be eliminated at this point.
- Using a survey instrument, ask each board member individually to rate the importance of each of the competencies to the future success of your organization. Use a four-point scale ranging from "not at all important" to "extremely important," encouraging members not to rate all competencies as "extremely important."
- Based on the results of the survey, work with the nominating or governance committee to narrow the list of desired competencies to no more than 10–12 priorities for your organization.
- With the full board, review and finalize a "short list" of desired board member competencies, presented in rank order by category.

Step 2: Identify the "Competency Gap"

In this step, you will engage the board in a self-assessment of the competencies demonstrated by members of today's board. To do this, you would:

- Work with the nominating or governance committee to develop a member self-assessment survey and a peer review survey, organized around the board-approved competencies by category developed in Step 1.
- Have each board member complete a self-assessment of whether/how well he or she demonstrates each competency today. Additionally, ask each board member to answer the same questions about every other board member in a confidential peer review.
- Tabulate the survey to compute an average score that indicates how well today's board collectively demonstrates the competencies needed for future success.
- Compute the "competency gap" for each of the board-approved competencies by comparing the relative importance of each competency against board members' self-assessment scores.
- Finally, and importantly, perform the same "gap" assessment for each of the next three years—assuming individuals whose terms would expire in each year would not be reappointed. In other words, identify how the "competency gap" would change if individuals on today's board were to leave due either to a term limitation or by non-reappointment.

Step 3: Articulate 2020 Desired Competency-Based Board

Step 3 focuses on the nominating or governance committee developing its ideal competency-based board composition for 2020. Using a five-year horizon to intentionally fill in the competency gaps dovetails with the typical three-year terms of most boards and allows for an orderly recruitment and development process.

This step follows the board self-assessment in Step 2 to ensure that the 2020 model is based in reality. If large competency gaps exist between today's board and the desired competencies identified in Step 1, the gap may not be fully closed within five years.

Exhibit 1: Sample Governing Board Member Competencies and Qualifications

Recommendation: Your board would create its own "starting" list of future competencies, using this list as a starting point for setting priorities and honing the list down to a manageable number relevant to your needs.

Knowledge & Expertise ("hard skill")
▪ Healthcare industry knowledge ▪ Understanding of the entire delivery system ▪ Governance/management distinction awareness ▪ Business/financial knowledge ▪ Human resources/organizational development knowledge ▪ Change management/innovation and transformation expertise ▪ Knowledge of reliability science for improving quality and patient safety ▪ Knowledge of customer service process improvement ▪ Expertise in public policy or community health planning
Personal/Professional Experience
▪ Service on board of large organization ▪ Experience in managing complexity or governing in a complex organization ▪ Experience in successfully navigating an organization during a period of rapid change
Personal Attributes (behaviors, "core competencies")
▪ Integrity ▪ Analytical thinking ▪ Strategic thinking ▪ Collaborative leadership style ▪ Ability to promote teamwork and build consensus ▪ Good listening and communication skills ▪ Ability to influence others ▪ Appreciation for perspectives of all stakeholders ▪ Appreciation for benefits from diversity on the board ▪ Ability to hold self and others accountable for achieving goals ▪ Interest in continuous learning/curiosity

Adapted by M. Jennings Consulting from *Planning for Future Board Leadership*, Elements of Governance, The Governance Institute, 2011.

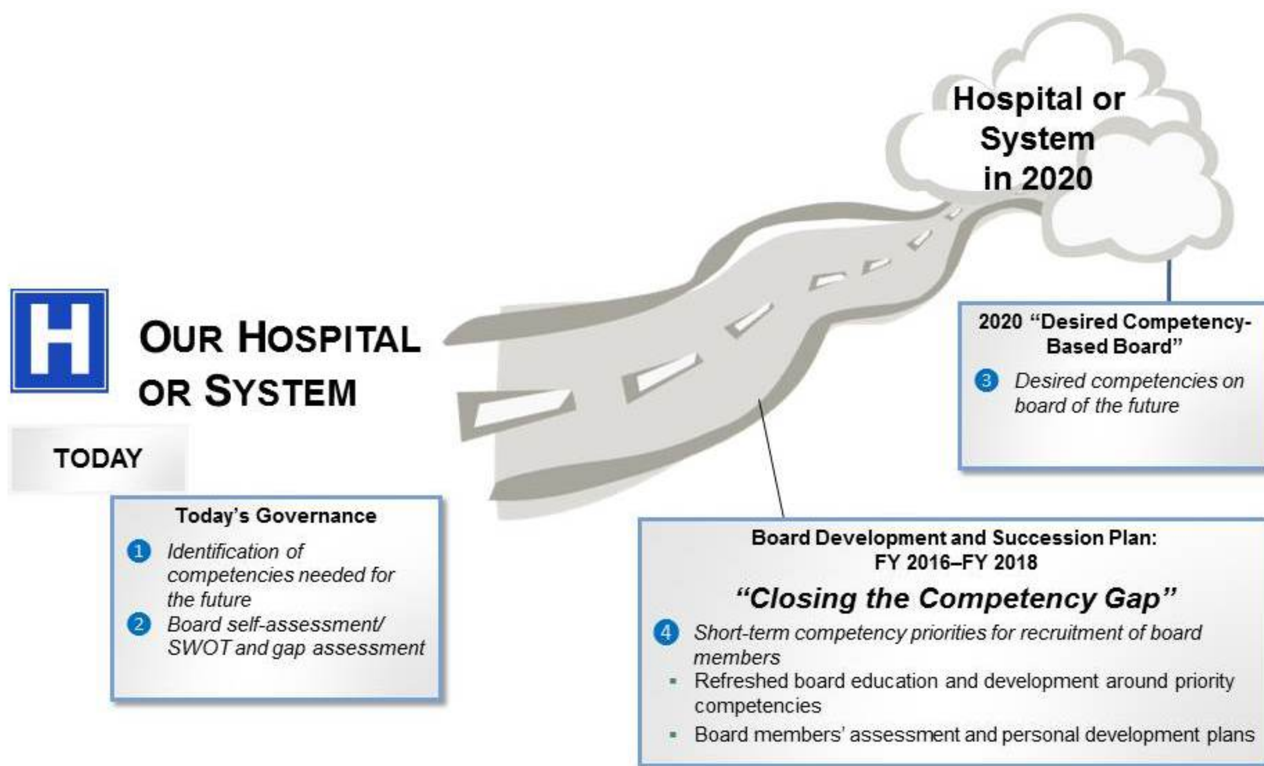
Step 4: Develop a Multi-Year Recruitment Plan

Recruitment is a key tool to close the competency gap, but as shown in **Exhibit 2** on the following page, it is not the only tool. A written board development plan, which includes formalized board education and development programs/processes, as well as personal development plans for each board member, also are critical elements to success.[5]

For recruitment to be successful in closing the competency gap, the organization must have the courage to carefully review each board member at the end of his or her term to determine whether and how that individual contributes to the desired mix of board competencies. This may require making difficult decisions about individuals who have been "good" board members but whose competencies either are duplicated by others on the board or are not those needed for the future. Unless you are able to take this courageous step, you may need five or more years even to begin to see your desired board mix of competencies emerge—and given the dynamic changes in the industry, waiting this long is not an option.

[5] For guidance on your board development plan, see Governance Development Plan, 2nd Edition (Elements of Governance), The Governance Institute, Winter 2011.

Exhibit 2: Developing an Action Plan to Build Competency-Based Governance



Below are steps to ensure that board recruitment facilitates a competency-based board:

- Identify and have the board agree upon the most important competencies to be augmented/added for each of the next three years. Each year, you may want to target three to five competencies for focused recruitment toward your end goals. This focus should be informed by the competency gap and take into account board retirements and members whose terms are expiring.
- Don't "assume" competency—especially in the experience and attributes domains. While education and training often are reliable indicators of knowledge and skills, you will need to incorporate new questions into your board interviewing process.
- Develop a competency-based interviewing process. This entails exploring with the individual his or her experience, behaviors, roles played, and outcomes impacted. It is important not to ask leading questions. For example, if you are looking for a consensus builder, you would *not* ask, "Do you see yourself as a consensus builder?" Instead, you might ask a question such as, "Can you give me an example of the role you played in a group that was faced with making a difficult decision when there were split opinions as to the best answer?" **Exhibit 3** on the next page provides an illustrative example of the types of interview questions you might consider if probing for competencies related to strategic/innovative thinking.[6] Remember, Rome was not built in a day! You are not trying to close all your competency gaps in any one recruiting cycle. Instead, focus intently on ensuring that this year's slate of nominees demonstrates the specific knowledge/expertise, experience, and attributes desired to help you build a board that can function as a high-performing team.
- Develop a pipeline of long-term candidates around competencies each would bring. Find ways to engage these potential board members in board committees to assess their capabilities and to begin their education and development process.

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[6] For additional examples of questions or the behavioral attributes associated with individual competencies, see Center for Health Care Governance, 2009, Appendix 4; and "31 Core Competencies Explained," WorkForce, September 2002 (available at www.workforce.com/articles/31-core-competencies-explained).

Exhibit 3: Sample of Competency-Based Interview Questions

Recommendation: Identify 3–4 key questions, by competency, that you want to ensure are asked during the interview process. Then, ask everyone on the interviewing team to evaluate how well the board candidate demonstrated each of the desired behaviors associated with each competency. The example below serves as a prototype of open-ended questions that work best in competency-based interviewing.

Example of Questions for Competencies Related to Strategic/Innovative Thinking

Think of a situation in which you were involved in brainstorming or strategic planning:

- What did you do to make sure you understood the organization's competitive position and its strengths and weaknesses as compared to competitors'?
- How did you contribute to the development of new ideas or strategic direction for the organization?
- How did you help organizational leaders successfully manage organizational change associated with the strategic direction?
- How did you help the organization anticipate the implications and consequences of potential strategies to prepare for possible contingencies?
- How did you incorporate general industry trends into thinking about what the organization needed to do to succeed in the future?
- How did you help others in your group to remain open to new approaches for addressing challenges or capitalizing on opportunities?

Conclusion

The warp-speed pace of change in today's healthcare industry means future high-performing hospital or health system boards will seek individuals with a broader range of knowledge, expertise, experience, and attributes than today. Proactive and intentional focus on board recruitment, education, and development will be critical to achieving the competency-based board right for your organization. Taking the time upfront to engage the entire board in identifying future competencies needed for success and to agree on the competency "gap" is the necessary foundation to a solid board recruitment plan. It is not sufficient to use a generic listing of board competencies as your plan or to engage only the nominating committee in defining what competencies are needed each year. Instead, the entire board should embrace the work associated with developing a 2020 competency-based board in service to the community and patients who rely on you.

Additional Board Recruitment Resources

The Governance Institute has several resources for helping you build competency-based boards. Below are a few we suggest:

Board Recruitment and Retention: Building Better Boards, Now…and for Our Future (White Paper, Spring 2013)

"The New Healthcare Shortage: Recruiting Human Capital to Serve on the Board" (*BoardRoom Press* Special Section, October 2013)

Governing the 21st Century Health System: Creating the Right Structures, Policies, and Processes to Meet Current and Future Challenges and Opportunities (White Paper, Fall 2013)

The Changing Face of the 21st Century Governing Board: New Challenges for Recruitment and Board Composition (Webinar, August 2012)

Board Recruitment (Elements of Governance, 2003)

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Physicians in Governance

By Joseph S. Bujak, M.D., FACP

There is a growing desire to increase the presence of physicians on governing boards of healthcare organizations. Governing boards recognize that redesigning healthcare with an emphasis on transparent accountability for the efficacy, efficiency, service quality, and appropriateness of care requires the leadership of physicians. Moreover, the transition from payment-for-volume to payment-for-value with the bundling of services together with economic consequences for failing to prevent never events or orchestrating care across time, geography, and professional domains reinforce the need to access physician "ownership" of the ideas that will drive the transformation of the enterprise.

Healthcare boards are rarely reimbursed for their work, and often meet for only a few hours per month—after all, you don't want to overburden volunteers. As a result, meetings have packed agendas, and only enough time to share predigested summaries of major issues with intent to achieve ratification of choices primarily made by administration. The complexities that confront healthcare organizations as they attempt to adapt to accelerating changes overwhelm administrators, much less the competencies of volunteer board members. Governing healthcare organizations now requires assembling members who bring sophistication and insight to the responsibilities that attend governance of such an important community asset. Caveat: the expertise that is needed is for an understanding of systems thinking, scenario planning, complexity science, creative problem solving, and relationship management. Those with historical experience in traditional facets of business management are too often locked into traditional ways of framing issues and fail to appreciate that what is needed is not discovering new places, but rather seeing with new eyes.

This challenge is further complicated by the consolidation that is occurring within healthcare. Large systems are swallowing up smaller independent community healthcare organizations. Now system boards/administrations make decisions that are imposed on boards that historically governed the once independent units. Attempts to franchise what were once independent entities threaten their unique identities and abilities to respond to local concerns. Add to this the tensions that accompany the increasing presence of physicians on boards and the situations become even more challenging.

Considerations for Physicians in Governance

The following is a list of some of the considerations that relate to the growing presence of physicians in the governance of healthcare organizations:

1. **Generational differences**: These apply across the membership of all boards. Most boards are demographically old. Younger individuals often reject decisions acceptable to older persons, and the opposite is also true. For example, older physicians believe that younger physicians have no work ethic, while younger physicians suggest that older doctors "get a life!" Comfort with technology, willingness to delegate, and reduced organizational loyalty are additional differentiators of the younger physician. Physicians have no collective identity and the opinion of one physician board member is just that.
2. **Employed versus independent**: The perspectives of these two aggregates of physicians are obviously different. In the first instance, it is problematic as to whether or not an "employee" can serve in governance of the employing entity. If on the board as representatives of an affiliated group of physicians, the loyalties of that individual are suspect. Are they there to lobby on behalf of their constituent group or serve on behalf of the organization as a whole? Certainly any independent physician has an inherent conflict of interest regarding decisions that clearly impact his or her work environment. They are especially concerned with the possibility of being isolated from referral patterns.
3. **Affiliated physician groups**: Often, physicians are structured as a self-governing subsidiary on the organizational chart. How does this structural relationship impact the physician in governance of the "integrated enterprise?" I have often written of the journey from "I" to "we" to "us" as the transformation of physicians from autonomous individuals to collective physician groups to integrated "partnership"

within the healthcare organization.[7] Too often the structurally separated physician group(s) reflect a union–management relationship and set up a potentially antagonistic relationship.

4. **Language and ethical divides**: Business persons who run healthcare organizations speak the language of business, frame issues from a business perspective, and apply business metrics to the definition of success. Clinicians speak the language of clinical medicine, frame issues from a clinical perspective, and apply clinical metrics to the definition of success. When analyzing the same data set, these two groups can arrive at totally different conclusions. Because to each the conclusions are perfectly clear—that the other cannot see it means that either they are not able to see it (after all, they are not a doctor) or that they choose not to see it. They are either incompetent or self-serving and in either case cannot be trusted. Moreover, there is an ethical divide that separates the two. Physicians are taught that it is their ethical responsibility to serve as *the patient's* advocate. That is, short of doing harm, it is his/her ethical duty to do all that he/she can to potentially benefit the patient, ideally independent of the patient's ability to pay. Healthcare administrators have an ethical responsibility to serve as an advocate for the *collective group of patients*. As stewards of a valuable community asset, it is their ethical responsibility to create the greatest good for the greatest number. Once resources are allocated here they are no longer available to allocate there. Each of these perspectives is attended by an equally valid but totally different set of ethics and no one can simultaneous serve both.
5. **Difficulty being vulnerable in public**: Historically physicians have been trained to an end point of individual excellence. Individual competence, knowledge, and diligence are the essentials necessary to create idealized outcomes. Failure is an attack on self-identity and self-worth. The "all-knowing" physician therefore finds it difficult to publicly acknowledge that he or she does not know. If one cannot acknowledge that his or her current state of knowing is either incomplete or incorrect, he or she cannot learn.
6. **Preference for debate rather than dialogue**: Physicians are action-oriented individuals who traditionally work to the principle of distributive justice. Attending a meeting at which nothing is decided is seen to be a waste of time. After all, physicians direct outcomes by giving (writing) orders. Healthcare administrators often work to the principle of procedural justice. The slow pace of decision making that results often drives doctors crazy. The generative responsibilities of governing boards demand dialogue wherein attentive listening and the suspension of judgment are imperative. These are not typical attributes of the action-oriented mechanic. Those in governance must act more like gardeners than mechanics. Gardeners don't grow crops; they create conditions in which crops grow. This is not the perspective of most physicians.
7. **Specialization and reluctance to accept accountability**: Physicians have historically been trained to be outstanding solo musicians. The transforming healthcare industry requires that all components of the healthcare team function as an orchestra. Progressive subspecialization compounds the challenge. As technology has expanded individual physicians have become progressively more focused on a specific disease or procedure(s). The doctor–patient relationship has been mortgaged to a doctor–disease or a doctor–technology relationship. This transformation makes the orchestration of care even more difficult. The hope is that the primary care physician or surrogate case manager (medical home) can be the integrator of care, or that "big data" can provide the guidance. The absence of clinically supportive informatics and the lack of understanding of multi-system disease make this extremely challenging for the primary care provider. In addition, I have personally found most physicians unwilling to accept accountability for outcomes of care. When components of that care are to be performed by others, and with the need for the physician to be perfect, it is difficult for the individual physician to accept overall accountability for the outcome.
8. **Consequences of serving as a decision maker, change agent**: While these aspects of physician culture may be transforming, two historically significant aspects impact physician behavior. Physicians comprise what is labeled as an expert culture. In

[7] See Joseph Bujak, *Healthcare Leadership: Guiding the Organization through Transformational Change* (white paper), The Governance Institute, Winter 2012.

expert cultures, members make all decisions from the personal perspective of how will this affect me? Individual autonomy has been the transcendent value within the physician community. For these reasons, the presumption to leadership within the physician community is seen as illegitimate. Secondly, in a world where the pace of change is accelerating exponentially, it is imperative that leadership act as agents of change. In any population, the number of individuals who potentially can imagine accepting transformational change is a small minority. The majority will act in defense of the status quo. Therefore physicians in governance face a dilemma. Failure to serve as a transformational leader will cause the organization to die. Acting as one, prompts rejection by the very group you seek to benefit. Sometimes that rejection can result in reduced referrals. These dynamics can isolate those physicians who seek to act in the best interests of the whole, especially when they acknowledge the legitimacy of certain business aspects of the enterprise. The realities of the peer review process are a good example of the complexity that attends trying to do "the right thing."

9. **Challenge of distinguishing good business from bad science**: How do you decide what is appropriate care? In a world of payment-for-volume, revenue generating activities are accepted. In a world of prepayment, unnecessary activities become cost centers. There are many examples that challenge the appropriateness of certain interventions (for example, the excessive amount of imaging and laboratory studies, surgery for back pain, how to approach mammography, and the role of PSA testing). What is the role of governance in this regard, especially when individual physicians or physician specialties can be impacted by decisions on where to allocate organizational resources?
10. **Changing physician reimbursement**: Physician reimbursement is significantly and often totally calculated based on productivity. As reimbursement is reduced and as services are bundled, there is an ongoing recognition that employed physicians are being paid in ways that are unsustainable. In a world of prepayment managing health and wellness, disease and case management, and the integration of information become the most significant value-added functions. How are these to be acknowledged and rewarded? What are the implications for the current reality of primarily rewarding proceduralists? What are the consequences of the need to redistribute funds/renegotiate physician contracts?

In summary, physicians who come to serve in governance must accept that they now serve as stewards of the entire enterprise in service of the "owners," as promoters of organizational purpose (mission), and as guardians of organizational values. They must be willing to prioritize organizational goals, which at times may conflict with their personal self-interest. They must be willing to become bilingual, to be able to understand and appreciate the importance of the business side of the enterprise without losing site of the clinicians' need to always place patient needs first. Finally, they must be willing to serve as transformational leaders, risking rejection by their colleagues in deference to serving the greater good.

The Governance Institute thanks Joseph S. Bujak, M.D., FACP, healthcare speaker, facilitator, and consultant, for contributing this article. He can be reached at jbujak@attglobal.net.

2015 Governance Trends for Non-Profit Hospitals and Health Systems

By Michael W. Peregrine, McDermott Will & Emery, LLC

A review of current developments has led me to the following perspective on governance trends for the remainder of 2015:

1. **Ensuring business judgment rule protection:** As the dimensions of board service increase, the availability of business judgment rule protection takes on added significance. Yet, in the current regulatory/litigation environment, the availability of the rule cannot be assumed. The board's approach to decision making must become more sophisticated in order to better ensure the sustainability of those decisions, and reduce the board's liability profile.
2. **Risk oversight:** The sharpened regulatory enforcement environment and the intricacies of corporate strategic initiatives combine to place new pressures on the board's risk oversight responsibilities. The proper exercise of those responsibilities may require a more focused board oversight template. The board must be proactive in ensuring that organizational-appropriate risk identification, management, and reporting protocols are in place.
3. **Director time commitment:** Directors should expect to devote substantially more time to governance matters, given the greater complexity of board agendas. A recent survey shows the annual time commitment of directors rising 13 percent since 2013 (to 278 hours)—not counting time spent on informal intra-board discussions and crisis management issues.[8] Support may come from greater agenda management and effective committee use.
4. **Strategic planning:** The changing competitive and financial landscape will place greater importance on board contribution towards the strategic vision. There will be an expectation of greater board involvement in, and accountability for, the strategic planning process. Board engagement on strategy will evolve towards the continuous and away from the episodic. Strategic issues should appear frequently on the board agenda.
5. **Board composition:** The board nominating process will take on added importance, with particular focus on composition and effectiveness-related issues. Primary among these is a competency-based selection process identifying candidates with expertise needed to monitor an increasingly diverse operational portfolio. Also important will be accommodating gender and other diversity factors, and addressing concerns with "overboarding" and outside business interests.
6. **Committee effectiveness:** The board's ability to conduct its affairs will increasingly depend upon the effective use of committees. This can be manifested through the following: composition of a majority of independent members, appointing members with demonstrated competencies, allocating both workload—and knowledge—across committees, ensuring proper horizontal and vertical communication, and establishing appropriate meeting frequency.
7. **Talent development:** Issues of executive talent management will emerge as an important governance role. CEO and executive leadership succession planning should be the subject of increased board attention. Non-CEO members of the executive leadership team, and their respective credentials, must receive greater exposure to the board. The compensation committee agenda should address the recruitment, retention, and development of executive talent, beyond that of the CEO.
8. **Cybersecurity and governance:** Hospital and health system boards should embrace emerging "best practices" for governance oversight of cybersecurity issues. These recognize the growing legal and reputational risks arising from the breach of patient health information. Formal governance practices should address matters of privacy and information technology/security, internal responsibility for cyber preparedness, recruitment of directors with cybersecurity experience, and management reports on cybersecurity matters.
9. **Tenure refreshment:** Increasing emphasis on governance effectiveness should prompt hospital and health system boards to address the appropriateness of director "refreshment" policies. These might include term limits, a mandatory retirement age, and similar mechanisms. Concerns with director entrenchment should be balanced against

[8] 2014–2015 NACD Public Company Governance Survey.

standards of director experience and performance. The lack of any recognized "best practices" should not prevent boards from conducting this dialogue.

10. **GC/CCO coordination:** A series of developments threaten to blur the important distinction between the system's legal and compliance functions. If left unaddressed, it could lead to significant organizational risk (e.g., tasking compliance officers to perform legal functions and loss of the attorney–client privilege). The board should address this risk by requiring clarity between the roles of general counsel and compliance officer.

The Governance Institute thanks Michael W. Peregrine, Esq., Partner, McDermott Will & Emery, LLP, for contributing this article. He can be reached at mperegrine@mwe.com.

New Resources for Supporting Your Board

Loma Linda University Health Reaches Out to Share Its Vision
This case study shares how Loma Linda University Health is building upon its strengths while adapting to the new demands of a rapidly changing U.S. healthcare system.
Click here to view.

Moving Your Organization toward Strategic Cost Transformation
Healthcare organizations need to take a comprehensive approach to strategic cost transformation. This Webinar offers guidance on how leaders can fulfill their increasingly important role of providing oversight in an era of decreasing volumes and constrained revenues.
Click here to view.

***BoardRoom Press*, Volume 26, No. 1**
The February issue includes articles on Conemaugh Health System's journey, bundled payments, igniting innovation, quality improvement, and a special section on aligning physician/provider compensation incentives.
Click here to view.

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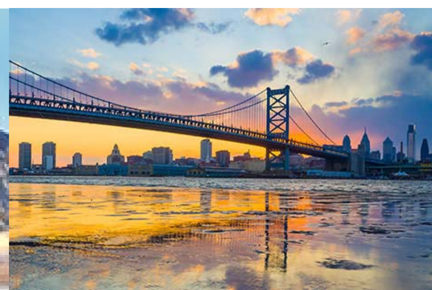
Upcoming Events

Leadership Conference
Boca Raton Resort & Club
Boca Raton, Florida
February 22–25, 2015

Leadership Conference
The Ritz–Carlton, Laguna Niguel
Dana Point, California
March 15–18, 2015



Governance Training Program in Quality & Safety
The Ritz-Carlton, Philadelphia
Philadelphia, Pennsylvania
April 7, 2015

Save the Date for Our Governance Support Conference

Gaylord Palms Resort & Convention Center, Orlando, Florida
August 9–11, 2015
More information and registration coming soon.

Our Governance Support Conference focuses on concerns and topics important to those who provide board support and coordination. It provides governance support professionals the opportunity to hear expert speakers, learn about new resources, gain knowledge on current healthcare trends, and network with peers and gain insights from those with a similar commitment to elevating board performance.

Click here to view the complete programs and register for these and other 2015 conferences.