Intentional Governance

Advancing Boards Beyond the Conventional

THE GOVERNANCE INSTITUTE

The Governance Institute®

The essential resource for governance knowledge and solutions®

9685 Via Excelencia • Suite 100 • San Diego, CA 92126

Toll Free (877) 712-8778 • **Fax** (858) 909-0813

GovernanceInstitute.com

Intentional Governance

Advancing Boards Beyond the Conventional

About the Authors

Sean Patrick Murphy is senior vice president and corporate general counsel for Solaris Health System in Edison, New Jersey. He is also a senior fellow at Jefferson University's School of Population Health. Mr. Murphy has spent his entire career in healthcare management and healthcare law, including three years as a Captain in the United States Air Force Medical Service Corps. He frequently speaks and writes on healthcare law and governance, and is a regular contributing author for The Governance Institute and Thomson West's *Health Law Handbook*. He received his master's degree in health services administration from George Washington University and his J.D. from Rutgers University School of Law, Newark. He can be reached at (732) 632-1533 or smurphy@solarishs.org.

Anne D. Mullaney is a partner in the law firm of Thorp Reed & Armstrong and chair of the firm's Health Law Section. Ms. Mullaney represents clients from many sectors of the healthcare industry including hospitals, healthcare systems, long-term care facilities, hospices, physician group practices, and rehabilitation companies. She focuses her practice on general health law, medical staff matters, governance issues, and regulatory compliance. She serves on the boards of Jefferson Regional Medical Center, Family Hospice and Palliative Care, and the Pittsburgh Regional Health Initiative. She received her master's degree in health services administration from the George Washington University and her J.D. from Duquesne University School of Law. She can be reached at (412) 394-7737 or amullaney@thorpreed.com.

Acknowledgements

The authors wish to acknowledge and gratefully thank Heather Bednarek, Esq., Florence Sinofsky, and Jennifer Elmezzi for the invaluable assistance they provided for this publication. Heather is a healthcare attorney at Pittsburgh's Thorp Reed & Armstrong. She received her undergraduate degree from McGill University in 2003, and her J.D. and M.P.H. in public health from the University of Pittsburgh in 2006. Florence is a third-year law student at Rutgers University School of Law, Newark. In the fall of 2010, she will be an associate with Sullivan and Cromwell in New York. Jennifer is a registered nurse and a graduate of Rutgers University School of Nursing; she is currently a third-year associate at Rutgers University School of Law, Newark.

About the Governance Institute

The Governance Institute provides trusted, independent information and resources to board members, healthcare executives, and physician leaders in support of their efforts to lead and govern their organizations.

The Governance Institute is a membership organization serving not-for-profit hospital and health system boards of directors, executives, and physician leadership. Membership services are provided through research and publications, conferences, and advisory services. In addition to its membership services, The Governance Institute conducts research studies, tracks healthcare industry trends, and showcases governance practices of leading healthcare boards across the country.

Special Thanks to Our Sponsors

The Governance Institute thanks Premier Partners Broadlane®, HBE Corporation, and Kaufman, Hall & Associates, Inc. for their continuing support of excellence in healthcare governance.

The Governance Institute Member Editorial Board

The Governance Institute's member editorial board provides expertise and opinion for our research and publications. We consider this a "working editorial board," and members are asked to comment on our annual education and research agendas, provide input on specific research questions, offer commentaries for publications, and selectively review draft white papers.

The composition of the member editorial board reflects The Governance Institute's membership overall: hospitals and health systems, varying sizes of organizations, private and public boards, children's hospitals, academic medical centers, secular and religious affiliation/sponsorship, geographic representation, physician CEOs, outstanding reputation, and a passion about governance.

The Governance Institute®
The essential resource for governance knowledge and solutions®
9685 Via Excelencia • Suite 100 • San Diego, CA 92126
Toll Free (877) 712-8778 • **Fax** (858) 909-0813
GovernanceInstitute.com

The Governance Institute is a division of National Research Corporation. Leading in the field of healthcare governance since 1986, The Governance Institute provides education and information services to hospital and health system boards of directors across the country.

For more information about our services, please call toll free at (877) 712-8778, or visit our Web site at GovernanceInstitute.com.

The Governance Institute endeavors to ensure the accuracy of the information it provides to its members. This publication contains data obtained from multiple sources, and The Governance Institute cannot guarantee the accuracy of the information or its analysis in all cases. The Governance Institute is not involved in representation of clinical, legal, accounting, or other professional services. Its publications should not be construed as professional advice based on any specific set of facts or circumstances. Ideas or opinions expressed remain the responsibility of the named author(s). In regards to matters that involve clinical practice and direct patient treatment, members are advised to consult with their medical staffs and senior management, or other appropriate professionals, prior to implementing any changes based on this publication. The Governance Institute is not responsible for any claims or losses that may arise from any errors or omissions in our publications, whether caused by The Governance Institute or its sources.

Table of Contents

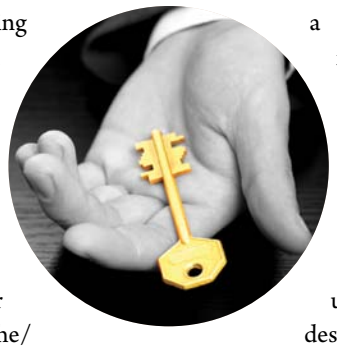
Foreword: Building Your Legacy as a Director

Why do directors agree to serve in such a complex, challenging industry as healthcare? There are many reasons people volunteer their time. Although it is hard to generalize motivations, it is safe to say that people who are willing to volunteer their time and energy want to do so in a way that makes use of their talents and permits them to contribute in a meaningful way to an enterprise they view as important.

That being said, hospitals are in fierce competition with other worthy endeavors for a limited volunteer pool. Yet the demands put on those who are willing to consider service on a hospital board are perhaps the most strenuous of all volunteer opportunities. Much has been written in recent years with regard to the complexity of issues facing the hospital or health system volunteer board of directors. The hospital industry is complex, the liability exposure on directors is real, and the financial and competitive forces facing healthcare providers can be overwhelming. Directors with little or no healthcare experience are expected to lead the organization through these complex times while receiving no financial remuneration for doing so. A trend towards director certification (discussed in more detail in this publication) presumably would require an additional time commitment. The appropriateness of the volunteer model of governance is being questioned with increased frequency as the industry becomes more regulated and competitive.

Nonetheless, the volunteer hospital board is here to stay for the foreseeable future. With national health reform efforts making front-page news, hospital and health system boards will be expected to move quickly to respond to changes. The challenges of the environment will certainly result in more pressure on hospital leadership—both management and board—as they work to maintain the viability of the organization. Ironically, it is just when the need for leadership is at its most acute that the pool for willing volunteers with the requisite skills seems to be decreasing. As the task of recruiting, engaging, and retaining the right talent becomes more critical than ever, successful organizations must position themselves in a way to attract and retain quality directors.

The task of recruiting and retaining quality talent begins, in part, with an understanding of what motivates a potential director to serve on a hospital board. This aspect of board recruitment has traditionally not gotten much attention or focus. Rather, board recruitment typically starts with identifying what skill sets the board needs and putting the wheels in motion to identify the people with those skills. This is, of course, a very important aspect of board recruitment. However, knowing more about the expectations of potential or current directors with regard to their board participation will help a board design a culture that will result in a more satisfying board experience. Questions such as, "What motivates an individual to consider serving on a hospital board given all its demands?" "What is a particular individual hoping to get out of the experience of serving on a hospital board?" "What talents or resources does a person believe he/she brings to the table?" serve as a good starting point when interviewing prospective directors as well as assessing current directors. These sorts of questions also help the board determine if the person is a good fit for the organization. Mutuality of goals and expectations is a critical component of long-term success.



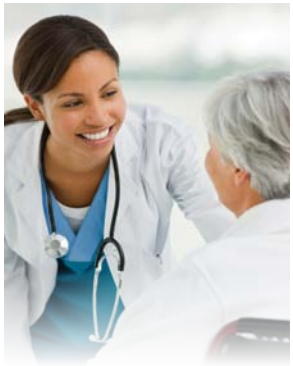
Most people who volunteer do so with the hope that their service will have a positive impact on the organization, that their service will in some way leave a legacy. Directors wonder how the organization will have benefited from their service after they leave the board. If time and effort contributed by the director does not result in tangible benefit, why bother?

Recognizing that board members have legacy goals is an important step in creating an intentional board (which is the focus of this publication). The more board leadership understands what a director wants and expects out of his/her board participation, the better the chance the relationship will be a successful one and that the director will stay committed, particularly in trying times. Likewise, the more a director knows what is expected of him/her, the more effective his/her service will be. Boards that can monitor and assess the satisfaction of directors in "real time" have a better chance of keeping them interested and productive.

Interviews with many current hospital and health system board members reveal a number of common themes relating to what draws directors to hospital service as compared to other potential volunteer opportunities or civic involvement. Most of these themes are lofty in nature—aspirational. None of them are particularly surprising. But all reflect a desire to "help," as defined by the director. Boards committed to understanding the goals or motivations of a specific director will of course have to identify the concrete expectations of a specific director, but these aspirational goals are instructive and a good starting place to understand director motivations.

Better Patient Care

Not surprisingly, the number-one reason given by hospital directors for their willingness to serve on a hospital's board was that they were motivated by the hope and belief that their participation on the board would result in the hospital providing better patient care. They viewed the mission of their hospital or health system to be a worthy one. They clearly had the desire to work hard to improve the delivery of care and to support those caregivers who were committed to serving the health needs of the people in the relevant service area, although they questioned whether their skill sets really had a direct effect on care directly. Although fairly new, the sharing of quality data and the increasing involvement of boards in quality improvement is viewed positively by directors and gives many directors the reassurance that their oversight efforts do make a difference.

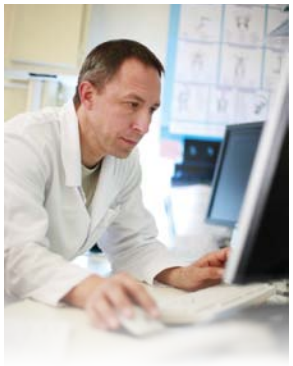


Efficient, Accessible, Affordable

A second factor frequently identified as a legacy goal is to have an impact on making the health services offered by the hospital or health system more efficient, accessible, and affordable. Business owners and business leaders alike cited the concern that the cost of healthcare is choking businesses and potentially affecting the competitiveness of the economy, both locally and nationally. They indicated that they were interested in understanding better the dynamics of the healthcare delivery system and using their business skills to affect the delivery of care in a way that makes it more efficient from a business perspective.

Vitality of the Region

A third common aspiration is the desire to work to ensure that good healthcare is available in the region; to protect the health status of the community. There is recognition that a hospital or healthcare system is a regional asset that directly affects the vitality of the region, and that this asset needs to be preserved. In many instances there is a strong commitment expressed to keep the hospital or health system independent and focused on the needs of the local community as compared to becoming involved in a bigger system—this was one motivation to serve as a board member. As community leaders, they felt that they could exert power and influence over decisions affecting the healthcare system in the region. Similarly, many expressed a belief that, due to the expertise they had amassed over the years in the other industries, they would help shape a viable strategic plan that could help position the organization to deal with competitive forces in the long term, and help the organization respond appropriately to market pressures.



Major Regional Employer

The final legacy goal that was commonly expressed related to the hospital or health system as a major employer in the region and the desire to help keep the hospital viable in order to keep good jobs in the community. Many directors expressed their belief that their expertise in human resource and personnel issues was or could be a valuable contribution to the hospital.

Understanding the motivation and legacy goals of current and/or prospective board members can help board leadership craft a board experience that is more fulfilling for the individual directors and more productive for the hospital. The reason the prospective director is asked to join the board is usually clear—they have the desired skill sets or social network. What is not always clear, however, is the reason the prospective director accepts the invitation to serve. Perhaps boards make assumptions as to why a person agrees to join or remain on the board. Traditionally, board participation was viewed an honor. It still may be, but it is more complex and multi-dimensional now. In any event, helping the individual director express answers to the questions, "Why am I here?" and, "What do I want to get out of this experience?" will help shape the culture of the board. The boards able to translate these aspirational goals into concrete goals will have more success in recruiting and retaining good directors.

Ask any hospital CEO and/or board leader and they can likely cite numerous examples of highly skilled individuals with great potential for being an effective director, who just did not "work out." Dig deeper and the reasons for the failure can usually be identified. Most directors complete at least their first term and do not actually resign from the board, but many do not perform to their full capacity. Directors who have not found the hospital board experience to be worthwhile can be instructive in building a better board going forward. The impediments to good experiences seem to fall into two general categories: culture and process. By better understanding how the culture and the processes of the board influence the performance of directors, continual improvement can be realized. In a sense, this board discernment process is akin to exit interviews for employees who leave the employ of the hospital. By knowing the specific impediments to a good employment experience, improvements can be made. Boards should consider adopting a similar process as part of its self-evaluation. Boards can only improve if they can identify areas of weakness and commit to improvement in a focused and intentional way.

Introduction

Hospitals and health systems are challenged on every front: enormous regulatory and public scrutiny, finances and inadequate reimbursement, and the demand (and more importantly, the governing board's desire) for high-quality, compassionate patient care. Meanwhile, healthcare teeters on unprecedented national reform that could literally "turn the industry on its head." All of this begs a simple but profound question: are hospital and health system governing boards prepared?

If good governance truly is more than a haphazard (or at best, disparate) collection of governance practices; if "high-performing boards" are truly culture-driven teams—"robust, effective social systems" that are more than the sum of their parts—then they need to do what every good team and athlete does: learn, grow, and improve. A governing board's primary responsibility is one of oversight; that is, reviewing and analyzing the organization's processes and performance. But in order to conduct this important job of oversight, the board must also look critically at itself, it's own culture and performance, and ensure the board is functioning at its peak, so it can truly focus on the real work of governing.

The time has come for governing boards to put stock not only in their organizations they govern, but also in themselves.

So…what are the additional, necessary components that take boards beyond mediocrity into excellence? The Governance Institute's biennial surveys measure board performance in recommended practices and evaluate board structure. Structure and practices are key components in driving board performance, but there is a third, possibly more important component to consider in driving board performance: board dynamics and culture.

This publication focuses on board dynamics and culture, and a related concept we call *intentional governance,* which involves deliberate and intentional processes that enable the board to realize its highest potential. This publication will include structure and practice components relating to the core responsibility of board self-assessment and development—director education, a board effectiveness program, processes for board recruitment, and doing more with the board self-assessment, for example—as well as ways to formulate an intentional process that has, as its outcome, full board engagement in its own development and improvement. The process involves a critical analysis of what works and what does not work for the board, and the individual directors who make up the board, in carrying out its oversight responsibility. It addresses the following questions (not an exhaustive list):

- What do we want to be?
- How do we get there?
- What works in our meetings?
- What information do we need?
- What plans do we have to improve?
- What are our collective and individual goals to reach optimal performance?

Intentional governance: deliberate and intentional processes addressing board structure, dynamics, and culture that enable the board to realize its highest potential.

The Foreword addresses "legacy"—the individual director's imprint on the organization. "Will my actions as a board member help bring the organization to a better place?" and, "Why am I here and what do I want to do to make this organization stronger?" Part of the discussion of legacy includes outlining a process to actualize that legacy; for example, what is the organization's strategic direction and how does it fit with the individual board member's priorities? What are the obstacles, steps, and actions the director can take to contribute to his/her legacy?

Combining board structure, practices, *and* culture into the framework of "intentional governance" will bring all of us closer to the elusive components of high-performing governance.

Background

The U.S. healthcare industry is in midst of fundamental change. We have watched as elected officials debate the merits of health reform and struggle to come to an agreement on how best to fund and organize our healthcare system. The stakes are high, with healthcare representing close to 18 percent of the gross national product and the cost of healthcare being blamed as a major contributor to our country's current economic woes. Due to financial pressures, hospitals and health systems are looking for new ways to deliver healthcare services more efficiently, and we are seeing an increase in hospital consolidations and mergers. Moreover, the traditional payment mechanism of paying for services rendered is being examined to see if this approach continues to makes sense, given the need to "bend the cost curve." This sort of critical thinking has given rise to more innovative payment methodologies as well as

new approaches to the delivery of care. There is much more focus on paying for outcomes, although there is much disagreement on how to design a system that successfully produces positive outcomes at a lower cost.

Clearly, these profound changes to the status quo require proactive responses from hospitals and health systems—organizations that are critical to the delivery of care. The issues are more complex and the challenges more intense than ever. The status quo is no longer enough for hospital management and governing bodies; these times require innovative leadership. Organizations that rise to the challenge and respond creatively and effectively to the pressures of the day will surely fare better than those that continue with "business as usual."

The examination is about who is on the board and why; it is about how directors interact with each other and how they interact with management; it is about how the board uses its time, how it establishes its priorities/agenda, and how it measures its effectiveness. It is about governing with intention.

The challenge lies in optimizing the skills of the directors in a way that truly adds value—that is, the creation of a highly effective governing body whose leadership trickles down through all aspects of the organization. This has always been the goal, at least from a theoretical perspective, but given the times, the imperative for boards to perform effectively and exclusively for the good of the organization is intense and immediate. Great boards will respond with intent, examining the needs of the organization and restructuring themselves to respond to those needs. This intent will be required in both culture and process design.

Recognizing the fact that volunteer directors often come to the table with little or no knowledge about or experience with the business of healthcare, an interesting and significant trend is emerging nationwide relating to director education. Twelve state hospital associations have implemented board certification programs, which focus on board education, providing instruction to directors to help them become more knowledgeable with regard to the healthcare industry and its unique demands. Clearly not a comprehensive fix for the knowledge gap, many see the trend as a good first step towards ensuring that directors have at least some fundamental understanding of the complexities of the industry. Similarly, there is a national trend being championed by the Securities and Exchange Commission (SEC) to define what a competent or qualified director is and what a qualified board looks like. Given the corporate scandals of the past 25 years, this seems like a laudable undertaking. But at this point, little has been written about what constitutes a qualified board; few benchmarks exist. Developing a definition for director competencies is becoming a hot topic.

Although it is impossible to argue that increased education of directors is a bad thing, it is not clear whether board certification programs will lead to a more qualified, high-performing board. Obviously, education alone is not the answer to a better board or more effective governance. Boards can become certified and directors can become more informed about reimbursement, fiduciary duties, hospital liability, and other basic topics, with no governance improvement. What is needed for true change is a sincere and honest assessment by the board of its strengths and its weaknesses, a realistic analysis of the type of board needed in this strange new world of healthcare, a plan to transform "what is" into "what needs to be," and a commitment to pursue excellence. The starting point for this analysis is a blank slate. What should the board look like? How should it function? This is true with respect to both process and culture. The examination is about who is on the board and why; it is about how directors interact with each other and how they interact with management; it is about how the board uses its time, how it establishes its priorities/agenda, and how it measures its effectiveness. It is about governing with intention.

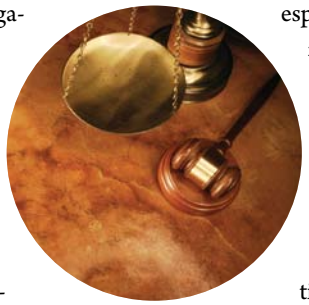
We are convinced that an effectively constituted board is essential to the success of a healthcare organization; it is not to simply fulfill the legal requirement that non-profit hospitals have a fiduciary board made up of members from the community. Many hospital CEOs struggle to see significant value from their board. Many see their board as another aspect of the operation that needs to be "managed." The path to becoming an essential, intentional board is not an easy one, but maintaining the status quo is just not an option. It does not happen simply by educating directors or staffing it with "qualified" individuals. It is a process of self-awareness, of self-definition, and of self-assessment; that the sum of the whole is greater than its individual parts. It is not only about overseeing the activities of management, it is about taking the actual act of governing with extreme care; of understanding and embracing the concept that if the board is excellent and accountable, the institution benefits. The governing process must be structured in a way that the board holds itself accountable for what it does and how well it does it, just as it holds management accountable for how well it manages the organization. (Similarly, the board holds the medical staff accountable for providing quality patient care.) Gone are the days when boards can simply assume they are doing a good job. The responsibilities of boards are just too great to continue on with business as usual.

In the pages that follow, we will take a brief look at the specific changes in the industry, including the increased call for transparency. We will review the important trend of board certification and discuss what it means to be qualified. We will look at what motivates directors to become involved and stay involved. We will examine some of the barriers often encountered by boards that impede good governance. We will then focus on "intentional governance"—what it means and why it includes board culture as well as board processes. Obviously boards are human organizations and there are no quick fixes. Only by being intentional, committed to becoming even more relevant, more accountable, and more effective, will hospital and health system boards truly add value to the organizations they govern.

Chapter 1.
The Changing Environment

In the wake of the Enron and AHERF scandals (among others), the Sarbanes-Oxley Act was signed into law in 2002, in efforts to hold public companies accountable to a host of new governance and financial rules to foster an ethical organizational culture. Though Sarbanes-Oxley did not apply to not-for-profit organizations, many non-profit hospitals and health systems voluntarily took on these new regulations, predicting the future scrutiny of non-profits that has now become reality.

In 2005, Senator Charles Grassley (R–IA) and the Senate Finance Committee pressed further by questioning not-for-profit hospitals' tax-exempt status. Committee concerns included "lack of effective enforcement vehicles available to the IRS to police tax-exempt organizations; perceived lax oversight exercised by governing boards of non-profit organizations; concerns with respect to excessive compensation paid to executives of tax-exempt organizations; deficiencies in Form 990 reporting by tax-exempt organizations; and perceived excess in travel, entertainment, and other related expenses of tax-exempt organizations."[1]



This attention on non-profits has not only continued, but also has become more intense over the past few years. Most recently, Grassley put forth an attempt to include more stringent charity care provisions in the economic stimulus package *(American Recovery and Reinvestment Act of 2009)*. Although the charity care provisions were not included in the final stimulus bill compromise, there are more stringent provisions in the newly passed health reform bill, including publicizing financial assistance plans and new requirements for community health needs assessments.

Finally, the rating agencies are also looking at governance as a factor in determining an organization's bond rating. Moody's Investors Service singled out the importance of governance in a Special Comment in 2005, *Governance of Not-for-Profit Healthcare Organizations,* reinforcing its position that governance is, and will continue to be, an important dimension of credit quality in the not-for-profit healthcare sector. In the past five years Moody's has continued to emphasize the importance of governance for bond ratings, especially during the financial crisis of 2008–2009.

The highly published corporate scandals over the last decade have resulted in a diminution of public trust when it comes to corporate boards. The public is questioning the practices and effectiveness of boards with increased frequency and veracity. Transparency is being mandated. Payers and bond rating agencies are recognizing the important role of the board and are even starting to reward good governance through such things as "pay-for-governance" initiatives. The demand for excellence in governance is now front and center.

IRS Form 990: Unprecedented Transparency

In response to these calls to increase transparency and accountability of governing boards in both the for-profit and not-for-profit sectors, the IRS is requiring increased transparency via the redesigned IRS Form 990. Prior to redesign, the Form 990 was a rather simple document that tracked how non-profit organizations receive and spend their money. In contrast, the new Form 990, with its 11-part "core" and 16 disclosure schedules inquires not only about non-profit organizations' financial transactions and executive compensation, but also their governance processes and managerial policies. The goal of the IRS is to acquire information relating to all facets of the inner-workings of non-profit boards.

The new Form 990 centers its transparency efforts on three key areas: conflict of interest, executive compensation, and community benefit. For conflicts of interest, the Form 990 seeks to expose the "disconnect" between conflict-of-interest policies and practice: the relationship between policies and effective managing of conflicts. Specifically, the Form 990 inquires not only whether the filing organization has a written conflict-of-interest policy, but also whether the organization regularly and consistently monitors and enforces compliance with the policy.

Likewise, organizations filing the new Form 990 must disclose whether they have a written

1 Michael Peregrine, "Sweeping Legislative Changes for Non-Profits Move Closer to Reality," *BoardRoom Press,* June 2005, The Governance Institute.

executive compensation policy and whether its policy includes a systematic review of compensation and expense reimbursement practices. Finally and perhaps most significantly, the new 990 contains a new disclosure schedule devoted entirely to collecting information specific to non-profit hospitals. This schedule, labeled Schedule H, includes a number of detailed inquiries relating to community benefit, charity care policies, means-tested government programs, and community needs assessments.

It is predicted that the new 990 will "become the *de facto* report card for assessing non-profit operations."[2] Considering the level of detail found in the form's questions and the fact that every Form 990 is available to the public, it is not difficult to imagine that this prediction will turn into reality.

The Transforming Delivery System: The Road to Accountable Care

The current turmoil existing in our healthcare industry has prompted many new theories and ideas relating to how organizations should best care for their communities and how these efforts should be funded. Our system of healthcare delivery is being "re-thought" at its most fundamental levels. By recognizing the inadequacies of the current system, novel approaches are being presented which, in many ways, challenge the most fundamental tenets of the relationship between healthcare quality, cost, and accessibility.

Responses to the question of how organizations can deliver quality, accessible healthcare, while maintaining low costs, include accountable care organizations, disease/care management programs, reducing avoidable readmissions, medical homes, bundled payments, and other initiatives. In short, the ways in which providers deliver care will be fundamentally changing in this new environment.

These concepts will demand full attention and support of the hospital/health system board. Boards will also have to examine their own organizations to determine whether they have the organizational structure(s) and human capital in place to provide the levels of structural and clinical integration that will be necessary. These issues will bring about more questions than answers, and boards need to be well positioned to deal with these kinds of sweeping industry changes.

2 Thomas K. Hyatt, Esq. et al., "Eight Things Nontax Lawyers Should Know About Health Care Tax Law," *Health Law Handbook* (Thomson West, Gosfield, ed. 2009), pp. 117, 120.

Chapter 2.
National Trends in Board Education & Development

For years, hospitals have monitored physician training and education as an important component in the granting of medical staff appointments and privileges. This is not surprising. Physicians dedicate years to formal studies, residencies, and fellowships. Thereafter, they sit for licensing and board certification exams; and throughout their careers they must fulfill ongoing education requirements imposed on them from a variety of sources. Tracking physician training and education is a cumbersome, but critical task—as training and education are essential components of physicians' ability to provide quality patient care.

In contrast, hospital boards have received little in the way of formal training in governance. Historically, most directors learned how to be hospital or health system directors through "on the job" training. Formal board education, to the extent it took place, was a matter left to the discretion of each individual board. However, in recent years, it has become increasingly apparent that informal, unstructured board and director education is not enough. In its 2007 report, *Principles for Good Governance and Ethical Practice*, the Panel on the Nonprofit Sector took aim at governance education, noting specifically: "The board should establish an effective, systematic process for educating and communicating with board members to ensure that they are aware of their legal and ethical responsibilities, are knowledgeable about their programs and activities of the organization, and can carry out their oversight functions effectively."[3]

Today, the vast majority of hospitals and health systems participate in some kind of regular, ongoing director education.[4] The Governance Institute has noted that educational programs, as part of annual education and development plans, provide the necessary building blocks for great governance. Healthcare institutions also appear willing to pay for such resources. The Governance Institute's biennial survey indicates that healthcare organizations frequently spend and/or budget significant amounts of money for governance training and education.[5]

At a minimum, "every healthcare governing board should have a structured, planned orientation program that familiarizes new directors with the organization, the issues facing it, the board structure and operations, and the roles and expectations of the individual directors."[6] As part of a general board orientation, each new director should receive information about the hospital or health system's mission, and training on the board's duties, policies, and current legal trends. In addition, they should become oriented on such matters as the organization's operation, organization, compliance, conflicts of interest, code of ethics, and quality matters. The problem is, many boards do not go much further than orientation, with little in the way of structured, ongoing board education. Given the increasing complex nature of the industry, governing boards need to do more.

The critical question has become whether untrained or informally trained directors can effectively direct a hospital or system, no matter how well intentioned they are, considering the fact that hospitals and health systems are some of the most complex systems in our society. In response to this, a trend of more formal director education has emerged. Specifically, several state hospital associations have begun to offer director certification programs. These programs, which were independently developed and structured, provide curriculum-based educational programs designed to ascertain that all healthcare boards have been appropriately trained and are at least minimally competent in specified areas (e.g. quality, safety, finance, and compliance). Further, some hospitals are now using board education (including director certification) as a condition of reappointment, not unlike medical staff requirements for continuing medical education.

3 Panel on the Nonprofit Sector, *Principles for Good Governance and Ethical Practice: A Guide for Charities and Foundations*, October 2007, p. 17.

4 See *Governance Structure and Practices: Results, Analysis, and Evaluation,* 2009 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute.

5 *Ibid.*

6 *Ibid.*

State Hospital Association Board and Director Certification Programs

Recognizing the need to develop the knowledge and expertise of those individuals willing to serve on the boards of non-profit hospitals, a number of state hospital associations have implemented voluntary certification programs. Some of the programs are designed solely for individual directors; some focus on the entire board, awarding certification, certificates, or special recognition status; and some states are doing both.

The movement towards board certification programs started in Texas in 2002. The program from the Texas Healthcare Trustees (an affiliate of the Texas Hospital Association) was expressed solely as a recognition program, and participants were rewarded as Recognized Trustees. A seed had been planted. A few years later, it matured into full-blown director certification programs, launched first by the Tennessee Hospital Association, and in quick succession by the Minnesota Hospital Association.

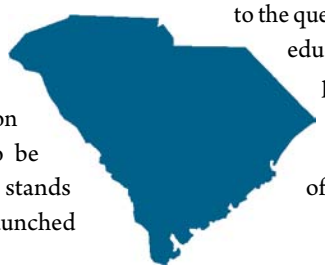
The next critical step was the judicial director training and oversight adopted by New Jersey in 2007, making director education no longer a matter of choice but a matter of law. Developments followed quick and fast. On the heels of the new law, the New Jersey Hospital Association adopted a director certification program, the basic structure of which was modeled on the Tennessee program. Georgia and Minnesota followed suit in 2008, Alabama and Nebraska in 2009, and finally South Carolina and Colorado in 2010. Other states also launched their own director education/certification programs in the same timeframe, though they opted for different approaches, becoming, in effect, mini-laboratories for potential alternatives to the question of director education.

In 2007, West Virginia launched its own program for governance education certification, empowering hospitals with doing their own tracking of director education. Following the Texas model, Washington adopted a recognition program in 2009 to celebrate those directors who chose to educate themselves. Alabama Hospital Association launched its Hospital Trustee Certification, also in 2009, relying on trustees' self-assessment, vetted by the hospital, of their educational efforts. Massachusetts, though, stood alone with a drastically different approach, and this relatively early in the process, in 2007. In close association with Blue Cross Blue Shield of Massachusetts, the state tested and launched a program last year whereby hospitals are paid directly by the insurers for quality of care. Part of that payment is based on directors' participation in education on quality of care and patient safety issues. 12 state hospital associations currently offer director certification or recognition programs: Alabama, Georgia, Massachusetts, Minnesota, Nebraska, New Jersey, Tennessee, Texas, Washington, West Virginia, Colorado, and South Carolina.

Five states offer a board-level certification, officially accrediting the whole board if 100 percent of the directors are individually certified and/or if the board as a whole has exhibited the behaviors and characteristics of a high-performance board. These programs usually allow for the "build-up" time necessary to reach such broad compliance (Tennessee set the bar at 60 percent the first year, with 100 percent over five years). The states with board-level certification are Georgia, Nebraska, New Jersey, South Carolina, Tennessee, and Texas. Texas follows the same approach for board certification as for director certification: it is a recognition program, based on the board's activities in the area of governance. In a slightly different vein, Nebraska examines both the certifications of a board's individual directors, as well as the actions of the board as a whole in its determination of certification.

(See Appendix 1 for more details on the individual state certification programs.)

South Carolina



The South Carolina Hospital Association (SCHA) makes what could seem to be a grand claim—that BOB (which stands for "Best on Board"), their newly launched certification program, brings governance to the next level. Beyond the marketing-speak ("evidence-based measure of board and leadership competency," "imperative and incentives for participation"), BOB seems to be an innovative program.

BOB chooses the more traditional, formal, approach to certification—like the Tennessee model. Board members become certified through a curriculum orchestrated around six governance modules: the role of the board, mission, finance, quality care, CEO relationship, and governance. The education process takes six hours, and certification is good for three years. While none of the program features BOB provides may be ground-breaking by themselves, the program does stand apart for bringing together the most sophisticated elements of the current certification models, and integrating them into a coherent whole.

More importantly, BOB brings with it the financial sweetener of a bonus or reimbursement increase from Blue Cross Blue Shield of South Carolina for those participating hospitals that reach 75 percent certification of their individual members.

As a component of the 2011 Hospital Recognition Program, participating hospitals that have 75 percent of their board members and senior hospital leaders obtain certification by completing two courses (essentials of healthcare governance and quality), will receive some financial support—either a lump sum or an increase in reimbursement—from Blue Cross Blue Shield of South Carolina and Blue Choice Health Plan.

What truly makes BOB stand apart is how it mixes the pay-for-performance feature of the Massachusetts Blue Cross Blue Shield program with the more traditional certification programs, and thus introduces a brand new perspective to healthcare governance. The program just began this year; if successful, it could be considered the best (current) answer to the questions of quality and director education. However, it is also possible that the program's complexity could stretch the already slim resources of hospitals and directors.

Competent & Qualified to Govern

Competent to Govern

The concept of "core competency" (as opposed to individual job-performance competency) was defined and first appeared in the landmark article, "The Core Competence of the Corporation" in the *Harvard Business Review,* 20 years ago.[7] In this article, core competency focused on organizational performance, not individual performance. The concept evolved one step further when Jim Collins, in his now famous book, *Good to Great*,[8] argued that businesses go even further—beyond what makes them good—and focus on "what they can do better than any other organization" in order to "find the path to greatness."

Clearly, competency thinking was never intended to imply mediocrity. It was intended to identify what made businesses and organizations and, later individuals, better and more effective. Notwithstanding this, competency thinking and practice has evolved over the years to mean different things to different organizations: ranging from "easy to measure" checklists for basic job skills and performance, to more sophisticated applications to achieve higher individual and organizational performance. However, for many, confusion still exists. Is competency job knowledge? Is it skills? Is it behavior? Or is it some combination, or all of the above?

Qualified to Govern

For years, shareholders in publicly traded companies have been increasingly concerned about director qualifications, believing that governing boards often do not have directors with enough or adequate industry knowledge. However, on December 16, 2009, the Securities and Exchange Commission (SEC) issued rules that not only require that corporations disclose to shareholders additional biographical information about directors and nominees, but also information about experience, qualifications, or skills that would qualify the directors and the board.

Like Sarbanes-Oxley, the proposed SEC rules only apply to for-profit, publicly traded companies. However, they are nonetheless significant. First, they target the very issues state hospital associations are trying to address through their board certification programs: the pursuit of qualified, competent boards. Secondly, there is likely to be a "spillover" effect, as was the case when both the rating agencies and non-profits throughout the country began to voluntarily adopt various Sarbanes-Oxley standards.[9]

7 C. K. Prahalad and Gary Hamel, "The Core Competence of the Corporation," *Harvard Business Review*, May 1, 1990.

8 Jim Collins, *Good to Great: Why Some Companies Make the Leap… and Others Don't,* HarperBusiness, 2001.

9 See Sean Murphy and Michael Peregrine, "Corporate Governance: A Practical Approach to Governance for Hospital and Health System Boards," *Health Law Handbook* (Gosfield, ed. 2008), p. 226; and Debra E. Blum, "Boards Change Governance Policies in Response to Congress," *Chronicle of Philanthropy*, December 5, 2007.

Chapter 3.
Building a Better Board: Intentional Governance

"The difference between this hospital and [the previous hospital where I served as CEO] is the way the board approaches its work. At my previous hospital, the directors were informed about a problem or issue and went about solving it on the spot. There was no attention paid to or respect for process. The 'solutions' were always knee-jerk. And it showed. The organization was in shambles. In my current institution, the board is driven by process. When an issue arises, the board refers the issue to the appropriate committee to be analyzed and dealt with. Data replaces emotion. Process trumps intuition. Sometimes it seems cumbersome, but the final outcome is almost always the right one. And it has led to better governance."

—CEO, hospital in Upstate New York

"We have met the enemy…." We know all too well how this famous quote ends. Unfortunately, things are no different within the confines of the boardroom, where often efforts to change fail at the door, even if directors know what should be done. There are many factors at play in facilitating change within an organization, any one of which can be powerful enough to derail even the most pressing initiatives. For a board to move from its present state to a high-performing board, it must focus on *intentional* governance—that is, adopting a series of deliberate processes that help the board avoid these issues altogether.

Put simply, if a board is to provide effective leadership to the organization it governs, it must go about its job with the same focus and "intentionality" as it would require of management. Although this proposition may seem somewhat self-evident, it has not been the practice of boards to be diligent about their own work. A board must be disciplined about the processes it puts in place to carry out its work, and measure and assess the effectiveness of its efforts on a periodic basis.

Ironically, proof of excellence is demanded from every facet of the healthcare organization, other than from the governing body. Management is judged in any number of ways ranging from the financial performance of the institution to the quality of care rendered to patients. Physicians on the medical staff are routinely measured, monitored, and peer reviewed. The board must do the same for itself.

This chapter focuses on some common governance challenges related to board structure, dynamics, and culture, and provides some *intentional governance* solutions to alleviating these challenges and/or avoiding them in the first place. Addressing these issues will help individual board members develop their legacies for board service, as discussed in the Foreword. Once the board can overcome these challenges and become accustomed to approaching governance with intention, it can move beyond the conventional and become a highly effective, efficient organism that is essential to the performance of the organization it governs.

How does a board begin the process of focusing on itself and the way it goes about its business as a means to achieve excellence in governance? How does a board learn to operate as a high-performing team rather than a collective group of individuals? This important transformation can only happen by putting in place processes—nuts-and-bolts mechanisms—that guide the work of a board, force it to focus on itself and its own effectiveness, and ultimately impose upon itself true accountability. This takes discipline and diligence. It is ***intentional governance.***

The ultimate goal of intentional governance is to find a way for the board to accomplish more, in more effective ways, in the same amount of time—to work ***better***, not harder.

Intentional Governance Spectrum

Board Recruitment	Board Structure	Board Culture	Education & Development	Evaluation & Performance	Continuous Governance Improvement	Leadership Succession Planning
Organizational needs	Proper size	Clear behavior expectations	Formal orientation	Board assessment	Board mission statement	Written policy statement
Board needs	Committee structure	Encourage robust engagement	Formal board education plan	Committee assessment	Track board performance	Leadership position descriptions
Requirements: training/ education, experience	Board role: clear definition, responsi-bilities/ accounta-bilities	Mutual trust and willingness to take action	Education goals and process to meet goals	Director assessment/ peer review	Evaluate efficiency/ effectiveness beyond annual assessment	Selection criteria
Stakeholder analysis	Distinction between managing and governing	Commitment to high standards	Resource allocation	Commitment to making changes	Continuous process analysis	Identification and development
Community representation	Effective meetings		Certification (?)	Appointment/ reappoint-ment qualifications	Challenge and change culture	Performance evaluation
						Connection to recruitment

Board Recruitment

"It's getting harder and harder to recruit directors—especially younger directors. Young people just don't want to serve. They're too busy or not interested; they have families, both spouses working, demanding jobs and careers, children—and often times elderly parents they have to care for."

—CEO, hospital in Northern New Jersey

The Challenge

Board recruitment is increasingly becoming a challenge; not only in healthcare, but for public and private companies alike. Recent data from the Intentional Governance Survey[10] indicate that 56 percent of respondents believe board recruitment is a challenge. Interestingly, results from focus interviews[11] were even more striking. Not only was board recruitment cited as a "near unanimous challenge" for hospitals and health systems, but also many ranked it as their "single greatest challenge"—especially recruiting "younger directors."

This is significant for many reasons. Most importantly, recruiting new directors for any governing board is essential if we expect hospital and health system governance (as we know it) to exist. Yet, board service (especially for non-profits) is not for everybody, and everybody cannot serve on a board. Focus interviews cited many reasons for this challenge, including concerns about:

1. Time commitments (personal and professional)
2. Liability
3. Conflicts of interest and related issues
4. Service restrictions/limitations (i.e., corporations limiting the number of external boards on which executives may serve)
5. Mission/community benefit/corporatization of healthcare (i.e., concerns that the "modern healthcare system" is becoming more of a business than a community-based, philanthropic organization)

10 The Governance Institute conducted surveys of conference attendees during 2009. Most of the 317 respondents were board members (75 percent), and the rest were a mix of CEOs, executive management, and physician leaders. The Intentional Governance Survey results presented in this chapter refer to the data collected from these surveys.

11 The authors conducted follow-up interviews with about 50 survey respondents (board chairs and CEOs).

Problem People/People Problems

In the context of board recruitment, the first impediment to effective governance is, of course, the people. An organization cannot live without the people inside, and the board, as a smaller structure representative of a larger organization, is also very much an image of the directors comprising the board. Simply because they are elevated to the position of board member does not mean that directors cease to behave in the various ways, positive or negative, that usually characterize them. Specifically, directors can develop behaviors and attitudes in their personal and professional lives that function as adaptive measures, which can be easily integrated or overlooked in a larger organization. However, these behaviors and attitudes reveal themselves with resounding clarity in a much smaller group (i.e., in the boardroom), where they can become disruptive.

How boards handle such people issues, in the small, intimate, and sheltered environment of the boardroom remains a difficult yet critical task. Waiting for the end-of-year member evaluation, if it happens, and if it is timely, still means that the board will be dealing with personality issues for the better part of a year. The primary concern lies in the disparate impact that one individual has on the organization as a whole, by virtue of being "at the top of the organizational chart."[12] The "wrong" member, in the "wrong" position, can easily derail a year's worth of success.

Conversely, lack of assertiveness is as much of an issue as a lack of adherence to social conventions. And if aggressive/disruptive/unproductive behavior is easier to notice and hopefully address, rubber-stamping is a much harder issue that is just as threatening to the success of the board.[13]

The first step in governance evaluation is to determine if the right people are at the table. One way boards can preempt potential people problems is by looking closely at some general qualifications of the members: willingness to serve, time availability, commitment and engagement, ability to step out of their own self-interest, objectivity, intelligence, communication skills, integrity, and values.[14] On this "foundational framework" of social criteria, boards can then overlay a skill-based filter, and a gender/diversity filter, to ensure that they do not recreate a microcosm of their social circle, and end up with a board fraught with people problems due to problem people.

12 Hildy Gottlieb, "Ongoing Board Education: Ensuring Board Members Have the Knowledge they Need," Community Driven Institute/ReSolve, Inc., 2005 (www.help4nonprofits.com/NPLibrary/NP_Bd_OngoingBoardEducation_Art.htm, accessed July 14, 2008).

13 Arkansas Trustee, *The Board's Fiduciary Responsibility*, Fall 2008.

14 Washington State Hospital Association, *Governing Board Orientation Manual*, pp. 6–7, (www.whs-seattle.com/manual/cover.html, accessed Feb. 22, 2010).

Focus interviews also revealed that the challenge of board recruitment is further complicated by the following related and deeply interconnected concepts:

1. **Personal skills:** whether the person is a "good match" for the board (e.g., whether director candidates possess requisite personal and human skills to enhance board performance)
2. **Board composition:** boards do not necessarily have the time, resources, or available talent pool to thoroughly examine/assess whether the people on the board are the right/best people to govern
3. **Board culture:** whether the person is a "good match" for the board

Intentional Governance Solutions

On the one hand, industry pressures and forces are migrating to "higher standards" of governance: that boards be prepared to prove that they are competent and qualified. On the other hand, most hospital and health system directors are uncompensated, often overworked ("under-paid") community volunteers doing the best they can. This is further complicated by the fact that, for many reasons, there appear to be fewer and fewer people who appear interested and willing to volunteer.

However, there is a more compelling argument for the board to be "intentional" with respect to its composition. We believe boards that are deliberate with regard to identifying and acquiring directors with "desired and needed" skill sets will be able to ask better questions. They will be able to provide management with better advice, guidance, and expertise. They will be better able to anticipate problems, future needs, and opportunities that might otherwise go unnoticed—or noticed too late. Finally, they will be better equipped to engage in the essential robust strategic discussions that move the organization forward in accordance with its vision and mission.

The first step in a formal board recruitment process is to identify the organization's needs as a whole (considering the mission, vision, and strategic plan, how the organization is performing against goals, areas of weakness, etc.); then evaluate and monitor its own composition and communicate with directors about retirement and/or other issues (e.g., business or family) that might cause the board to experience a sudden, unexpected shift in composition. Through this analysis, the board can identify the kinds of expertise needed to help the organization meet its goals.

The board should not be looking at a generic "prescription" or list of board member skills and competencies and then attempt to fill the board with those who fit the prescription. Every organization is different and the needs of each organization are unique. The board should take care to focus its recruitment and development efforts by looking at the needs of the organization first.

Next, a high-level stakeholder analysis will help the board identify community members who have the potential to be board members, and determine how to maintain communication with these potential directors. Remember to take into account during this analysis that community hospital boards should represent the communities they serve.

The next step of the process is to overlay the board needs and requirements over the board/director skills and qualifications. This will help drive the twin objectives of board recruitment and board education and development by revealing areas of weakness or "expertise holes" in the board. The board can then assess the best way to fill those holes—through director education and development, and/or bringing in new board members with different skills, depending on the nature and complexity of the issue.

Board Structure: Ownership, Organization, and Control

The Challenge

The structure of the board should fit the needs of the hospital's corporate structure, while giving appropriate weight and credence to governance functions such as succession planning, board education, and so forth. The right structure will allow a board to focus on governing the institution. All too often, however, boards hold on to traditional structures and practices. Given the increasing demands (and scrutiny), and the necessity to streamline governance to accomplish more, faster—well, it's like forcing an Edsel to do the work of a Prius.

Intentional Governance Solutions

In order to keep an eye on the end goal, a board must structure itself so that it can delegate the focused and tactical operations that could otherwise distract from the broader picture. It must be the right size, and research shows that median board size for high-performing hospitals is about 14 board members, and for health systems, 15 board members.[15]

The optimal board structure is one where the board operates through committees, task forces, or advisory councils. This is not an area where one model fits all, however. Every hospital board is unique. This means, mostly, that boards should not be structured along "accepted" lines of accountability, but along what makes specific sense for a specific institution at a specific time. It also means that boards may choose to operate nimbly through *ad hoc* committees or through task forces, or through quasi-individual smaller groups. Flexibility is the key word.

15 Note: The Governance Institute is not recommending one particular board size; organizations must consider their own unique circumstances. The median board size mentioned here is shown in Governance Institute biennial survey data. See, for example, *Governance Structure and Practices: Results, Analysis, and Evaluation,* 2009 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute.

One pitfall in particular that boards must be mindful to avoid is to carry committees beyond the temporal needs that led to their creation. Too often, committees get set up to address a specific need, and end up staying as formed, with somewhat amorphous agendas, because members like to chair committees, and committee members treasure the close relationships and routine tasks to which they have become accustomed. Instead, committees must come and go as they acquire or lose relevancy. Setting up committees for the sake of having committees, organizing an advising board to serve termed-out board members, or creating executive committees because it makes the organization and the directors look larger and more prestigious, are not decisions driven by the exigencies of the organization, but by the self-interest of the board members, and actually hinder the progress of the board.

Managing or Governing?

The Challenge

Whatever form of governance structure they choose, boards must define their role clearly. Are they in the business of leading the organization forward, or are they in the business of ensuring the organization does what it is supposed to do? The difference is momentous in terms of its consequences.

Boards are at the top of the organization, and they know it. But, then what?

Too many boards and board members are engaged in overseeing the details of the programs they put in place—managing—rather than keeping their gaze focused on the big picture and looking at the collective direction that their efforts contribute to—governing. Ineffective boards carry a myopic vision from the committee sub-meetings to the boardrooms, checking all the right boxes but still missing the fact that the train is off the tracks. That is how boards can end up in situations where financial committee reports are presented month after month, showing good control of historical trends and good financial management, but missing the fact that the operating account is empty until there is no choice but to put employees on furlough. Shuttles have exploded for much less.

Intentional Governance Solutions

Effective boards conduct their responsibilities within specific parameters of board responsibility and accountability. Regularly reviewing a checklist of responsibilities will help keep the board on track, and will enhance board–management interactions during board meetings. A checklist may be used as a starting point for discussion. (See Appendix 2 for a sample checklist of management versus governance responsibilities. Remember, every board is unique, so adjustments may have to be made to the checklist for any particular board.)

Non-profit healthcare organizations are different from for-profit businesses, and traditional business experience can carry directors only so far. Directors can easily succumb to the temptation to focus on—and meddle in—matters that are familiar to them, and neglect the imperatives of the organization as a whole.

Key points to consider:

- The very nature of governance "roles" helps boards take strategic approaches to issues rather than focus on operational matters.
- Boards stray into operations and away from policy for two main reasons: 1) they pursue what is most familiar to them, and 2) they lose faith in the CEO.
- Ideally, the board and the CEO have a symbiotic relationship, each being accountable to the other and pursuing the same goals. Optimal organizational performance is a joint endeavor.[16]

Effective Meetings

The Challenge

Governing boards are often ostracized for "spend[ing] more meeting time in passive mode, listening to reports and conducting routine business, than they do actively discussing substantive matters of policy or organizational strategy."[17] With the recent influx of board accountability and expectation, it is imperative that boards reassess their current status quo with an eye for efficiency and aspirations to govern well.

Intentional Governance Solutions

It may be time to scrap the traditional monthly, two-hour board meeting and consider longer but less frequent board meetings. The point is not to allow for more reporting from management, but rather to allow more time for discussion and strategic questioning—with each board member participating to his or her fullest in the give-and-take on key issues.

Some object that with the increase in board work, boards should meet more frequently, not less frequently. However, focused work is better than possibly rushed and interrupted work, and an efficient committee structure and schedule, as well as routine communication from the organization's CEO and board chair, ensure that issues aren't "lost" between meetings.

16 Elements of Governance®: *The Distinction between Management and Governance,* The Governance Institute, 2006.

17 Barry Bader, "The right stuff, the right way: 10 ways to improve board meetings," *Great Boards,* Winter 2005 (www.greatboards.org/pubs/Ten_Ways_to_Improve_Board_Meetings.pdf, accessed February 22, 2010).

Effective Board Meetings

Possibly the most basic constraint for effective governance relates to the increasing time demands placed on directors. It's just difficult for board members to devote the time needed to fulfill their responsibilities as directors. But time is not the sole issue. Often, board meetings themselves lack the requisite structure, or meaningful purpose, to provide for productive outcomes. As discussed above, board meetings are often highly consumed by monotonous tasks, unworthy of such intelligent conglomerations. Such confining influences often inhibit discussions of pertinent and/or unforeseen events.

Since the board's meetings may very well be the only means of communication between its members, it is critical that all members are well informed and prepared for the same. Each meeting must be driven by an appropriately structured agenda so directors can assess the areas for discussion, the order of relevance, and the predicted time allotments.[18]

Members should also be provided with comprehensive information packets on all areas of discussion prior to the meeting. These packets should be read and digested prior to all gatherings, with some even suggesting that "at a minimum, board members should receive the following prior to a board meeting: agenda, minutes from the previous meeting, topic reports or information summaries, additional background reading, and concise summaries with clear recommendations and that specify clearly the board action required."[19] This is because *informed* members are more likely to be *interactive* participants.

To encourage member attendance, meetings should be at convenient times and locations, of which members are notified well in advance. The meetings may be mapped out and distributed each calendar year to most effectively ensure total attendance. As stated earlier, attendance is an important aspect of keeping all members up-to-date, informed and involved. Finally, boards should set aside time at the conclusion of meetings to evaluate the productivity, and discuss the potential for improvement and change. Such recommendations will effectuate a continuous process of critique and growth, essential to the board's future productivity.[20]

18 Bader, 2005.

19 Healthcare Trustees of New York State, *Boardroom Basics: What Every Healthcare Trustee Needs to Know*, 2008 (http://htnys.org/training/boardroom_basics/docs/boardroom_basics.pdf, accessed February 22, 2010).

20 Bader, 2005.

Culture: It's Larger than Life

The Challenge

Perhaps the most critical aspect of governance is also the most elusive to define, measure, and create. It is culture, variously defined as "the way we do things around here," or "the way people behave when no one is looking." Organizational culture is a mix of an organization's formal rules and rituals, its espoused values (behaviors it professes), and its values in practice (behaviors it demonstrates and rewards). Like their organizations, boards have a culture too.[21]

How does one define a board culture that promotes success, and distinguish it from the culture that prevents success?

It is important to emphasize that having effective processes does *not* ensure the board has an effective culture. For example, keeping track of attendance at meetings, conducting board self-assessment retreats, focusing on governance as a separate line item at each meeting—all these steps might convey the message that governance is real and here to stay. Assuming the organization has recruited the right people for the board, various board and personal dynamics also may be seen as a proxy for an effective culture.[22] These processes are necessary but do *not* sufficiently address the issue of culture.

Here are a few examples of a dysfunctional board culture:[23]

- **The board is dominated by an individual**. When a board is dominated by the chair, CEO, or a board member, chances are:
  - » Board members may be reluctant, or worse yet, discouraged from actively participating.
  - » Board members effectively abdicate their fiduciary responsibilities.
  - » Cliques form and meetings take place outside the boardroom.
  - » The checks and balances needed for effective governance are eliminated.
- **Board members do not feel qualified to offer their perspective**. Board members lacking healthcare experience may not feel qualified or are intimidated from offering their perspective. Some suggest that not only are there no dumb questions, but that all board members should be required to ask at least one question. The board, board chair, and CEO want and need each member's perspective.
- **Board chair and CEO are buddies**. If the chair and CEO are too friendly, chances are:
  - » The board sees itself as a rubber stamp for decisions already made.
  - » Open and candid discussions may be stifled.
  - » The roles of the CEO, board chair, and individual board members are blurred.
  - » Board members may withdraw from participation.

Intentional Governance Solutions

Intentional governance necessitates intense examination of the board's culture and practical steps to rectify problems and/or consolidate gains. Much is covered in this publication about the working of the board and the effectiveness of board processes, but unless you have a culture that supports the active and independent participation of every member, nothing else matters.

Intentional governance necessitates intense examination of the board's culture and practical steps to rectify problems and/or consolidate gains.

Lawrence D. Prybil, a University of Iowa professor and healthcare governance expert, compared governance structures, practices, and aspects of culture in high- and low-performing health systems.[24] Prybil found that boards in high-performing systems exhibit "three dimensions of board culture" and nine specific behaviors under these dimensions:

Robust engagement

- Board meetings are characterized by high enthusiasm.
- Constructive deliberation is encouraged at board meetings.
- Respectful disagreement and dissent are welcome at board meetings.
- The board is actively and consistently engaged in discourse and decision-making processes. Most board members are willing to express their views and constructively challenge each other and the management team.

Mutual trust and willingness to take action

- The board's actions demonstrate commitment to our organization's mission.
- The board tracks our organization's performance (financial and clinical) and actions are

21 Barry Bader, "Culture: The Critical but Elusive Component of Great Governance," Special Commentary in *Governance Structure and Practices,* The Governance Institute, 2009.

22 Rex P. Killian, J.D., "Health System Governance: Board Culture," *BoardRoom Press,* December 2007, The Governance Institute.

23 *Ibid.*

24 Lawrence Prybil, Ph.D., et al., *Governance in High-Performing Community Health Systems: A Report on Trustee and CEO Views,* 2009.

taken when performance does not meet our targets.
- There is an atmosphere of mutual trust among the board members.

Commitment to high standards
- The board systematically defines its needs for expertise and recruits new members to meet these needs.
- Board leadership holds board members to high standards of performance.

"Assessing and improving a board's culture is not nearly as straightforward as making changes to board size, committee structure, written policies, or meeting frequency, but without a commitment to the development of an active and responsible governance culture, changes in the rules and rituals of governance are likely to have a minimal effect on board performance. On the other hand, talking first about the kind of culture the board wants to create and then designing structures, policies, and practices that will facilitate development of that culture can be a much more effective way for a board to continually improve itself."

(From Barry Bader, "Culture: The Critical but Elusive Component of Great Governance," Special Commentary in *Governance Structure and Practices*, The Governance Institute, 2009.)

Shaping and changing board culture is difficult but worth the effort. Sometimes the board needs to get rid of directors who do not reflect the values the governing body wishes to reflect. Board leadership can shape the culture by demanding that the behavior of all directors conform to the board's values. Leaders must stimulate discussion by encouraging participation and by soliciting different points of view. The atmosphere in the boardroom must be one that encourages directors to ask the tough questions without fear that the questions they ask are "dumb" questions. This is particularly true with new directors. Directors must be encouraged to be persistent and ask their questions a second or third time if they are not satisfied with the answer.

The culture must encourage dissent and avoid false consensus. Rather, *true* consensus must be forged.

Board Education and Development

"I know some states are requiring board education for hospital trustees and that other states have board certification programs. Maryland has nothing! I'm concerned that we're not doing enough. That's why I've decided to start our own board education program. This way we can show our community that we're doing this, even though it's not required."

—Board Chair, Maryland Hospital

The Challenge

Board education: most boards are already doing it, and frankly, many are doing it well. The Intentional Governance Survey indicated that 80 percent of respondents believe they have an effective ongoing board education program; yet, ironically, 80 percent also indicated that they would benefit from a more comprehensive

education program. Moreover, 87 percent felt that ongoing board education would enhance board performance.

In some respects, the Intentional Governance Survey says it all. Many CEOs and hospital boards are currently spending countless hours learning about healthcare, hospitals and health systems, and governance. Yet, the complexity and demands of the industry are unending. Specific challenges with respect to board education include the following:

1. **Model:** there is no single standard (educational model) or curriculum for board education. This is not to suggest that there should be; however, there appear to be wide variations of practice with respect to board education, and concern by some board members that they not only need "adequate training and education," but that it should be documented.
2. **Budget:** again, there are wide variations in board education budgets, ranging from zero to $75,000 a year.
3. **Time:** education takes time, a precious commodity for many board members. For some, the real challenge is trying to "juggle" their oversight function and obligations with education.
4. **Culture:** whether the hospital (management and the board) respects the importance of education—an informed board, a board in the dark, or a "rubber stamp."

Intentional Governance Solutions

Board education needs to start the very first day a member joins the board. Board members should learn about and be oriented to the industry, the hospital/health system, the community, and the other board members.

As discussed in Chapter 2, the proliferation of state hospital association board certification programs is a sign of the growing importance of formal board education. Data from the Intentional Governance Survey support a growing concern that board education not only occurs, but also that it should be documented in some formal way. Specifically, 86 percent of respondents indicated that formalizing—and tracking—board education would be beneficial.

For a board to govern with intention, board education must be more than a periodic event. It must be an integral part of the board's mission, purpose, and agenda; not an idea or plan that gets dusted off annually. This will not be easy, especially when one considers the many pressing industry and operational issues that boards and directors face on a daily basis. And like any other agenda item, board education and development must be measurable, and measured. This is part of the overall evaluation that boards need to conduct, of their members and of themselves.

As a part of intentional governance, board education needs to be deliberate, planned, and appropriate. The board should be committed to a formal board education plan that includes everything on the education spectrum from orientation, certifications, seminars, and board retreats to inclusion on and integration with the board meeting agenda. The complexity and demands of this industry require nothing less.

Evaluation and Performance

"We conduct an annual board assessment, but that's where it ends. I would have a very hard time doing much more than that—at least now. These guys devote a lot of time to this place and they're not paid a dime. It's not easy asking someone to volunteer their time only to turn around and criticize them. On the other hand, things have to change. If we don't dig deeper and start giving each other meaningful feedback about our performance, we're going to wind up losing our best directors."

—Chairman of the Board, health system in Pennsylvania

The Challenge

Performance evaluation (both individual board member assessment and conducting a full-board self-assessment) is a fundamental governance responsibility. Research from The Governance Institute shows that it is consistently a low-scoring area for most boards as far as adoption of and performance in recommended practices for board evaluation.[25] Performance evaluation needs to timely, meaningful, and include an action plan for improving areas of weakness identified through the evaluation process.

25 The Governance Institute's 2009 Biennial Survey results showed that overall performance in the area of board self-assessment and development scored 3.74 on a 5-point scale, the second lowest score of the six core responsibilities and three fiduciary duties. Previous surveys (2007, 2005) showed similar results. See *Governance Structure and Practices* (The Governance Institute, 2009).

The Intentional Governance Survey shows that a staggering 83.9 percent of respondents feel that "the board would be more effective if members were given feedback about their performance, either annually or upon reappointment." Beyond individual performance, a similarly high percentage of respondents (83.1 percent) report that tracking "board performance would help the organization respond to increasing attention, scrutiny, and the demand for accountability."

Effective board and director evaluation is one of the great challenges of high-performing governance. Specific issues include:

1. **Culture/internal resistance:** for a board member, there is a tension inherent in being an unpaid volunteer and having to go through the process of performance evaluation.
2. **Standards:** There are no standards or requirements for individual director assessment; though there are accreditation standards and third-party tools for the full board assessment.
3. **Implementation:** Much of the most important feedback that directors can receive is "subjective" (i.e., related to behaviors). It takes leadership and skill to implement processes that enable the board to give meaningful feedback that will result in meaningful change.

Intentional Governance Solutions

Board evaluations can be effective tools that shed light on the collective performance of the board as a whole. Board assessment needs to be methodical, balanced, and fair. Intentional governance requires that this examination be done on an ongoing basis, and that there be "real commitment to making appropriate changes as a result." (See the sidebar on self-awareness for more information on individual board member assessment.)

First, board assessments must be formal, in writing, with clear and neutral evaluation of the different dimensions of governance, of management, and of effectiveness. Preferably, a committee should be charged with structuring the evaluation process, and selecting an evaluation tool that is statistically valid and reliable.[26] Likewise, the committee should help to evaluate the data and integrate it into the "continuous governance improvement" loop (discussed below).

Second, and most importantly, the assessment must lead to action. Action should include not only feedback, but essentially it should also include opportunities for director and board improvement (e.g., board education and development). Board self-assessment is the baseline—the point at which the board must begin. It must feed forward into continuous governance improvement, standards, and structure, and planning for the future of the board itself.

Self-Awareness

The popular initiative in governance today is performance measurement—especially individual board member performance measurement. Yet, for many members, such performance measurement does not belong in an environment of volunteerism. "I should give up my family time, my money, and my best efforts, and on top of it, be judged?" Such are the unspoken thoughts that the specter of individual performance evaluation raises. The feeling that measurement should be strictly reserved for the people getting paid is subtly emphasized by governance literature on this issue.

Individual board member performance evaluation can be used effectively to highlight areas of strength and weakness—both of which the individual may be unaware. Like the peer review process for physicians, individual director performance evaluation should be considered a routine component of board service, and should be spearheaded by the governance committee or, in the absence of this committee, by the board chair. (See Appendix 3 for a sample individual board member assessment.)

26 It is highly recommended that boards use a third-party evaluation tool that has been tested and verified for effectiveness, such as The Governance Institute's BoardCompass®.

Continuous Governance Improvement

"I went to a governance seminar that talked about restructuring meeting designs to allow for more education and more time to talk about vision, goals, performance, and the industry itself. So I brought this up at a meeting. Specifically, I suggested that we hear fewer committee reports and that we rely more on our dashboards. Several committee chairs became defensive and aggravated—especially the chair of the finance committee, who responded, 'Do you mean to tell me that we should not be spending time looking at our financial statements with the shape we're in?' I tried to convey that most of the important financial information is already on our dashboard and that there is no need to duplicate the process. We could use a 'special finance report' to address any serious financial concerns. The finance chair became increasingly irate at these suggestions. In the end, nothing changed. I'll tell you in confidence—I'm resigning from the board at the end of the year. I'm just going to say that I am too busy with other obligations. I don't have time for this."

—Board Member, hospital in Ohio

The Challenge

Continuous governance improvement assumes that the board is mindful of itself, its governance function. Yet, governance process and practice is rarely a board agenda matter. Many boards assume that governance is an outcome. Hence, many boards seem to focus more on their oversight functions and outcomes than their own functions and processes.

Is it time to do things differently? Fifty-seven (57) percent of respondents to the Intentional Governance Survey agreed their meetings would be more productive if they concluded with a meeting evaluation.

Likewise, another 83 percent thought that documentation or tracking of board performance would help their organization "respond to increasing attention, scrutiny, and the demand for accountability." Yet, are boards ready to add to their responsibilities? Change what they are doing? Stop doing "what has worked" for many years?

Boards need to evaluate their own processes in the same manner and with the same vigor that they evaluate the hospitals and health systems that they are charged to govern. Challenges include:

1. **Inertia:** Gravity has a way of keeping us from doing things differently, from taking on the challenge of change.
2. **Lack of model or mandate:** Boards have neither a systemic model nor mandate to perform regular and ongoing governance improvement.
3. **Metrics:** No uniform method of measurement.
4. **Culture:** Boards that are change-averse will find this very unsettling.

Intentional Governance Solutions

Boards need a process that will enable them to regularly evaluate their effectiveness—beyond the annual self-assessment. Intentional governance means the governing board takes time to assess everything it does. The board regularly asks questions that are critical to its performance:

- Are our meetings effective?
- Do we have the right information that we need to govern?
- Is our board organized and structured properly?
- Are our committees organized and operating effectively?
- Are we accountable stewards of our community assets? Can we prove it?

Fortunately, healthcare boards already have experience in this area. Continuous process analysis and improvement is not a foreign concept to hospitals and health systems; notably, it's a common component of the hospital's quality program. Likewise, board members who work in business and industry are also familiar with the many varied continuous quality improvement programs and initiatives that exist.

In this era of increasing accountability and transparency, boards must incorporate this concept into their own culture: the ability to validate its practices and processes, using objective and subjective tools. If the board has evidence or otherwise believes that its processes are less than effective, it needs to evaluate, construct (or de-construct, as the case may be), and change.

In order to do this, the board must be cognizant, mindful, and aware of its essential purpose. It can do this by establishing its own *board* mission statement—a concise description of the board's essential purpose in protecting and benefiting the organization it governs. After that, it should describe and define the necessary functions it must perform to achieve its underlying mission. Finally, the board needs to implement processes to carry them out.

Board Leadership Succession Planning

"He had been a long-time board member—he served over twenty years. He was a successful businessman and a large donor. He believed in the hospital and his heart was in the right place. But he was narrow-minded, argumentative, talkative, and he lacked necessary leadership skills—people skills—that were needed to build consensus or recruit [new directors]. He wanted to be the chairman and the board felt it had no choice. No one stood up to him. These were five of the worst years of my life. Now he's gone, and I'm stuck trying to rebuild my board. The entire thing… was a disaster."

—CEO, hospital in Montana

The Challenge

Now that all of the previous governance challenges have been tackled with intention and your board is functioning at its peak potential, the final challenge of securing new board leaders—long before the current leaders rotate off the board or out of leadership positions—must be added to the intentional governance spectrum to close the loop.

Most hospitals and health systems have a medical staff development plan—a process to evaluate the number of physicians, specialist mix, and ages of physicians to ensure that "major clinical gaps" are filled and that there is an orderly, planned approach to manage "physician succession planning" (i.e., hospital/health system plans to recruit and replace older, retiring physicians).

It has also become an accepted practice for large corporations to engage in CEO and management succession planning; however, board leadership succession planning has largely been ignored. Meanwhile, the Intentional Governance Survey indicated that 81 percent of respondents believed their hospital or health system would benefit by having formal policies and procedures for board leadership succession planning.

Challenges include:

1. **Time and resources:** proper succession planning requires the identification of a selectable pool of potential candidates, and the screening of those candidates in terms of skills and organizational fit. Recruiting for a board is not the same as recruiting for a job. Therefore the "interview process," for lack of a better phrase, cannot be conveniently compressed into a matter of hours and weeks. It must be an ongoing process, led by all board members, through meetings, conversations, social interactions, and complemented by an active search for people presenting the right skill mix and/or diversity mix—people who may not even know yet that they are candidates. The investment in time and resources is significant.
2. **Mandate and culture:** of course, there can be no investment in the time and resources from the board without a mandate from the current leadership. The fact that board leaders are already in place can instill a sense of complacency where replacing them is concerned. Thus, succession planning may be difficult unless there are clear guidelines from the board as to the length of time each individual member can serve in a leadership position.
3. **Governance:** as mentioned above, a strong succession planning function is the outcome of all preceding governance functions. Success in this area is unlikely if there are other significant gaps in the intentional governance spectrum (e.g., lack of intentional plans for board recruitment, board development, board assessment/performance measurement, and continuous governance improvement).

Intentional Governance Solutions

Board leadership succession planning is essential to protect the corporation from potential upheaval in the event a key board member leaves, either suddenly or through the normal process of retirement and attrition. Moreover, leadership succession planning is the final link on the chain of proper governance; hence any deficiencies in the other internal governance functions discussed in this chapter only exacerbate issues of leadership succession planning.

Essential elements of board leadership succession planning include:

- A written policy statement
- Leadership position descriptions
- Selection criteria
- Leadership identification and development (partnering/mentoring programs, etc.)
- Leadership performance evaluation

Governing boards need to be intentional throughout the spectrum: from board recruiting to leadership succession planning. The governing board should have an idea about when board leaders contemplate (or may be contemplating) leaving the board (for whatever reason) so that the board can effectively identify new members in advance of their departure, in order to continue the vital governance leadership continuity loop.

Conclusion

The importance of overcoming the governance challenges described in this publication point directly to the increased public attention and emphasis being placed on not-for-profit hospital and health system boards. Healthcare is at the forefront of the minds of the American public and has been for over two years, as we prepare ourselves for the imminent changes of health reform legislation. Studies on the effects of the board's oversight on quality of care are showing not only improved quality of care, but also stronger connections between the performance of the governing body and the overall performance of the organization.[26] The research on governance effectiveness will continue, and through the search for these connections, leaders will continue to seek concrete pieces to complete the elusive, high-performing governance puzzle.

We are convinced that an effectively constituted board is essential to the success of a healthcare organization. This publication has attempted to provide boards with a strong, solid foundation to clear the way for them to deal with what truly matters for their organizations: the delivery of high-quality patient care to the communities and people they serve.

The intentional governance spectrum is a starting point, so the board can "get its own house in order" and therefore govern the institution more effectively. Boards should carefully review the processes and solutions included in this spectrum, and compare those with the board's current processes and practices, to see where there is room for change and improvement. By doing so, boards have the opportunity to overcome countless, significant barriers.

The healthcare industry continues to increase in complexity and thus the responsibilities and challenges of the governing body continue to grow. We hope that through intentional governance—deliberate and intentional processes addressing board structure, dynamics, and culture that enable the board to realize its highest potential—boards will see that they have *more* time to govern more effectively. That they can work *better,* not harder, and build a legacy of continued success for their organizations, which are vital to their communities and to our society as a whole.

26 See, for example: *Quality* (signature publication), The Governance Institute, 2006; Joanna Jiang, Carlin Lockee, and Irene Fraser, "How Hospital Governing Boards Enhance Quality Oversight: An Application of the Agency Theory Perspective," conference paper, International Conference of Academy of Innovation and Entrepreneurship, Beijing, July 2009.

Appendix 1.
State Board Certification Program Details

			Certification Process	Requirements	Standards
ALABAMA (2009)	Alabama Hospital Association	The Alabama Hospital Trustee Certification Program	• Hospital submits the interest form to AlaHA • AlaHA sends Trustee Certification Checklist to hospital • Trustee to complete all items on checklist by year-end • Checklists certified by the hospital CEO and board chair • Final Hospital Certification to AlaHA • Certificates are valid for one year	**CHECKLIST** Trustees must complete the assessment each year.	Participation, basic knowledge, continuing education, and other skill sets vital to effective governance. AlaHA Trustee Resource List provides information on various governance resources: • *Trustee* magazine • AHA News, AHA News Now, Hospitals and Health Networks • Books & other publications: » *The Excellent Board* (Books I and II) » *Getting to Great* (best practices) » *Better CEO-Board Relations* (advice on CEO recruitment, compensation, communication, and the chair–CEO relationship) » *A Great Board: Building and Enhancing Non-Profit Boards* (nine benchmark principles) • Web sites: » Trustee and Community Leadership » AHA's Center for Healthcare Governance » American Hospital Association » Board Source » Joint Commission » Hospital Compare » Institute for Healthcare Improvement » National Quality Forum

			Certification Process	Requirements	Standards
GEORGIA (2008)	Georgia Hospital Association	Georgia Hospital Trustee Community Accountability Education Certification Program	Signed attestation by the board chair, hospital CEO, and the individual trustee, that he/she has: • Completed a minimum amount of education on healthcare and leadership topics • Met or exceeded the requirements of trustees as outlined in the hospital's bylaws and other relevant governance documents	Base certification: 12 hours coursework first year (8 hours potential AP credits) Re-certification 8 hours yearly (4 hours face-to-face every 2 years)	Lectures • Board Structure • Building an Exceptional Board: Effective Practices for Healthcare Governance • Disruptive Governance: The Board's Role in Leading Change • Boardroom Basics: Roles and Responsibilities of Hospital Boards • Strategy—A Board Member and Trustee Perspective • Board Self-Assessment and Evaluation • CEO Evaluation and Succession Planning • The Hospital Board's Role and Responsibility to the Community • Strengthening Ethical Wisdom: The Four Disciplines of an Ethical Board • Understanding and Interpreting Hospital Financial Reports: Tools for Trustees • Engaging Physicians in Enduring Relationships: Recapturing the Common Ground • The Hospital Board's Role and Responsibility for Quality and Safety • Bioterrorism/Pandemic Flu/Emergency Preparedness • What Board Members Should Know about Information Technology Face-to-face programs • GHA Annual Membership Meeting (approximately 8 hours) • GHA Annual Trustee Conference (approximately 8 hours) • GHA Regional Forums (approximately 1.5 hours) • GHA Annual Summer Meeting (approximately 6 hours) • GHA Center for Rural Health Annual Meeting (approximately 9 hours) • AHA Center for Healthcare Governance Annual Meeting • AHA Center for Healthcare Governance Trustee Community Accountability Program • AHA Annual Membership Meeting
			Hospital/Full Board Certification Written statement to GHA that the organization's entire board has annually adhered to governance standards		Yearly requirements 1. Each board member has met the requirements for trustee certification 2. Hospital shows a commitment to trustee certification with annual budget for trustee education 3. Demonstrate a commitment to care management and coordination of resources 4. Give examples of community accountability and transparency 5. Give examples of community benefit and outreach programs to meet identified needs 6. Utilize data from the GHA State of Health Data Report to identify and address areas of need especially for the uninsured and underinsured 7. Integrate local health efforts with state programs 8. Include a report on quality and safety at each regular board meeting 9. Provide D&O insurance for hospital trustees and indemnify trustees for legal actions

			Certification Process	Requirements	Standards
IOWA (2010)	**Iowa Hospital Association**	**Trustee Education Certification for Iowa Hospital Governance**	• Notice of intent to participate • Completed TEC Standards form verified by the hospital board chair and CEO • Completed forms submitted to IHA for approval • Recognition of certified trustees at annual IHA Governance Forum	Basic level: • Complete all items listed under basic standards • 12 hours of trustee education for certification and re-certification • Hospital orientation process recognized to satisfy some requirements Advanced level: Complete basic and advanced standards	Core curriculum for all Trustees/Basic Standards • Board roles and responsibilities • Fiduciary duties of care, loyalty, and obedience • Characteristics of a high-performing board member • Board role in quality • Board role in strategic planning • Board role in medical staff relations • Hospital payment and finance • Federal and Iowa hospital laws and regulations • Public hospital requirements • CEO evaluation • Board self-assessment • Environmental assessment and healthcare trends Advanced Governance Standards • Governance best practices • Characteristics of a high-performing boards • Conflict management and resolution • Micro-governance vs. micro-management • Disruptive board members • Board development • Grassroots advocacy • Community benefit • National healthcare trends

			Certification Process	Requirements	Standards
MASSACHUSETTS (2008)			Two programs: • Pay-for-performance measures for quality oversight by boards • One-year grant program to further trustee quality oversight	Governance curriculum funded by BCBS of MA	Six levers of responsible governance: • Mission • Culture • Performance • Leadership • Strategy • Allocation Pay-for-performance plan: Bonuses tied to governance, staggered over three years • First year: bonus if at least 75% of board members attend classes on quality improvement. • Second year: boards must create a quality improvement plan that identifies three quality or safety gaps. • Third year: governance plan to eliminate five quality or safety gaps and the board must link the CEO's performance evaluation to quality improvement. One-year grant program: Hospitals receive $50,000 and must provide $25,000 in matching funds

			Certification Process	Requirements	Standards
MINNESOTA (2006)	Minnesota Hospital Association	Board Certification for MHA Trustees		• 12 EUs in Principles of Effective Governance • 8 in Strategic Planning and Positioning • 4 in Fiduciary Duties • 4 in Board Development and Self-Assessment • 4 in Quality/Patient Safety • 3 in General	• Principles of Effective Governance • Fiduciary Duties • Strategic Planning and Positioning • Board Role in Quality/Patient Safety • Board Development and Self-Assessment

			Certification Process	Requirements	Standards
NEBRASKA (2009)	Nebraska Hospital Association	Hospital Trustee Community Accountability Education Certification Program	Signed attestation by the board chair, hospital CEO, and the individual trustee, that he/she has: • Completed a minimum amount of education on healthcare and leadership topics • Met or exceeded the requirements of trustees as outlined in the hospital's bylaws and other relevant governance documents	• Six hours per year • Mixed direction as to whether these come from roster offered in 2009 • Certification form holds program similar to that of New Jersey/Tennessee	SECTION I: Basic standards of board involvement SECTION II: Meeting the fiduciary duties of care, loyalty, and obedience, and governance obligations to bylaws, accreditation standards, and laws. A. Ethics and conflicts of interest B. Commitment to quality of patient care C. Commitment to the organization's financial health SECTION III: Commitment to governance educational development SECTION IV: Participate in performance evaluation of self, the board, and the CEO SECTION V: Participate in advocacy efforts on behalf of your hospital and healthcare in Nebraska

			Certification Process	Requirements	Standards
NEW JERSEY (2007)	New Jersey Hospital Association	Trustee Certification	Complete all basic standards; CEO signature; Trustee Council approval Advanced level: complete basic and advanced standards; CEO signature; Trustee Council approval	New board members certified within two years Board certification: 100% board certified	Basic standards of board involvement • Meeting the fiduciary duties of care, loyalty, and obedience, and governance obligations to bylaws, accreditation standards, and laws. • Ethics and conflicts of interest • Commitment to quality of patient care • Commitment to the organization's financial health • Commitment to governance educational development • Participate in performance evaluation of self, the board, and the CEO • Participate in advocacy efforts on behalf of your hospital and the healthcare industry Advanced Certification • Board and committee meetings • Quality of patient care • Governance educational development • Advocacy efforts on behalf of the hospital and healthcare industry

			Certification Process	Requirements	Standards
SOUTH CAROLINA (2010)	South Carolina Hospital Association	Best on Board (BOB)	• Certificate of completion, in effect for three years • Course can be completed in person or online	Three levels of certification: Level One/Essentials • Essentials of Healthcare Governance course • Online test (score of 75% required) • Seasoned participants can take test only Level Two/Advanced • Completion of at least one Level Two course (Finance, Quality, or Leadership) • Online test (score of 75% required) Level Three (board leadership) • Completion of Level Three board/ leadership team activities	Level One • Essentials of Healthcare Governance course • Six one-hour modules: » The role of the board » Mission » Finance » Quality of care » CEO relationship » Governance Level Two • Three courses with more in-depth learning » Finance » Quality » Leadership Level Three • Currently under development • Interactive group learning experience
			Two programs: • Pay-for-performance measures for quality oversight by boards • One-year grant program to further trustee quality oversight	Governance curriculum funded by Blue Cross/Blue Shield of SC	Pay-for-performance plan: Hospitals that have 75% of their board members and senior leaders certified will receive financial support in the form of a lump sum or increase in reimbursement.

			Certification Process	Requirements	Standards
TENNESSEE (2006)	Tennessee Hospital Association	Governance Certification for Tennessee Hospital Trustees and Boards	Complete all basic standards; CEO signature; Trustee Council approval Advanced level: Complete basic and advanced standards; CEO signature; Trustee Council approval	New board members certified within two years Board certification: 100% board certified	Basic standards of board involvement • Meeting the fiduciary duties of care, loyalty, and obedience, and governance obligations to bylaws, accreditation standards, and laws » A. Ethics and conflicts of interest • Commitment to quality of patient care • Commitment to the organization's financial health • Commitment to governance educational development • Participate in performance evaluation of self, the board, and the CEO • Participate in advocacy efforts on behalf of your hospital and healthcare industry Advanced Certification • Board and committee meetings • Quality of patient care • Governance educational development • Advocacy efforts on behalf of the hospital and healthcare industry

			Certification Process	Requirements	Standards
TEXAS (2002)	Texas Healthcare Trustees	Texas Academy of Governance	The Texas Academy of Governance recognizes trustees, hospitals, and health systems that meet Academy standards. Trustees Texas governing board members of hospitals, health systems, and health related organization boards are eligible to become a Recognized Trustee for a period of two years. Hospitals Texas hospitals and health systems are eligible to become a Recognized Hospital/Health System for a period of three years. Academy recognition of a hospital does not convey recognition to individual board members.	Supporting documentation can include: • Personally signed statements • Attendance records • Newspaper articles • Board meeting minutes • Governance education certificates of attendance • Resume • Letters or statements from your hospital CEO or board chair • Records of offices held • Copies of board agendas	Trustee Standards • Commitment to hospital and community • Commitment to meeting the fiduciary duties of care, loyalty, and obedience, and governance obligations in bylaws, accreditation standards, and laws • Commitment to governance educational development • Adherence to conflict-of-interest policies • Participation in self, board, and CEO performance evaluation • Board meeting preparation

			Certification Process	Requirements	Standards
WASHINGTON (2009)	Washington State Hospital Association	Governing Board Orientation Manual	The 2009 Governance Education Task Force Report recommended against WSHA engaging in an activity to certify the quality, content, or competence achieved by hospital and association-led continuing board education.		Best Practices commitment • Hospital boards are autonomous in determining the most suitable governance education • Each hospital is encouraged to have a structured, long-term board education plan that demonstrates the hospital's commitment to board competence and effectiveness. • Each hospital governing board is encouraged to have a policy declaring the board's commitment to high-quality board orientation and education and stating the expectations of board members' participation. • Each hospital governing board is encouraged to develop a board assessment process. • Each hospital governing board is encouraged to evaluate its performance periodically. • Each hospital is encouraged to have a budget for governance education. • Each hospital is encouraged to establish a process to document board member participation in governance education.

			Certification Process	Requirements	Standards
WEST VIRGINIA (2007)	West Virginia Hospital Association	Governance Resource Manual	From Annual Meeting 2007: The session focused on the roles and responsibilities of hospital trustees and was highlighted by the introduction of the association's voluntary trustee certification program. Currently under development, the program is designed to assure core competencies of hospital board members in this era of greater public accountability (www.wvha.com/media/5%20quicklinks/AM/SnapShotAM2007.pdf). (No mention in Annual Meeting 2008)	The West Virginia Hospital Association has developed tools for hospitals within the state to document and demonstrate their compliance with the "certification" process.	Software is available at www.wvha.org, under the Hospital Governance Resources. The program enables individual trustees to record their attendance at educational programs in which they may have participated, and also provides a Microsoft spreadsheet for hospitals to record their Trustees' compliance by educational topic. While the state grants wide discretion to its hospitals and their trustees in determining which trainings are appropriate, it strongly encourages the hospitals to carefully record the educational attendance of their trustees. Such information is to be entered into the spreadsheet provided, by persons appointed "tracking and recording coordinators" by the hospital systems. Coordinators will receive accurate information from the individual trustee education records, from those trustees called on by the CEO to participate in the process. The completed spreadsheet is to be e-mailed to the WVHA, where it will be compiled into a statewide report.

Appendix 2.
Management vs. Governance Sample Checklist

Overall Direction (Mission, Vision, Values)	Governance	Management	Both	Recommended*
Revise mission, vision, values				G
Determine annual goals				G
Monitor progress on goals				G
Determine strategies to achieve goals				B
Recommend policy				M
Approve policy				G
Implement policy				M
Change bylaws				G
Employ outside consultants (counsel, financial, etc.)				B
Ensure compliance with regulations				B
Strategic Planning				
Develop strategic plan				B
Approve strategic plan				G
Approve strategic plan budget				G
Approve deviations from strategic plan				G
Finance				
Approve annual operating budget				G
Approve capital budget				G
Approve deviations from operating budget				G
Approve deviations from capital budget				G
Approve senior management travel budget				M
Board Effectiveness				
Prepare and administer a board self-assessment program				G
Prepare and approve a board orientation program				B
Recommend changes in board composition				G
Recruit new board members				B
Quality of Care				
Recommend criteria for credentialing				M
Approve criteria for credentialing				G
Recommend quality indicators				M
Approve quality indicators				G
Establish standards for quality of care				G
Monitor quality improvement program				B

* G = The responsibility of the board.
M = The responsibility of the CEO/executive management.
B = The board and CEO/management share the responsibility.

Management	Governance	Management	Both	Recommended*
Hire CEO				G
Specify CEO performance expectations				G
Develop CEO annual goals				M
Prepare CEO transition/succession plan				B
Evaluate CEO				G
Operations				
Assess organizational problems and suggest solutions				M
Hire Director of Nursing				M
Approve a raise for Director of the Emergency Room				M
Approve revisions in nursing career ladder				M
Terminate contract with health insurance carrier				B
Approve professional recruitment strategy				B
Secure a strategic alliance/merger				B
Approve expansion of a program				B

Source: Elements of Governance®: *The Distinction Between Management and Governance,* The Governance Institute, 2006.

Appendix 3.
Sample Individual Board Member Assessment Questionnaire

Contextual Dimension			
The Board Member:	**Yes**	**No**	**Needs Improvement**
Understands and supports the organization's mission and vision			
Reinforces the organization's values			
Is guided by the organization's mission, values, and culture in his or her decision making			
Educates himself or herself regarding:			
The healthcare industry			
The organization's institutional structure			
The organization's local market			
Key factors that contribute to the success of the organization			

Strategic Dimension			
The Board Member:	**Yes**	**No**	**Needs Improvement**
Develops a knowledge and understanding of the organization's strategic plans			
Is a visionary, projecting the role of the organization based on current social, economic, and political developments five to ten years into the future			
Anticipates and articulates both possible threats to the organization's survival and potential opportunities for gain			
Supports and empowers the CEO and management team			
Promotes and participates in the development of senior executive succession plans			
Identifies both potential problems/solutions and organizational weaknesses/strengths			

Analytical Dimension			
The Board Member:	**Yes**	**No**	**Needs Improvement**
Develops a knowledge and understanding of the types and quality of the organization's programs and services			
Reviews and remains informed about the organization's budget and financial condition as presented in financial statements and other supporting documents			
Approaches issues from a broad, impartial, and institutional perspective			
Analyzes all aspects of multifaceted issues prior to voting			
Asks questions, raises doubts, and encourages the expression of differing opinions when discussing issues and proposals brought before the board			
Considers the concerns and interests of all stakeholders in the organization			
Is willing to challenge management in a constructive manner			
Respects his/her fellow board members and the integrity of the governance process			
Promotes a collegial and collaborative working relationship with the medical staff			
Represents the organization to external constituencies and the interests and concerns of external constituencies to the organization			
Has contributed to the achievement of the organization's mission as a result of his/her service on the organization's board			

Educational Dimension			
The Board Member:	**Yes**	**No**	**Needs Improvement**
Understands the roles and responsibilities of a board member			
Distinguishes between his or her role as a board member and the role of management			
Seeks opportunities for trustee education and leadership development			
Educates himself/herself regarding the legal requirements and stipulations under which he/she acts as a trustee			
Educates himself/herself regarding the accreditation and regulatory standards with which the organization must comply			
Has successfully served on other boards or has sat in on the meetings of outside, similar boards			
Possesses the skills and attributes necessary to assume the board chair position, or is willing to serve as an understudy for a new board role			

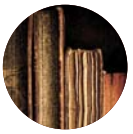
Board Member Practices			
The Board Member:	**Yes**	**No**	**Needs Improvement**
Offers his or her professional expertise when appropriate			
Does not monopolize the board's time or deliberations			
Attends, prepares for, and participates in board meetings			
Actively participates in board committee work			
Assumes a fair workload with his or her colleagues			
Is available outside meetings to act as a sounding board for the CEO or to advise management			
Participates in the evaluation of the CEO			
Does not get involved in the daily operations of the organization			
Is willing to be a mentor to newer board members			
Regularly attends hospital and/or health system functions			
Identifies potential candidates for board membership			
Offers appropriate agenda items			

Personal/Interpersonal Dimension			
The Board Member:	**Yes**	**No**	**Needs Improvement**
Fosters a sense of collaboration and cohesiveness among fellow board members			
Maintains objectivity regarding his or her comments and those of others during deliberations			
Respects the confidentiality of board deliberations			
Avoids conflicts of interest and readily discloses any potential conflicts of interest			
Demonstrates composure and resilience in times of crisis			
Has demonstrated achievement in a chosen profession			
Possesses integrity and a professional demeanor			
Is creative			
Is pragmatic			
Understands and carries out his or her fiduciary responsibilities of loyalty, care, and obedience			

Note: *You may choose to use a different method of rating such as "does well" or "excellent, good, fair, and poor." Choose the method that best suits your needs, especially if you customize the template. Provide a section for comments as well.*

Source: Elements of Governance®: *Individual Board Member Assessment* (2nd Edition), The Governance Institute, 2010.

References



Center for Healthcare Governance and Health Research & Educational Trust., *Competency-Based Governance: A Foundation for Board and Organizational Effectiveness*., Washington, D.C.: Center for Healthcare Governance, The American Hospital Association, February 2009.

Collins, Jim. *Good to Great: Why Some Companies Make the Leap… and Others Don't.* New York: HarperBusiness, 2001.

The Governance Institute. Elements of Governance®: *The Distinction between Management and Governance.* San Diego: The Governance Institute, 2006.

Healthcare Trustees of New York State. *Boardroom Basics: What Every Healthcare Trustee Needs to Know.* New York: Healthcare Trustees of New York State, 2008.

Lawrence Prybil, Ph.D., et al. *Governance in High-Performing Community Health Systems: A Report on Trustee and CEO Views.* Chicago: Grant Thornton, LLP, 2009.

Lockee, Carlin, M.P.H. *Governance Structure and Practices: Results, Analysis, and Evaluation,* 2009 Biennial Survey of Hospitals and Healthcare Systems. San Diego: The Governance Institute, 2009.

Lockee, Carlin, M.P.H. and Kathryn Croom. *Quality* (Signature Publication). San Diego: The Governance Institute, 2006.

"The Medical Model of Governance." *Health Law Handbook* (A. Gosfield, Ed.). Eagan, MN: Thomson West, 2009.

Moody's Investors Service. *Governance of Not-for-Profit Healthcare Organizations,* Special Comment. New York: Moody's Investors Service, 2005.

Panel on the Nonprofit Sector. *Principles for Good Governance and Ethical Practice: A Guide for Charities and Foundations*. Washington, D.C.: Panel on the Nonprofit Sector, October 2007.

Peisert, Kathryn C. Elements of Governance®: *Building a Comprehensive Board Orientation Program*. San Diego: The Governance Institute, 2008.

Washington State Hospital Association. *Governing Board Orientation Manual* (2nd Edition). Seattle: Washington State Hospital Association, 2006.


XX%
FSC
Mixed Sources
Product group from well-managed forests, controlled sources and recycled wood or fiber
Cert no. XXX-XXX-XXX
www.fsc.org
© 1996 Forest Stewardship Council