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Bad Governance: How to Fix It (or Better Still, How to Avoid It)

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Public hospitals and health systems do not have a monopoly on bad governance. Recent history is rife with widely publicized examples of ineffective governance in non-profit and for-profit organizations of many kinds. (Remember Enron? And you don't have to go any further back in history than last week to find a classic example of terrible non-profit governance, involving the National Rifle Association.[1])

However, governmental entities (including public hospitals) should be held to high standards when it comes to effective governance, and too often those standards are not met. Despite improvements in recent years, I continue to see a steady stream of instances of less-than-stellar public hospital governance. Many of these situations could (and should) have been avoided.

Examples of Bad or Ineffective Public Hospital Governance

To take one current example, in early March of this year, *The Baltimore Sun* broke a story about a breathtaking pattern of bad governance involving the board

1 Josh Kovensky, "In Widening Corruption Scandal, NRA Accused of Funneling Funds to Board Members," *TalkingPointsMemo.com*, June 10, 2019.

Guarding Against Ineffective Governance: What Immediate Steps Can Boards Take?

- Evaluate your current conflict-of-interest and ethics policies, as applied to both the board and senior management; when were these policies adopted? Do they need updating? Are they routinely being followed by both the board and management?
- In public hospitals that are also part of state universities or other governmental entities (like cities and counties) this review should include the procurement and open records requirements of the relevant government entity, in addition to the board's own policies.
- Conduct an inventory of all hospital or system contracts or other relationships that benefit, or relate in any way to, board members and/or their businesses and immediate family.
- Determine whether those contracts have been reviewed and approved by the board with sufficient transparency and accountability under the board's conflict-of-interest policies, and reviewed by counsel with respect to relevant procurement and tax laws.
- Take appropriate remedial action if necessary, including submitting them to the board for approval or—in extreme cases—terminating the contracts or relationships or putting them out for public bid.
- If you do not already do so, conduct an evaluation of the board's activities, effectiveness, and culture—look in particular at the possibility that some board members may have significantly more influence and power than others, including access to management, and take steps to remedy the situation if it exists.
- Such steps could include term limits for board officers and committee chairs, having a clear succession process for identifying and selecting new board members, and conducting regular educational programs targeted at expanding inclusiveness, among other actions.
- Finally, consider taking appropriate steps with regard to board members who routinely fail or refuse to check their personal agendas at the boardroom door, and/or insist on engaging in behavior during board meetings that is contrary to the policies, decisions, culture, or best interests of the hospital or system. Such steps could range from candid offline conversations or remedial education about the role of the board, to initiating actions to remove or replace the member in extreme situations where the behavior itself is sufficiently disruptive.

of directors of the University of Maryland Medical System (UMMS). In sum, the article indicated that nine members of the system's 30-member board were engaged in substantial and lucrative financial arrangements with the system. Subsequent reporting found that many (although not necessarily all) of these arrangements were entered into by the system without being submitted to or approved by the board, and also that the practices were adopted by some of the subsidiary boards in the system. In all, dozens of reports in *The Baltimore Sun*, along with follow-up reporting by *The New York Times*, *The Washington Post*, and other sources, have painted a broad picture of a system that appears to have lost its focus on effective governance.[2]

UMMS was created in 1984 by the state of Maryland to assume responsibility for the University of Maryland's hospitals and clinics.[3] While UMMS is technically a non-profit corporation, the system includes substantial public assets and programs, including the state-owned hospitals and clinics of the University of Maryland and a hospital system formerly owned and operated by Prince George's County, Maryland. UMMS's 30-person board includes several *ex-officio* members. The remainder of the board is appointed by the Governor, based on recommendations of other (primarily governmental) entities, and includes university regents, members of the state legislature, and other public officials, in addition to politically connected private citizens. UMMS thus represents a cautionary tale of ineffective governance.

Widespread scrutiny of the UMMS board started when *The Baltimore Sun* reported that nine prominent board members had earned millions for their companies through deals with UMMS—including $500,000 the system paid Baltimore Mayor (and UMMS board member) Catherine Pugh for self-published health-related children's books.

To its credit, once these problems came to light, the system and the state moved rapidly to address them. Three board members (including Mayor Pugh, who had originally been appointed to the board when she was a State Senator) resigned from the board immediately, and four other board members and the system CEO were put on leave. Ms. Pugh later resigned from her elected office as well, and the CEO also subsequently resigned from the system. In early May, the board chair and two additional board members resigned. The board appointed a committee to investigate the allegations, and the state legislature also enacted legislation requiring many reforms in the system's governance. A new 25-member board will be created in 2020, with 23 members appointed by the Governor. The board engaged a consulting firm to conduct an investigation, including a top-to-bottom look at the system's ethics and conflict-of-interest policies.[4]

> "Outraged by the revelations, the Democratic leaders of the General Assembly and Republican Governor Larry Hogan agreed to fast-track reform legislation that will terminate the terms of all UMMS board members by the end of the year. The board members, who sit on the board as unpaid volunteers, would have to apply for reappointment if they wanted to return. The bill also will prohibit board members from getting no-bid contracts from the system, and require them to submit financial disclosure forms to state leaders in Annapolis, not just regulators." *The Baltimore Sun*, April 9, 2019

As highly visible as it has been, the UMMS board situation is far from unique in providing recent examples of bad or ineffective public hospital governance. Consider the following additional examples that have arisen in other public hospital governing boards in recent years:[5]

- Members of one local public hospital board were appointed by elected members of the public governing body that owned the hospital. One member was appointed by each elected official from

2 See e.g., Luke Broadwater, "University of Maryland Medical System Pays Members of Volunteer Board Hundreds of Thousands in Business Deals," *The Baltimore Sun*, March 13, 2019; Farah Stockman, "Baltimore Mayor Resigns in Scandal over Contract," *The New York Times*, May 2, 2019; Rachel Chason, "Deals Were Pervasive at UMMS Affiliates," *The Washington Post*, May 17, 2019; and "Term Limits Were Often Overlooked," *The Washington Post*, June 3, 2019.

3 Many other state universities created similar corporate structures for their teaching hospitals in the 1980s, including (among others) the state universities of Arizona, Florida, Alabama, Nebraska, Massachusetts, Minnesota, Vermont, Georgia, and West Virginia. A number of those universities have subsequently rethought (and in some cases undone) these governance reforms.

4 On June 12, 2019, the consultant selected by the UMMS board issued a report on its review. The consultant's key finding was that "Members of management appear to have taken upon their own authority the right to enter into contracts with board members that resulted in personal gain...interacting with board members in ways that overstep the standard understanding of the role and authority of the board." See Rachel Chason, "Review Finds Flaws in UMMS Contracts," *The Washington Post*, June 13, 2019.

5 Unlike the UMMS example, the details of which have been widely reported, certain characteristics of these additional situations have been altered to protect the identity of the relevant systems and individuals.

that person's district. Board membership was considered a political appointment and few members thus had any relevant experience. Some considered it an honor and a service to the community, but others saw it as an opportunity (depending on the politics of the appointing official) to seek to slash the hospital's funding or even close the hospital. The resulting board meetings were usually contentious; the board could rarely reach consensus on major decisions, and the hospital was ultimately turned over for management to a for-profit company.

- The board chair of a county hospital authority was widely considered one of the most powerful "behind the scenes" political operatives in the state. He was an attorney whose firm had done all the legal work for the authority for many years. The current board had never considered changing firms because of the chair's power and influence and because "they've always done our work." The chair directly oversaw the firm's work. Ultimately, a federal investigation uncovered a large number of physician contracts, entered into over many years, in violation of federal Stark and anti-kickback laws. The CEO (who had been handpicked by the chair) was the only official who had intimate knowledge of these contracts. In the end, the authority paid a very large penalty and was subject to a corporate integrity agreement for five years. The chair was forced to resign and the CEO was personally indicted for Medicare fraud.
- In a hybrid university hospital board (not UMMS) that included representatives of city, county, and state government, many board members felt that their primary responsibility was to the government entity that appointed them. In particular, one board member appointed by local government felt his/her role was to expand certain specific hospital services regardless of need or cost—even to the extent of (unsuccessfully) lobbying the state legislature to divert funds from the hospital into programs and services that were actually opposed by a majority of board members and the university. When the hospital CEO finally succeeded in convincing the legislature that the hospital opposed the board member's proposal, the board member turned his/her attention to disruptive efforts at subsequent board meetings to get the board to fire the CEO. (The board member's term ultimately expired and he/she was not reappointed; the CEO retained his job.)

Good Governance Best Practices

What are the takeaways from the UMMS situation and these other indicators of bad or ineffective governance? I suggest that situations like these could be addressed—and even avoided in the first place—if a few simple governance "best practices" are adopted by public hospital and health system boards:

- **Reevaluate the size of the board:** In some cases, there is little that can be done about the size of a public hospital or health system board when it consists of an elected or appointed body like a state Board of Regents or county Board of Supervisors. However, many cities, counties, and state universities, as with the UMMS example cited above, have dedicated hospital boards that are more susceptible to change. Problems can arise when such boards are simply too large for effective governance. Large boards may be suitable for organizations like museums, symphony orchestras, and hospital fundraising foundations, but for hospitals, large boards are more likely to open the door to bad governance. Small cliques often form on large boards that can wield disproportionate influence over the rest of the board and the CEO. Other board members are left with relatively little influence, with the result that they either lose interest or pursue goals that are not consistent with the organization's best interests. High-performing public and private university health systems have been reducing the size of boards over the last decade. On average, 11–18 members is within the range identified as a "best practice" in the literature for non-profit health systems. This finding was confirmed by my recent unpublished survey of the governance "best practices" of 10 high-performing multi-hospital systems, which was conducted for a large non-profit academic health system that included both public and private hospitals. Six of the 10 systems surveyed had boards within this range, and two of the three systems with larger boards reflected a desire to reduce board size in the near future.
- **Address board composition:** While the composition of some public hospital and health system boards is dictated by state or local laws that can be difficult to amend, in recent years many state universities, counties, and cities that own hospitals have appointed dedicated boards in a variety of legal structures. Those include authorities, public benefit corporations, public-private hybrids, and even non-profit corporations. (In fact, at least in metropolitan areas, the public

hospital whose board consists only of elected or statutorily mandated appointees is very much in the minority today.) All of these legal structures offer the opportunity to identify and recruit high-quality board members with a range of skills, experience, and diverse backgrounds. The range of skills and experience considered desirable for both public and private academic health system boards has expanded in recent years to include a number of new areas of expertise. Given the trend toward streamlining system boards, adding members with the desired additional expertise can be challenging for health systems. One way to meet this challenge among surveyed systems has been to limit the number of *ex-officio* or "constituency-based" board members. Having a large number of *ex-officio* directors raises the question of whether a board is representational rather than strategic. Our survey of 10 large public and non-profit academic health systems found that most had four or fewer *ex-officio* members.

- **Develop an effective board member recruitment and succession planning process:** High-performing public hospital boards should carefully assess governance expertise, skills, availability, and capabilities of their members and identify gaps in needed expertise and other criteria (including gaps in diversity). Where dedicated hospital or health system boards have been created by governmental entities, board member terms and term limits may be susceptible to change. In such cases, reasonable term limits (e.g., a limit of three to four three-year terms) should be considered a "best practice" and should be enforced in all but the most unusual circumstances. This is most effectively accomplished by maintaining an ongoing recruitment and succession planning process to identify and "vet" potential new board members to fill slots before terms are up. Governing boards should take the same care in selecting new board members as they would take in recruiting a CEO or other C-suite managers. Use a headhunter if necessary, interview carefully, and avoid selection through cronyism or to satisfy political needs. A dedicated governance committee and chief governance officer can help develop a successful process.
- **Regularly evaluate boards and directors:** Most high-performing hospital and health system boards have their members conduct annual individual self-assessments, and some also ask board members to evaluate their peers. Almost all healthcare organizations have explicit expectations for attendance, preparedness, and other kinds of involvement for board members.
- **Set clear governance roles for subsidiary or owned hospitals:** Effective public multi-hospital system governance models place clear limitations on the authority, accountability, and decision-making responsibility allocated to local hospital boards in the system. In high-performing systems recently surveyed, owned system hospitals either do not have their own boards or are part of a governance structure with regional or "market" boards that are responsible for several hospitals. In those systems that do have local hospital boards, the role of those boards has been redefined in recent years to focus on a more limited (but essential) set of duties and responsibilities, with particular emphasis on maintaining and improving linkages to their local communities. System boards are taking on more fiscal and strategic responsibilities for owned hospitals. Where subsidiary boards are used, it is imperative that members of such boards follow the same conflict-of-interest and ethics policies as members of the system board.
- **Avoid undue political influence:** This may be easier said than done with some public hospital boards. However, as the UMMS example indicates, when politicians wear multiple hats that include serving on a hospital system board, it becomes essential to maintain an arm's length relationship between an elected official's role as a member of a governing board and their responsibility as elected officials (or university regents) for a broader range of governmental functions. Limit the membership of elected officials on board committees so that everyone has an opportunity to participate—and avoid having an entrenched or well-connected "clique" centered around politically powerful members that could dominate board decisions and deliberations.
- **Maintain a policy for public communications:** Who speaks for the board? Public hospital boards should maintain a clear policy about who may speak for the board and the organization, and under what circumstances. Many effective boards limit public communications to the board chair and CEO (except where otherwise explicitly approved). In the event a board member seeks to "go rogue" and separately announce or even lobby for policies that are not approved by (or in the best interests of) the hospital or health system, the board should have a mechanism in place for censuring (or as a last

resort, expelling) the offending member.

- **Have a robust conflict-of-interest policy:** A strong conflict-of-interest policy is important in all hospitals and health systems, but it is essential in a high-performing public hospital system, which is entrusted with managing and governing public assets, programs, and personnel. In the UMMS example, it became clear that the system did not have an effective conflict-of-interest policy in effect. One board member even told reporters that he did not recall ever being informed of, or having an opportunity to vote on, several of the contracts raised in the investigation. In response to the revelations, on May 31, 2019, UMMS finally did adopt a strong conflict-of-interest policy.[6] Its provisions include the following:
  - A prohibition on sole-source contracting with any UMMS board member
  - Requirements for the recusal of non-independent board members from certain deliberations and decision-making activities
  - Provisions that restrict relevant board leadership positions to independent board members
  - Detailed procedures for the disclosure of interests by UMMS board members, officers, and management-level employees
  - The process for identifying and addressing conflicts of interest
  - The process for handling violations of the conflict-of-interest policy
  - A requirement that every board member attest to compliance with the conflict-of-interest policy
- **Educate board members about conflict-of-interest policies and enforce them at every meeting:** It is not enough simply to adopt a policy. UMMS apparently did have a policy in place, but it appears to have been rarely enforced. One board member was quoted in the press as having no memory of some of the large dollar contracts entered into by the system with board members. It is not necessary to prohibit all board member contracts, although the prohibition of single-source contracts (as in UMMS's new policy) would appear prudent in some situations. Encourage members of board and management to come forward when they observe what they believe to be a violation, with a clear-cut non-retaliation policy also in place for "whistleblowers." Board and organizational culture generally should involve trust and transparency. Finally, once a conflict is approved, affected board members should also not be in a position to directly affect CEO and C-suite compensation and bonuses.

In conclusion, while bad or ineffective governance can occur in any setting, the challenges faced in the public sector can require a higher level of transparency and attentiveness to conflicts, ethics, and fiduciary responsibilities than in other sectors. All of the general requirements of effective hospital and health system governance are applicable to public hospitals, but there are also additional demands, brought on by the need to be conscientious stewards of important public assets and resources. As a result, the consequences of bad governance are often magnified in the public sector when those demands are not met.

6 The new UMMS conflict-of-interest policy can be accessed at www.umms.org/news/2019/umms-adopts-new-conflict-of-interest-policy.

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