BoardRoom Press

A Bimonthly Journal of News, Resources, and Events for Today's Healthcare Boards

THE GOVERNANCE INSTITUTE ■ VOLUME 31, NUMBER 1 ■ FEBRUARY 2020

GovernanceInstitute.com

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Leadership, Boards, and the Hard Job of "Soft" Skills

Building an Effective Enterprise Cyber Risk Management Program

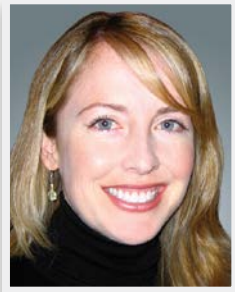
SPECIAL SECTION

Rethinking the Governance of Public University Teaching Hospitals

Assessing and Renewing Board Governance

ADVISORS' CORNER

Employee Engagement: What Is the Board's Role?



Time Is Not on Our Side

Our lead article of our first issue of the new decade emphasizes that change and transformation take time, unless it is forced upon us. It is true that change shouldn't be rushed into and that sustaining change requires a deeply thoughtful approach to changing an organization's culture and habits from the ground up. The board plays a critical role in this endeavor.

We see hospital-based organizations working against the clock to try to chip away at advancing outpatient, ambulatory, and mobile health strategies. We know healthcare leaders are aware of the changes that need to happen, and many are making changes to their senior management teams, organizational structures, and strategies in order to address these changes. What we don't see are requisite changes at the board level. Our 2019 biennial survey of hospitals and healthcare systems was published in January, and the data shows that over the past decade, while organizations are striving to make the right changes to deliver value-based care, their boards are still doing the same activities with the same kinds of skills. The majority of change that has taken place over the past decade to prepare for success with value-based payments and population health management are to add new goals to the strategic plan. Boards have not added more physicians or nurses (in fact that number is diminishing). Boards are not focusing on recruiting new members with "second curve" competencies (the top skill being sought in new board members remains a financial background). Very few boards are regularly assessing the performance of individual members, or keeping a current executive leadership succession plan. Most importantly, boards are only spending about a third of their meeting time discussing and making decisions on strategic priorities of the organization. Changing strategic goals to incorporate value-based care and population health targets is a strong first step. But we believe that boards need to do more, change more, in order to help their organizations truly transform.

Kathryn C. Peisert, *Managing Editor*

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Leadership, Boards, and the Hard Job of "Soft" Skills

By David C. Pate, M.D., J.D., FACP, St. Luke's Health System

In healthcare today, executives must learn both the "hard" and "soft" leadership skills needed to effectuate cultural change. As boards look to develop internal leaders for succession purposes or interview external candidates to fill a CEO vacancy, they will better ensure the success of the new leader if they select the candidate based on an assessment of these soft skills.

David C. Pate, M.D., J.D., FACP
Immediate Past President and CEO
St. Luke's Health System

The hard skills that we learn academically—finance, accounting, marketing, operations, business law, human resources, mergers and acquisitions, etc.—and practice daily to run the organization, are foundational. Soft skills are becoming even more important for leaders but are not often part of a healthcare professional's training. These skills differentiate a mediocre leader from a great one, or sometimes a successful leader from an unsuccessful one. Leaders who succeed in the CEO role often do so because they possess these soft skills.

Soft skills consist of, among other things, effective communication; holding others and oneself accountable; building, developing, and leading teams; emotional intelligence; vision; inspiring others; integrity and empathy; listening; and leading people through influence rather than authority.

These abilities are not easily taught, but they are telling. Whether leaders possess soft skill competencies is often apparent to the staff of the organizations they lead.

Numerous examples exist of leaders lacking soft skills who, demonstrating little insight into their own failings, have caused tremendous turnover in their leadership ranks and nearly driven their organizations to ruin.

Examples of leaders who have demonstrated a command of the soft skills are just as readily available. John "Jack" Lynch III, FACHE, President and CEO of Main Line Health in Bryn Mawr, Pennsylvania, is one such leader. When I worked for him, he made an effort to get to know everyone, regardless of how much pressure he was facing. People felt he genuinely cared about them. He has assembled great teams of leaders and led his organizations to great heights.

One can often judge the strength of a leader by the strength and longevity of his or her leadership team. Soft skills make the difference between a leader others work for and a leader who others want to work for and follow.

Transformational Leadership

Leading people through change requires the use of such soft skills as vision, communication, and trust. If people are going to follow you through times of change, they must see where they are going, understand why change is needed, and trust you will guide them to a better place.

It is also true that no matter how many soft skills are brought to bear, there are likely to be holdouts. Not everyone will be willing to support a movement in the direction of substantial change. It is human nature to want to hang on to what you know, can control, and can predict. In the case of big bets, fear of change can prove risky. Before you decide to commit fully to a change, it is essential to ensure your stakeholders are engaged with and aware of the need for the transformation.

In 2017, St. Luke's Health System, in Boise, Idaho, placed 34 percent of its revenue under global risk agreements, its first step toward providing value-based care. This gained the attention of the market and the organization's physicians and employees in a way that simply dabbling in value-based arrangements could never have achieved.

Faced with an imperative to transform, healthcare organizations must adapt quickly and not retreat from change. Unfortunately, many organizations end up retreating, and when leadership waivers, management resists. When management resists, boards get cold feet and great team members leave.

St. Luke's made its transformation after years of planning while still operating under a fee-for-service reimbursement model. This enabled the system to compensate for early losses from risk arrangements.

With fee-for-service reimbursement now declining, a possible result is that many health systems will resist changing their business models until they are forced to by the losses they will experience under fee-for-service. By that point, they will be pressured to change without the benefit of having years to plan and prepare or the ability to offset early losses under a value-based care model with ongoing fee-for-service reimbursement. That could lead to a downward financial spiral for some organizations.

Thankfully, that is not St. Luke's story. Although it has not completed its shift to a value-based environment, it is well on its way, thanks to the fantastic team of executives, a supportive board, thousands of dedicated employees, and the system's amazing physician partners behind this successful transformation.

Soft skills are the differentiators between satisfactory leaders and great leaders, especially in times of change. They can be taught to some extent, but it is essential for young leaders to have

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Key Board Takeaways

Boards at healthcare organizations undergoing transformation optimally support leadership and the team by understanding that:

- When leaders do succeed, it is often due to the presence of "soft" skills.
- Transformational leadership can be the hardest of all forms of leadership, unless the change is forced upon you. Otherwise, change takes time.
- Getting people to change requires setting a clear vision, a case for urgency, an outline of how to get there, and communication. Leaders must be prepared to tell the story repeatedly and in different ways.
- Trust, hard work, and relationships are essential to success. People have to trust leaders, and leaders have to work hard to develop and maintain relationships. They are what you will fall back on when times get tough.
- Board and executive team alignment is critical.

Building an Effective Enterprise Cyber Risk Management Program

By Bob Chaput, Clearwater

The CEO of a large, national ambulatory surgery center organization once told me, "Taking care of our patients' information is just as important as taking care of our patients." His commitment to information security served as a touchstone for his organization as they built their enterprise cyber risk management (ECRM) program.

A robust, proactive ECRM program is your organization's best defense against cyber attacks. In the first place, if executed properly, an ECRM program will minimize the risk of an incident occurring. But if/when a cybersecurity incident or data breach does occur, an effective ECRM program can help shield you and your organization from claims of negligence or willful neglect.

In a best-case scenario, you would be able to defend yourself and your organization by honestly and unequivocally communicating the following points:

- Our board has been and is proactively engaged in ECRM.
- Our board has adopted and communicated strong governance principles that require a risk-based (not checklist-based) approach to ECRM.
- Our executive team is responsible and accountable for ECRM and we have formed a cross-functional team of leaders across the organization to execute our ECRM strategy.
- We have adopted the National Institute of Standards and Technology (NIST) Cybersecurity Framework and use it as the basis for our ECRM program.
- We have implemented the internationally recognized NIST process for ECRM (NIST Special Publication 800-39 and NIST Special Publication 800-37).
- We engage with our liability insurance brokers on a regular basis to inform our cyber risk-transfer and risk-retention decisions.
- To ensure progress and continuous process improvement of our ECRM program, we monitor all changes in our program, measure our program maturity annually, and execute continuous improvement plans.
- In recognition of the dynamic nature of cyber risks, we conduct ongoing risk analyses and execute risk management plans to ensure any risks we accept are below our risk appetite.

> With the mass digitization of healthcare and the explosion of electronic healthcare data, systems, and devices, the ability to protect the confidentiality, integrity, and availability of patient information is critical to your organization's success.

Some of these statements might not be meaningful to you at this point. That's okay. The goal, drawing on my professional experience, is to give you the understanding and actionable information needed to be able to establish or improve your organization's ECRM program. When you have implemented the steps I outline in this article, you will be able to make the statements above, with the confidence and knowledge that you have put into action a program that meets accepted standards of care for managing cyber security risk, protecting your patients and organization from cyber threats.

Key Board Takeaways

The following questions will help you think about the terms and concepts referenced in this article and how they might be applied in your organization:

- Has your organization's C-suite and/or board discussed and agreed upon a common set of definitions related to cyber risk and cyber risk management?
- Have these definitions been documented in your organization's ECRM strategy and communicated throughout the organization via ECRM training?
- Has your organization already, or is it currently, conducting ongoing, rigorous, comprehensive, enterprise-wide risk analysis that would meet the Office for Civil Rights' expectations?
- As C-suite executives and board members, have you discussed, debated, and established your cyber risk appetite?
- If your organization has conducted a risk analysis, are you using the results of that analysis to inform your cyber risk treatment decisions?
- Do you believe the C-suite and board are fully exercising their leadership, oversight, and fiduciary responsibilities with respect to ECRM?

The Bottom Line

Information is literally the "lifeblood" of your healthcare organization. Especially today, with the mass digitization of healthcare and the explosion of electronic healthcare data, systems, and devices, the ability to protect the confidentiality, integrity, and availability

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Rethinking the Governance of Public University Teaching Hospitals

By Larry S. Gage, Alston & Bird LLP and Alvarez & Marsal

Most public universities with medical schools own their primary teaching hospitals, which typically are multi-faceted academic medical centers (AMCs) that provide a wide range of complex specialty patient care services, conduct substantial amounts of basic and clinical research, and serve as the principal training sites for graduate and undergraduate medical education, as well as for nursing and other medical specialties. The governance and legal structure of public university AMCs take many different forms across the country. For over 50 years, public universities that own or operate AMCs have engaged in a quest for the "optimal" governance structure. That quest has never been more important than it is today, when public universities are confronted with major challenges to their future success and viability. As a result, many public universities have recently been revisiting past governance reforms and rethinking their governance structure.

A substantial majority of public universities with medical schools built or acquired teaching hospitals over the course of their existence, in support of what has come to be known as the classic "tripartite mission" of research, education, and patient care. As early as the 1970s, many public universities sought to identify the most effective structure for governing their hospitals, which often led to restructuring and even divesting their AMCs.

This article explores the origins of the restructuring trend, offers examples of the governance structures adopted and new strategies being pursued, and provides lessons learned from these recent efforts to revisit and further reform the governance and legal structure of public university hospitals and health systems.

Origins of the Restructuring Trend

Starting in the mid-20th century, public universities initially began to distance themselves from their hospitals by pursuing a strategy of restructuring or privatization of the governance and legal structure of their hospitals.[1] From the outset, there were several underlying forces behind this trend. The enactment of Medicare and Medicaid had greatly expanded the resources available to fund patient care for the poor and the elderly, but medical schools feared that reimbursement under these government programs would be inadequate to support the full cost of AMCs.

The introduction of Medicare GME payments in the late 1970s and the creation of other supplemental payment programs like Medicare and Medicaid disproportionate share hospital (DSH) payments in the 1980s partially eased these concerns but did not fully eliminate them. As subsequent legislative battles have clearly shown, what the government giveth the government can taketh away, and universities were concerned about insulating themselves from potential future losses in their expensive teaching hospitals. This may seem quaint today, when so many AMCs are doing well financially, but the concern at the time was very real.

Restructuring also had the potential benefit of relieving public university teaching hospitals of many of the bureaucratic pressures that fed those fears of future losses. State and public university civil service requirements were often inflexible and hampered the ability of AMCs to recruit and retain high-achieving faculty physicians and administrators. Procurement constraints that were perhaps suitable for a university's English department proved to be burdensome and slow for AMCs. The ability of some public AMCs to raise capital to improve or replace major teaching hospital facilities or acquire state-of-the-art equipment was hampered by the limited ability or willingness of states or public universities to incur the necessary debt. At the same time, public university AMCs were faced with most of the same challenges that confronted private universities, which often had more flexibility to address them.

Efforts to reform the governance and legal structure of public AMCs picked up steam in the 1980s, with a significant

Key Board Takeaways

Board members of public university AMCs should:

- Recognize that perhaps the most difficult leadership challenge involves changing organizational behavior and culture. Leaders are usually adept at recognizing external threats, but not so facile in changing the needed behaviors to meet these threats. To do so requires transformational leadership and a deep introspective analysis of each institution's ethos, strengths, weaknesses, and, importantly, what unique contributions each institution can make to improve health and well-being.
- Constantly educate themselves about the rapid changes in clinical care delivery and finance so that their governance structure can optimize the ability of the AMC to operate nimbly in a highly competitive market, while ensuring alignment of education and research activities with the clinical care enterprise.
- Focus on the importance of system-wide integration and coordination of the major components of their AMCs—including hospitals, clinics, faculty practice plans, and medical schools.
- Pay careful attention to the flow of funds between and among the various components of the AMC clinical enterprise. The cross-subsidization model, whereby research and education are supported by clinical income, is under substantial pressure in today's healthcare industry.
- Appreciate that hospitals cannot be considered in isolation; the governance structure must facilitate coordination of all components of the clinical enterprise (inpatient hospitals, outpatient clinics, and faculty practice plans). Importantly, the most effective governance structure is one that advances the "virtuous cycle" of academic medicine, which recognizes that high-quality clinical systems attract the best faculty, staff, and students, which in turn strengthens the education and research programs, further enhancing clinical care delivery.

1 Larry Gage, "Why Do Public Teaching Hospitals Privatize?", Book chapter from *The Privatization of Health Care Reform: Legal and Regulatory Perspectives*, Oxford University Press, 2003.

Trends Affecting AMCs

Recent efforts by public universities to rethink the governance and legal structure of their AMCs have been undertaken in response to a range of trends and challenges that are currently facing all AMCs, whether public or private:

- Despite efforts to "repeal and replace," health reform has dramatically changed the healthcare landscape.
- Many elements of health reform that require system integration and governance reforms have already been implemented and most of them cannot be undone, since they have been adopted by Medicare, many state Medicaid programs, and private insurers/employers.
- The overall trend is toward closer alignment through standardization of management and governance within large, integrated systems.
- Increased benefits flow to those clinically integrated networks that engage in system-wide collaboration to reduce costs, redesign patient care, and improve quality and patient experience.
- Changing career goals of students/residents require new models of multi-disciplinary education.
- In addition to the need for new information systems, there has been a revolution in communication technology for physicians, medical schools, hospitals, and (perhaps most profoundly) patients.
- Substantial variation in practice patterns and costs across the U.S. health system will provide opportunities to those who can get ahead of the curve in identifying and implementing best practices.
- Narrow networks created by payers have increasingly sought to exclude high-price AMC providers from their networks.
- Additional trends likely to affect the AMC include potential future reductions in important Medicare and Medicaid supplemental payments, the demand for greater transparency over quality metrics, accountability for population health, the shift from fee-for-service to value-based payment methodologies, and the deinstitutionalization of hospital care.
- Many services previously provided to patients on an inpatient basis will be outpatient services in the future (or have already become outpatient services), such as chemotherapy, knee/hip replacements, spinal fusion, cardiac catheterization, and appendectomies.
- The current AMC model relies on funding streams likely to diminish in the future as a result of these trends, putting sustainability in question without reforms.

number of public universities (as well as other public teaching hospitals owned and operated by cities, counties, and other governmental agencies) converting their teaching hospitals to other governance structures. As **Exhibit 1** on the next page indicates, "privatization" or restructuring took many different forms. Some public universities were content with creating advisory boards within the university structure, while others transformed their teaching hospitals into semi-autonomous governmental entities such as authorities, created new freestanding non-profit corporations, or sold to or merged with existing non-profit systems. On occasion, some state universities even transferred their teaching hospitals to for-profit companies.

Examples of the various governance structures adopted by public university AMCs in the 1980s are summarized below.

Governance Structures Adopted by Public University AMCs

Advisory or Operational Board within the University

While most AMCs convene a range of committees, the creation of a simple advisory board with limited operational powers and duties has rarely been thought of as "reform" by university-based AMCs. Nevertheless, some universities do maintain such boards.

The University of Michigan Regents, for example, delegate certain powers to a Hospitals and Health Centers Executive Board, while making clear on the board's Web site that "the Regents are ultimately responsible for establishing the mission, goals, and objectives of the hospitals and health centers, and for the quality of medical services provided at UMHHC." The Michigan board, which is composed almost entirely of university personnel, meets monthly.

Recent changes to other advisory boards, such as at the University of California and the University of Washington, are discussed later.

Authorities

A number of state university AMCs have restructured as quasi-independent authorities. In some cases, as with the University of Colorado, legislation was enacted to create an authority only after the University was unable to implement a private non-profit model due to litigation and public controversy. The University of Colorado used its semi-autonomous authority structure to build an entire new campus on the grounds of a former military base, as well as to support more recent governance reforms.

State universities transferring hospital governance to authorities or other quasi-governmental structures included the Medical College of Virginia, Kansas University, and the University of Wisconsin. The authority structure was attractive because it was, in effect, a "designer" option. While the authority structure enables a university to create a dedicated governing board of independent members with a needed range of skills and experience, the university's regents or trustees (and/or the state governor) could retain control over board appointments. Authorities are typically created under dedicated state laws that can specifically grant powers to their governing boards, such as the ability to create their own personnel and procurement policies and systems, buy and sell property, incur debt, and enter into partnerships or ventures with private entities.

Newly Created Non-Profit Corporations

Hospital authorities do not necessarily address all the governance concerns that have led public universities to reconsider their legal structure and governance. They are still government entities subject to potential bureaucratic constraints. For these reasons, a substantial number of public universities went beyond this step, creating new freestanding non-profit corporations. The Universities of Maryland, West Virginia, Florida, Arizona, Nebraska, Vermont, and the Medical College of Georgia all took this additional step.

In some cases, universities similarly privatized their faculty practice plans,

Exhibit 1: Examples of Public University AMC Governance

No Separate Board	Advisory Board*	Hybrid Board with Some Delegated Powers	Newly Created Non-Profit Fiduciary Board**	Merger with Existing System with Fiduciary Board***
• SUNY System • UT Medical Branch • UT Southwestern • MD Anderson • U Kentucky • U Virginia • U Illinois Chicago	• U California • U Washington • U Michigan	• U New Mexico • U Vermont • Georgia Regents U • U Florida Gainesville • VCU • MUSC • Ohio State • Kansas University Kansas City	• U Maryland • U Wisconsin • U Alabama-Birmingham • U Nebraska • UT Tyler • Texas Tech • UPMG • U West Virginia • U Florida Jacksonville	• U Colorado • U Minnesota • U Arizona • New Jersey (Rutgers; UMDNJ) • UT Tyler • UMass Memorial • Kansas University Topeka

* The UC Board of Regents reconstituted its existing health services committee by adding four independent, non-voting health industry experts to serve in an advisory capacity; the committee retains a number of delegated powers and duties with respect to the UC Health system. UW Medicine recently disbanded a quasi-fiduciary board and replaced it with a purely advisory board.

**Independent freestanding authority, taxing district or non-profit corporation.

***Public university AMC owned/operated by private non-profit or for-profit system.

Source: Table compiled by Larry Gage, Alston & Bird LLP.

creating new non-profit (and occasionally for-profit) corporations to provide clinical care to patients. Initial boards of these new corporations were appointed by the universities and, in some cases, the universities retained control over future appointments and reappointments. (Other boards became more self-perpetuating after the initial board was selected.) Linkages were maintained with such newly created corporate entities through contracts and agreements that set out requirements for teaching, research, and funds flow. These agreements also called for financial support for the medical school, which can take several forms—lease payments, academic support payments, "Dean's taxes," etc.

The University of West Virginia created a non-profit corporation in order to build a new major teaching hospital for its medical school, and the Medical College of Georgia spun off its hospitals and clinics into a non-profit system in order to insulate the college from potential financial risk in a state with a weak Medicaid program.

The University of Maryland's non-profit corporation (UMMS) was created in 1984 by the state of Maryland to assume responsibility for the University of Maryland's hospitals and clinics.[2] While UMMS is technically a non-profit corporation, the system includes substantial public assets and programs, including the state-owned hospitals and clinics of the University of Maryland and a hospital system formerly owned and operated by Prince George's County, Maryland. The system has subsequently acquired several smaller hospitals around the state and has also assumed responsibility for the three-hospital system owned by Prince George's County. In 2019, due to the discovery of major conflicts of interest among board members of the University's non-profit corporation, the Legislature formally disbanded the existing board, replacing it with a new board that will be seated in 2020.[3]

The University of Florida created the non-profit Shands system in the early 1980s and subsequently acquired non-profit teaching hospitals in Jacksonville and several other smaller communities in the northern part of the state. (While Shands Gainesville still exists as a non-profit system, in recent years it has seen its autonomy eroded; it has severed its ties with its Jacksonville affiliate and entered into joint ventures with a hospital company to operate some of its smaller facilities.)

Merger with Existing Non-Profit or For-Profit Corporations

Another group of public universities went even further in privatizing their hospitals, by selling them to (or merging them with) pre-existing private non-profit or for-profit corporations. Early examples included the University of Massachusetts (UMass Memorial Heath), the University of Cincinnati, Indiana University, the University of Minnesota, and the University of Oklahoma.

The University of Massachusetts has merged successfully with a non-profit system to create UMass Memorial Health Care in central Massachusetts, and the University of Minnesota sold its university hospital to the non-profit Fairview Health Services (now known as M Health Fairview).

This model is by no means limited to state university AMCs. Private universities like Georgetown, George Washington University, St. Louis University, Tulane, and Creighton have all sold or otherwise transferred their hospitals to other non-profit or for-profit systems. Conversely, some of the most prominent non-profit AMCs have expanded their networks by acquiring or affiliating with other hospitals across their region and in some cases around the country. They include Partners HealthCare, Johns Hopkins Health

2 Larry Gage, "Bad Governance: How to Fix It (or Better Still, How to Avoid It)," *Public Focus,* The Governance Institute, June 2019.
3 *Ibid.*

System, and Mayo Clinic, among others. hbm nnnnn

Recent Trends: The Quest Goes On

In sum, over a half-century of public teaching hospital restructuring initiatives has led to a wide range of governance structures across the country for such hospitals. In the last several years, however, many universities have begun to question their previous steps, pursuing new strategies. These strategies are intended to promote better integration and alignment of all the key components of what Steven Wartman, M.D., Ph.D., the immediate Past President of the Association of Academic Health Centers, and others have called the "virtuous cycle" that underlies the AMC's tripartite mission (see **Exhibit 2**).[4] Recent trends in further restructuring AMC governance have stemmed in part from a broader recognition that each of the components of this virtuous cycle must work together in an integrated fashion in order for all of the elements of the tripartite AMC mission of education, research, and clinical care to succeed.

The State University of New York (SUNY) operates four medical schools and three AMC campuses, with no separate governing body apart from the SUNY Board of Trustees. SUNY convened a Task Force on Hospital Governance in 2019 to recommend potential governance reforms for the university's AMCs. SUNY had previously convened no fewer than four different commissions or task forces to consider governance concerns, dating back to the mid-1980s. (The current task force report is expected to be received by the SUNY Board of Trustees in the first quarter of 2020.)

Wartman, who is a member of the 2019 SUNY task force, has written that "the traditional tripartite missions of education, research, and patient care can no longer be seen as ends in themselves. Rather, they should be a means to fulfill the mission of improved health and well-being of their communities as efficiently as possible...Recalibration of teaching, research, and patient care requires realignment—it will be a test of leadership because there are barriers at every level, including leadership, faculty, staff, governance, economics, and politics."[5]

Other public universities that continue to operate their teaching hospitals directly without fiduciary or even advisory boards, have taken to heart the desirability of at least some oversight and guidance from independent board members. Following a study by the Rand Corporation,[6] the University of California health system (UC Health, which is composed of six medical schools and five hospital AMC campuses) developed an expanded health services committee under the Board of Regents that includes several prominent independent healthcare industry experts.

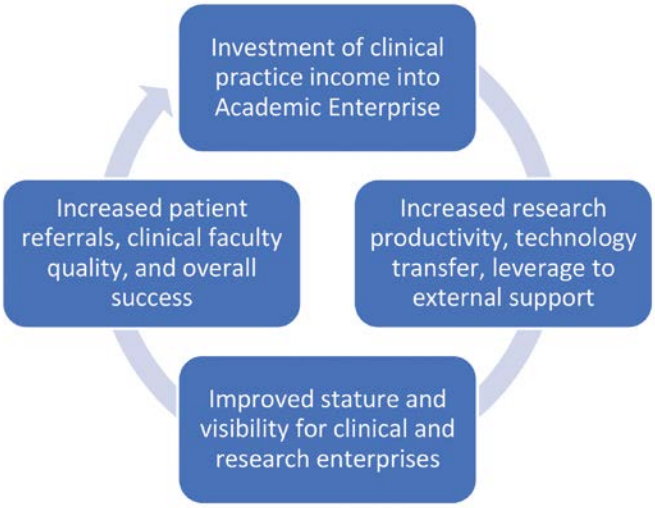
The new, expanded health services committee was delegated a number of specific powers and duties, in

Asking the Right Questions

The 2019 SUNY Hospital Governance Task Force asked itself "What questions should we be asking?" They answered this as follows:

- What governance model best preserves the important contributions of the clinical enterprise (hospitals, faculty, and other elements) to support the tripartite mission of SUNY?
  - » Financially?
  - » Academically? (ability to recruit faculty, students, residents, fellows, etc.)
  - » Research?
- What model best supports SUNY AMCs in achieving competitive dominance?
- What governance model gives each SUNY AMC the tools and support needed to succeed in its own market?
  - » Together, as a statewide system?
  - » To develop national/international centers of excellence?
- What model best incentivizes SUNY AMCs to achieve "best in class" operational and financial efficiencies?
  - » Address current civil service and HR constraints?
  - » Procurement constraints?
  - » Ability to partner effectively with non-governmental entities?
  - » Timely decision-making process?
- What model best supports the integration and alignment of hospitals, physicians, and other providers and SUNY medical (and other) schools that is the requisite standard for high-performing AMCs today?

Exhibit 2: Virtuous Cycle



Source: A.S. Levine et al., "The Relationship between the University of Pittsburgh School of Medicine and the University of Pittsburgh Medical Center—A Profile in Synergy," *Academic Medicine*, September 2008.

4 Steven A. Wartman, "Toward a Virtuous Cycle: The Changing Face of Academic Health Centers," *Academic Medicine*, September 2008.
5 Steven A. Wartman, "Academic Health Centers, The Compelling Need for Recalibration," *Academic Medicine*, December 2010.
6 Ramya Chari et al., "Governing Academic Medical Center Systems: Evaluating and Choosing Among Alternative Governance Approaches," *Academic Medicine*, February 2018.

order to permit it to address a range of identified concerns:[7]

- The system is facing a highly competitive industry characterized by declining reimbursements, rapid consolidation, unpredictable policy environment, and growing patient/payer expectations.
- The new environment requires creative solutions, scale, system integration, agility, and rapid strategic growth.
- The current administrative and operational structure hampers and often prevents the development of these system changes required by the new environment.
- Many of the current systems and procedures with which the health system copes were designed for a policy and market era that no longer exists.
- The length of time from idea to plan to program is far too long.
- The deliberate speed at which the system can hire staff at market-level compensation, as well as its ability to prudently contract and execute initiatives, is being diminished at a time when its competitor systems face no comparable limitations.
- Systems around it are growing larger, more competitive, and aggressive in the pursuit of its people, patients, and ideas.
- The proliferation of mergers and alliances makes it clear that system size, solid financial performance, and increasing emphasis on quality and accountability will be the key variables for continued success.

Rand Corporation researchers identified seven criteria for evaluating UC Health's governance structures:

- Timeliness and efficiency of decision making
- Ability to provide strategic guidance
- Ability to take advantage of system-level efficiencies
- Ability to maintain alignment across the triple mission
- Responsiveness to local (market or community) conditions
- Expertise (among board members)
- Feasibility (or the costs and perceived risks of transitioning to a new governance system)

However, other observers have pointed out that "many of these criteria will have different meanings depending on whether they are applied to the specific governance of an individual AMC or to the overall governance of a system of AMCs...As in many other endeavors, it depends on the people and culture of the institutions."[8]

> "Academic medical centers must embrace profound, meaningful changes to time-honored, treasured, and now increasingly ineffective and unaffordable ways of carrying out our missions."
>
> *—Mark Laret, CEO, UCSF Medical Center and UCSF Benioff Children's Hospital, University of California Center for Health Quality and Innovation's 2013 Spring Colloquium*

Rethinking Earlier Governance Reforms: A "New Wave" of Restructuring

Similar efforts to rethink AMC governance at other public universities have led to a new wave of governance reforms. As at SUNY and UC Health, those universities without a separate governance structure have sought to create new options, while other universities have sought to reintegrate the components of their AMCs and otherwise reassert control of both the hospital and practice plan.

This apparent reversal of prior privatization trends is due in part to the success of many public university AMCs. For one thing, well-managed public university teaching hospitals (like many of their private sector AMC counterparts) have turned out to be very profitable entities—often serving as the tertiary or quaternary anchor of entire regions. These AMCs have developed outstanding reputations, often topping the rankings published by various publications and quality-rating organizations.

Most public university AMCs have also increasingly been viewed as capable of producing revenues, not losses—badly needed support for public universities that still charge relatively low tuition and in some states are increasingly starved for resources by state legislatures. Moreover, where public universities that had privatized their teaching hospitals had also spun off their faculty physicians into private corporations, the resulting lack of coordination was leading to a fairly chaotic situation when it came to integration and coordination. This has proved to be particularly problematic at a time when payers and patients have begun demanding more coordinated approaches to care and greater accountability for outcomes, not just paying fees for a volume of services.

As a result, several public universities that previously engaged in restructuring their systems under one or another of the models outlined above have recently further modified their previous structure. In most cases, the goal was to better align the activities and incentives of the university's teaching hospital and faculty practice plan, to enable the university to better coordinate patient care, education, and research, to respond to the growing emphasis on care coordination, improved quality, and value-based purchasing. Some universities have identified as problematic the separate agendas and initiatives of multiple boards composed of different individual members in addressing what were often similar issues and strategies from different perspectives (and occasionally with conflicting goals and outcomes).

The state universities of Colorado, Alabama-Birmingham, Nebraska, Florida, Georgia, Ohio State, and Maryland, among others, have all revised their previously restructured health system boards to impose greater university control over all three legs of the tripartite mission. Snapshots of several of these recent efforts to rethink state university hospital AMC governance are summarized below.

University of Colorado

As noted above, the University of Colorado no longer owns and operates its teaching hospital. University Hospital was restructured in the 1990s as a freestanding hospital authority. The authority has since created a joint operating agreement, known as UC Health, to enable it to operate University Hospital along with a non-profit system in Fort Collins and a city-owned system in Colorado Springs to form

7 Report of Dr. John Stobo to UC Regents Health Services Committee, unpublished.
8 David S. Guzick and Donald E. Wilson, "Governing of Academic Medical Centers Is Indeed a Complex and Unique Operation," *Academic Medicine*, February 2018.

a multi-hospital system that covers most of the state population east of the Rocky Mountains. The University's Vice President for Health Affairs serves as the board chair of the University Hospital and a UC Health board member. CU Medicine is the business arm that represents the faculty in the university practice plan, although the faculty remain employees of the University and its College of Medicine to remain eligible for sovereign immunity for malpractice as state employees. These faculty staff the University Hospital and Children's Hospital of Colorado, which serve as the tertiary referral centers for the entire system. CU Medicine implemented a novel risk-based health plan for all 40,000 University employees. UC Health is focusing on initiatives to develop team-based care and the improvement of ambulatory care quality and primary care/referring provider networks to take advantage of their state-wide footprint.

University of Arizona

In 1984, the University of Arizona created non-profit corporations for its major teaching hospital, University Medical Center, and its faculty practice plan, University Physician Healthcare. In 2011, the two corporations were brought back together under a single non-profit parent, the University of Arizona Health Network, while retaining their separate legal status for certain purposes. Following this merger, in 2014, the University of Arizona entered into an agreement to merge the UA Health Network into a private, non-profit hospital system, Banner Health, based in Phoenix.

The expressed goal of the merger with Banner was to create a nationally leading health system that provides better care and improved patient and member experiences; expand University of Arizona Medical Center capabilities for complex academic/clinical programs such as transplantations, neurosciences, genomics-driven precision health, geriatrics, and pediatrics while providing for investment opportunities in other areas; and bolster fiscal sustainability, eliminating persistent shortfalls and low operating margins currently experienced by the University of Arizona Health Network. The merger resulted in the elimination of $146 million in debt for the University and included a commitment from Banner to spend "$500 million within five years to expand and renovate the medical center, and build new facilities..." among other goals.[9]

University of Alabama-Birmingham Medicine

UAB Medicine is the non-profit corporation that includes UAB Hospital, which has 1,157 beds. In 2012, the UAB Health System (Health Services Foundation, or practice plan, the UAB School of Medicine, and UAB Hospital) was reorganized under UAB Medicine, an umbrella organization responsible for "realignment."[10] The expressed goal of realignment was a "sharper focus on a single, distinct mission for the entire organization; governance that reflects the full scope of efforts across research, education, and clinical care; strengthening of trust through transparency and accountability; increasing physician leadership throughout every aspect of UAB Medicine...and greater opportunity to improve financial stability for growth."[11]

A Joint Operating Leadership (JOL) body was formed with the creation of UAB Medicine. It is comprised of the Dean of the School of Medicine (SOM), the President of the Health Services Foundation, and the CEO of UAB Health System. In addition, three SOM Department Chairs serve on the JOL (currently surgery, medicine, and radiology). The JOL meets weekly and forms the administrative leadership of UAB Medicine; it is responsible for ensuring resources are allocated to all three missions (clinical, research, and education). The JOL is not a legal entity but a cooperative decision-making body.

A key goal of the restructuring was transparency and accountability. This commitment enabled UAB Medicine to implement a new funds flow process in 2014 in which all collections from the faculty practice plan and the hospital and clinics are combined. This model was based on (and implemented in concert with) a similar model developed at Stanford University.

A funds flow oversight committee was created to ensure accountability. Members include the JOL leadership, five clinical chairs (surgery and medicine *ex-officio* and three elected by the Health Services Foundation executive committee), two non-voting senior faculty members, certain senior officials of the Health Services Foundation and the health system, and the Senior Associate Dean for Administration/Finance of the SOM.

The revised governance structure and funds flow model are said to have addressed several problems:

- Previous misalignment of faculty and the hospital
- Weak accountability and sustainability
- The fact that some departments were in financial difficulty under the previous model, despite "mission support"
- Fragmented and confusing funds flow

Under the new system, there is a central funds flow account, all revenues are pooled, all clinical costs are centralized, infrastructure and clinical expense has been removed from departmental responsibility, a new academic enrichment fund/dean's tax has been created for the SOM, and departmental financial performance has improved.

Nebraska Medicine

Nebraska Medicine is a fully integrated non-profit system organized in 1997 following the merger of University of Nebraska Medical Center (UNMC) and a non-profit hospital. While Nebraska Medicine is a non-profit corporation with a separate board of directors, UNMC also continues to be directly governed by the Board of Regents, but with considerable delegated powers to Nebraska Medicine.

9 University of Arizona, "The University of Arizona Health Network and Banner Health Launch Effort to Create State-Wide Organization to Transform, Advance Health Care in Arizona" (Press Release), June 26, 2014.
10 Kirby I. Bland, M.D., "University of Alabama Birmingham Funds Flow Model," Presentation to the Society of Surgical Chairs, American College of Surgeons, October 4, 2015.
11 *Ibid.*

The system was expanded in 2016 to include clinics, the NU faculty practice plan, and other components.

University of Washington Medicine

Prior to 2018, UW Medicine's board of directors consisted largely of prominent members of the community and, while not independent of the University, enjoyed substantial delegated authority from the Regents, University President, and Executive Vice President for Health Affairs.

In July 2018, following a loss by UW's four-hospital system of over $75 million in 2017, the Board of Regents dissolved the former UW Medicine Board, effective September 1, 2018, and created the UW Medicine Advisory Board (UWMAB) to advise the Board of Regents on all aspects of UW Medicine.

The UWMAB is now composed of no more than 10 members, including two members of the Board of Regents, with the University President and CEO, UW Medicine, serving as additional *ex-officio* members. Some members of the previous board continue to serve on the new advisory board, which no longer has any delegated powers.

University of Oklahoma

The University of Oklahoma first transferred its teaching hospital to the investor-owned HCA Health Services in 1998. HCA, an investor-owned corporation in Nashville, Tennessee, had managed the hospitals under a joint operating agreement with the University Hospitals Authority and Trust (UHAT), which had been created by the University for this purpose. In 2017, UHAT and the University of Oklahoma created an Oklahoma-based non-profit corporation, OU Medicine, Inc., to acquire HCA's local interests, and the new corporation (with a community-based board) assumed responsibility for the hospital in early 2018.

University of Texas/Tyler and Kansas University

Also in the last two to three years, these two public university AMCs have pushed the governance envelope in the other direction, developing public-private partnerships to include shared governance and ownership between public universities, private non-profit entities, and a private equity-funded hospital management company with a unique business model. Both universities have recently entered into partnerships with an investor-owned hospital company called Ardent Health and regional non-profit systems to create hybrid entities with governance and ownership structures that include active participation by the universities.

The Kansas University Hospital in Kansas City was restructured in 1998 when its ownership was transferred from the University to a separate authority no longer managed by the School of Medicine. This separate structure enabled it to enter into the partnership with Ardent. In 2017, Ardent partnered with Kansas University to acquire St. Francis Health, a non-profit hospital in Topeka, Kansas that was renamed The University of Kansas Health System St. Francis Campus.

In 2018, UT Tyler partnered with Ardent and a regional non-profit system called East Texas Medical Center to form the 10-hospital UT Health East Texas.[12]

Conclusion

In conclusion, a number of lessons can be learned from these recent efforts to revisit and further reform the governance and legal structure of public university hospitals and health systems:

- Successful AMCs are typically organized as highly integrated and multifaceted health systems, with effective business management, a shared commitment to common goals, and meticulous attention to the academic, competitive, and regulatory demands of today's health system.
- Success does not necessarily correlate with a particular legal structure or governance model. The most effective systems studied have succeeded in a range of legal structures in aligning business, clinical, and academic performance to meet the diverse, and sometimes conflicting, needs of the modern academic health center.
- Regents (or trustees) are still in charge of public universities, even where there has been some separation of direct system governance. However, most successful public university systems have created boards to directly govern their health systems and have delegated considerable authority to those boards.
- Physician leadership is essential. But effective governance combines strong physician leadership with effective and often non-physician independent board members and AMC management.
- The components of high-performing systems are fully aligned and integrated (hospitals and physicians), through common or shared governance, through common ownership, or strong (and longstanding) affiliations, even across multiple hospitals and broad geographic areas.
- Governance should be specifically tasked with policy approval and oversight of quality, patient experience, and the constant improvement of care coordination.
- It is beneficial for both governance and management practices to be consistent and based on commonly shared and understood principles.

Common Themes and Leadership Principles for AMCs

- The academic health system of the future will be system-based.
- Academic health systems require strong and aligned governance.
- University relationships will be challenged to evolve as academic health systems grow and develop.
- Competitive viability and long-term mission sustainability will require radically restructuring the operating model for cost and quality performance.
- Academic health systems must "evolve rapidly or risk becoming high-priced, anachronistic institutions in a landscape of highly organized health systems."

Source: Advancing the Academic Health System for the Future: A Report from the AAMC Advisory Panel on Health Care, AAMC, 2014.

The Governance Institute thanks Larry S. Gage, Senior Counsel, Alston & Bird LLP, and Senior Advisor, Alvarez & Marsal, Inc., for contributing this article. He can be reached at larry.gage@alston.com.

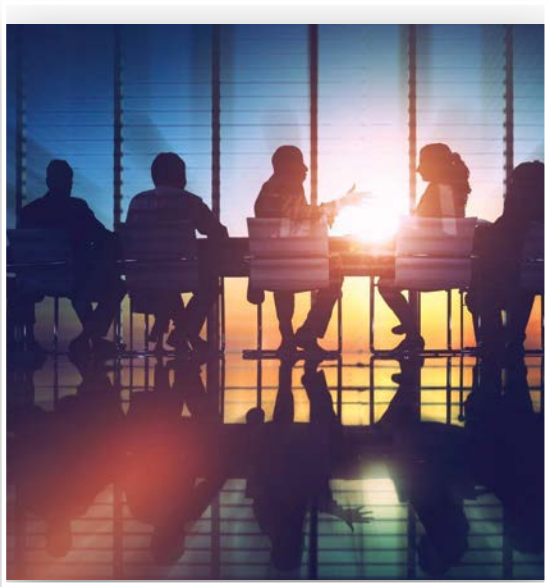
12 More information is available on the Ardent Health Web site at https://ardenthealth.com/about/our-history.

Assessing and Renewing Board Governance

By Pamela R. Knecht, **ACCORD** *LIMITED*

A recent report from the National Association of Corporate Directors (NACD) argues that "the pace and scale of change require a *different modus operandi from the board governance model prevalent for the last 100 years*, a new approach involving greater speed of decision making, proactive behaviors, adaptability, and innovation."[1] Its authors also state that "boards must approach their own renewal through the lens of shifting strategic needs to ensure long-term competitive advantage."

Although this report was developed primarily for corporate boards, its findings are just as relevant for not-for-profit healthcare boards that are helping their organizations transition from volume to value. Healthcare boards should revisit their governance models to ensure they are strategic, proactive, innovative, and able to make decisions quickly in the changing environment. And yet, according to The Governance Institute, only 58 percent of boards use the results from a formal self-assessment process to establish board performance improvement goals at least every two years.[2] The AHA's 2019 governance survey found that almost one-third of boards have *not* conducted *any* type of board assessment in the last three years.[3]



Rationale for Board Assessment

In addition to the rationale described above, there are other reasons for healthcare boards to assess their governance models now. Governance assessments can help assure external regulators such as the IRS and state attorneys general that the board is appropriately overseeing the community's assets. Issues of concern include executive compensation oversight, regulatory compliance, and conflict-of-interest management. Boards that routinely assess their practices are more often perceived by regulators and legislators to be performing their roles appropriately.

A board assessment can also be a powerful tool for assuring internal stakeholders such as executives, physicians, and directors themselves that the board is doing its job well. A governance assessment can uncover issues impacting the board's effectiveness and efficiency in each of its fiduciary duties and core responsibilities. Those issues may be task-related, such as whether the capital plan was sufficiently analyzed, or cultural, such as whether the board engages in robust conversations with management while respecting the governance-management distinction.

A board with a reputation for continuously assessing and renewing itself is also more attractive to current and potential board members. Therefore, a board assessment can be a powerful tool for recruiting and retaining highly qualified directors.

Determine Which Population(s) to Assess

The first step in board renewal is to determine which population(s) to assess: the full board, committees, chairs, or individual directors. The Governance Institute provides tools for assessing each of these populations.

The most common group to assess is the full board, but boards intent on becoming great also conduct other types of assessments. For instance, asking each finance committee member whether they are receiving needed information in a timely manner can help management better support that committee's review of the annual budget. In turn, the finance committee will be more comfortable providing its recommendations to the full board.

Another group to evaluate is the board's leaders. A chair can substantially impact the effectiveness of the board or committee, both positively and negatively. At one health system, the board chair was so concerned with keeping things "under control and on time" that he routinely cut off important discussions. After a while, board members stopped asking questions or offering suggestions, and it became an ineffective, rubber-stamp board. A chair assessment helped identify these and other issues that were creating a sub-optimal board. As a result, the chair requested individual coaching, which improved his ability to facilitate robust discussions with his peers.

Individual board member assessment is a best practice, but it is not often done. Only 28 percent of boards surveyed by The Governance Institute assess the performance of individual directors. This type of assessment can be very helpful, but it should be pursued carefully so

Key Board Takeaways

- Assess the board's governance model to ensure it focuses on strategic issues and acts with appropriate speed.
- Carefully consider the various options for board assessment.
- Determine which population(s) to survey: full board, committees, chairs, and/or individuals.
- Decide on the appropriate scope of the assessment: targeted or comprehensive.
- Choose the best approach: document-based, survey-based, observation-based, interview-based, or a combination.
- Create a board development action plan.

1 *The Report of the NACD Blue Ribbon Commission, Fit for the Future: An Urgent Imperative for Board Leadership*, 2019.
2 Kathryn C. Peisert and Kayla Wagner, *Transform Governance to Transform Healthcare: Boards Need to Move Faster to Facilitate Change*, 2019 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute.
3 American Hospital Association, *2019 National Health Care Governance Survey Report.*

that directors feel supported, not critiqued. The most successful individual assessment processes are undertaken by boards with healthy cultures that are looking to "up their game" regarding performance improvement.

Decide on the Scope and Scale

The next decision is the scope and scale of the assessment. A typical full board self-assessment instrument is comprehensive; it includes 70–80 questions covering all three fiduciary duties and six core responsibilities of boards. There are also specific questions to ascertain how well the board is functioning. These comprehensive assessments create baselines for measuring the board's performance over time.

By contrast, some boards choose a highly targeted approach. For instance, the governance committee for a new health system board carefully selected 12 questions to help them assess whether directors felt the new board had made progress on its priorities over the first year. This focused assessment had multiple benefits: less board member time was required to complete the assessment and leadership received specific feedback on key issues.

Choose the Appropriate Approach(es)

Choosing the correct assessment approach is critical, and yet, this step is often neglected. There are four different methods for assessing a board: document-based, survey-based, observation-based, or interview-based.

In a document-based approach, the bylaws, charters, and policies are compared to best practices. If the observation approach is used, someone attends a board or committee meeting, silently taking notes on the board's effectiveness (e.g., amount of discussion, agenda adherence, etc.). The survey-based approach uses a written instrument that is most likely administered electronically. An interview-based approach usually entails one-on-one discussions with directors using a common questionnaire.

The correct approach to use is dependent on many factors, such as the desire for national benchmarking, the need to identify cultural issues, the availability of governance expertise, and time. Since each assessment approach has its advantages and disadvantages, the governance committee should carefully choose the one(s) that best meet their board's needs at this time. It may be helpful to utilize more than one approach (e.g., if the challenges the board is facing are difficult to identify). **Exhibit 1** includes some of the pros and cons of the four approaches.

Exhibit 1: Pros and Cons of Each Survey Approach

Evaluation Approach	Pros	Cons
Document-Based	• Least amount of board time • More objective	• May not provide whole picture • May focus too much on documents • Requires governance expertise
Observation-Based	• Identifies cultural issues • Requires little to no board time	• Requires governance expertise
Survey-Based	• Allows more board involvement • Enables benchmarking	• Takes more board time • Requires survey expertise (not necessarily governance expertise)
Interview-Based	• Provides opportunities to better understand the real issues • Engages board members in issue identification and problem-solving	• Most amount of board time • Requires governance expertise • More subjective

Prioritize Board Development Action Planning

Regardless of the population, scope, or approach selected, the assessment will only lead to board renewal if it results in a board development plan. The governance committee should ensure that a written action plan is created with a limited number of agreed-upon priority actions, lead responsibility, and due dates, and that the plan is implemented.

By using a disciplined approach to assessing and then renewing its own board governance model, the board can ensure the long-term success of the organization it is responsible for overseeing.

*The Governance Institute thanks Pamela R. Knecht, President and CEO, **ACCORD** LIMITED, for contributing this article. She can be reached at pknecht@accordlimited.com.*

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of patient information is critical to your organization's success.

In addition to information, another essential currency in healthcare organizations is trust. There is perhaps no other industry more based on trust than healthcare. Patients entrust their healthcare providers with detailed, sensitive information about themselves, and they trust that this information will be protected. It's important for all of our stakeholders, but especially for our patients, that we maintain their trust by establishing, implementing, and maturing an ECRM program.

Talking about ECRM may seem technical and complex. And yes, it can be both. But it is important to remember that the role of executive leadership and the board is to provide informed direction and oversight for the organization's ECRM approach, activities, and strategy. It is not the board's role to micromanage cyber security efforts in the field, but to provide leadership and guidance that optimizes the organization's cyber security efforts.

It is not the board's role to micromanage cyber security efforts in the field, but to provide leadership and guidance that optimizes the organization's cyber security efforts.

An oft-used phrase that describes the board's role is, "eyes open, nose in, fingers out." This can be applied to a board member's approach to ECRM, as well. "Eyes open" means be informed:

understand what it means to have an effective ECRM program in place. "Nose in" means understand where your organization is in relationship to best practices and standards related to ECRM; and provide leadership with respect to closing any gaps between established ECRM practices and your organization's approach. Finally, "fingers out" means leave the details of execution to your organization's appropriate team members.

Many executives and board members struggle with where and how to focus their organization's ECRM efforts. I suggest beginning with the following three steps—keeping in mind that the board's role is to provide oversight for these activities, not to personally implement them:

- Step 1: Identify, and then prioritize, all of your organization's unique cyber risks.
- Step 2: Discuss, debate, and settle on your appetite for cyber risk; i.e., determine what level of risk your organization is prepared to accept.
- Step 3: Address each risk, making informed decisions about which risks you will accept, and which you will address (avoid, mitigate, or transfer) and then execute on that plan.

Healthcare data, systems, and devices are more voluminous, more visible, more valuable, and, at the same time, more vulnerable than ever. The risk of a catastrophic cyber attack on your healthcare organization is real. To address this risk, you must engage in a discussion about what cyber risk is, what the potential impacts could be on your organization, and what steps need to be taken to establish, or improve, your ECRM program.

The Governance Institute thanks Bob Chaput, Executive Chairman and Founder, Clearwater, for contributing this article. This article is excerpted from his soon-to-be-published book Stop the Cyber Bleeding. *To learn more or inquire about obtaining a copy of the book, contact Mr. Chaput at bob.chaput@clearwatercompliance.com.*

Leadership, Boards...

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role models who demonstrate these soft skills and to have the opportunity to practice them. Learning soft skills comes with experience. Even the most seasoned healthcare leaders must continue to hone these essential but more elusive competencies, and boards are well-advised to assess and hire for leaders' soft skills.

How can a board identify transformational leaders with a good command of soft skills? Look for experience in successfully leading a significant change, even if there are mistakes along the way. When leading through a significant change, every leader is bound to make mistakes. How they handle those mistakes so that they still lead the organization through the change will tell you a lot about their soft skills. It is also important to talk to others who went through the change with the leader to gain an understanding of their perspective of that person's leadership.

It may also be time to start targeting recruitment of new board members for their soft skills. Board members can be incredible mentors and advisors to leaders, especially during challenging times. Having board members with strong soft skills can be of incredible value in advising about approaches to take in difficult situations.

The Governance Institute thanks David C. Pate, M.D., J.D., FACP, Immediate Past President and CEO, St. Luke's Health System, for contributing this article, which was adapted from a column in the summer 2019 issue of Chief Executive Officer *newsletter. He can be reached at njohnson@slhs.org. His writing can be found at www.stlukesonline.org/blogs.*

Employee Engagement...

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it does come up, what solutions are offered to boost employee engagement?

A common option to boost employee spirits across the board is a pay increase. If we boost salaries and wages enough, won't people be happier in their jobs? The simple answer is yes. Glassdoor.com studied the relationship between an increase in employee salary and an increase in employee satisfaction and there *is* a relationship. For every 10 percent increase in salary, an employee's satisfaction only increases 1 percent.[3] Even massive, across-the-board raises don't boost employee satisfaction in any meaningful way.

The Link between Employee Engagement and Patient Engagement

According to NRC Health's Employee Engagement survey results, only 41 percent of employees felt the organization was delivering on the patient experience. These same studies reveal a correlation between high patient satisfaction and high employee engagement. The inverse is also true: low employee engagement in an organization greatly increases the chances it also suffers poor patient satisfaction. Nearly all the organizations I spoke with had not looked at their patient and employee data sets together, even though it's clear the two worlds are linked.

> When a vital metric like patient satisfaction is linked to employee engagement, it becomes a board-level issue.

Crosswalking employee data with other pertinent feedback isn't the only way to boost employee engagement efforts. The concept of a pulse survey arose as an answer to the massive, bogged down annual survey. Pulse surveys are more frequently deployed to employees (anywhere from quarterly to weekly) but are much shorter in length. They allow for quicker feedback on a broader range of topics and offer a lessened risk of survey fatigue on the employee taking them.

A Hard Benefit of Employee Engagement

Diversicare, a Tennessee-based senior living system, found that a boost in employee engagement also had another positive side effect: a decrease in employee turnover. By boosting their employees "would recommend" scores just 9 percent, they saw a 27 percent decrease in employee turnover over the next nine months.[4] Besides the obvious financial benefits of stemming turnover, it's much easier to engage an employee audience that isn't heading for the exits.

The Heightened Need for Employee Engagement in Healthcare

Employee engagement can be truly difficult to attain and maintain. But healthcare is a special calling and those who provide it deserve every opportunity to be engaged in their work. Boards often take a passive role, when their expertise outside healthcare can be beneficial to boosting engagement. When a vital metric like patient satisfaction is linked to employee engagement, it becomes a board-level issue. In the coming year, consider thinking about—and measuring—employee engagement differently and consider doing so from the boardroom to the breakroom. Engaged employees make for a better patient experience, which leads to a higher-performing organization.

The Governance Institute thanks Ryan Donohue, Corporate Director, Program Development, NRC Health, and Governance Institute Advisor, for contributing this article. He can be reached at rdonohue@nrchealth.com.

3 Mario Nuñez, "Does Money Buy Happiness? The Link between Salary and Employee Satisfaction," Glassdoor, June 18, 2015.
4 NRC Health, "Workforce Engagement Improves Culture and Decreases Turnover," 2019.

Employee Engagement: What Is the Board's Role?

By Ryan Donohue, NRC Health

A Google search of the phrase "employee engagement" returns 256 million results. In the business world, employee engagement has had a wonderful decade-plus run describing every effort to engage employees everywhere. Employee engagement was at first a welcomed heir to its much-maligned predecessor: employee satisfaction. Companies of all verticals have come to agree that simply satisfying employees is not enough, nor is it particularly easy to do. Employees need to be thoroughly *engaged* in their work.

The State of Employee Engagement

The employee engagement movement begs the question: are most employees engaged in their work? The short answer is no. Engagement means truly connecting with your work and having your purpose fulfilled. It's a high bar, especially for hourly workers and those new to the workforce. Simply satisfying employees is also not widespread—2017 was the first year the number of U.S. workers who consider themselves satisfied with their jobs had crossed 50 percent (at just 51 percent) in the past decade.[1]

It seems the conversation around employee engagement is more prevalent than engagement itself. At a recent Governance Institute Leadership Conference, I asked an audience comprised of CEOs, board chairs, and board members what activity they most closely associated with employee engagement. The consensus was their annual employee engagement survey. This echoes conversations I've had across healthcare—we focus on employee engagement because we measure it.

HR Surveys: A Mountain of Measurement

Measuring something is different than committing to it. In fact, measurement can even become a barrier to action. I spoke with several human resources executives of hospitals and health systems large and small and one commonality surfaced: the annual employee engagement survey is a massive undertaking. Even with help from outside firms, most HR managers do much of the survey building themselves—by getting input from just about every department. Eliminating past questions can be a sensitive exercise and adding new questions causes concern about question order and survey fatigue. One HR manager mentioned the process can take up to six months if all potential stakeholders are involved. The top reasons managers gave for dissatisfaction with the annual survey are that "the data isn't timely" and surveys "don't account for a regularly changing workplace."[2]

Then there's the actual survey deployment. Internal campaigns must be conducted to coax and convince as many employees as possible to complete the survey. A low completion rate casts doubt over results and can be a signal of low engagement before reading any results. A high completion rate requires an intense amount of effort to get the last 5 to 10 percent to complete the survey. All of this requires energy from a department that isn't spilling over with available resources.

The annual employee engagement survey has taken on a life of its own and the benefits are foggy—even at the top. Just 26 percent of organizational leaders said employee engagement is "very important." Only 31 percent of managers strongly agreed that their companies consider engagement a top priority and 16 percent outright disagreed.

Regardless of how much energy is spent engaging employees, there's clearly a discord on how important the topic is to an organization. As a board, how much is employee engagement discussed? Is it something that comes up regularly—as with the one in four leaders who feel it's important? Or does it fall in the "nice to know" camp and isn't on the board's radar? Should it even be on the board's agenda? When

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Key Board Takeaways

Potential action steps boards can take to rethink employee engagement include:

- Form a board subcommittee on employee engagement, or place the responsibility in an existing committee such as quality, if there is bandwidth there to address the issue appropriately.
- Consider breaking out of the annual survey rut and asking new questions, even if it affects trending.
- Experiment with a pulse survey in between annual surveys—or even replace the annual survey with smaller, more user-friendly surveys throughout the year.
- Define what "employee engagement" means for your organization specifically and share this definition with employees.
- Communicate with employees directly and let them know that engagement in all its forms is important.

1 Lauren Weber, "U.S. Workers Report Highest Job Satisfaction Since 2005," *The Wall Street Journal*, August 29, 2018.
2 NRC Health's Employee Engagement studies, 2018.