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Board Orientation Manual

Providing Essential Knowledge and Solutions to Achieve Excellence in Healthcare Governance

SIXTH EDITION

A SERVICE OF

nrc HEALTH

The Governance Institute®

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The Governance Institute

The Governance Institute provides trusted, independent information and resources, tools, and solutions 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.

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Welcome to the Board!

> Never doubt that a small, committed group of individuals can change the world. Indeed, it's the only thing that ever has.
>
> —*Margaret Mead*

As a new board member, you are beginning a period of service that brings with it prestige, credibility, influence, and personal satisfaction. You bring a lot of time, effort, and a sincere desire to improve the health of your community.

Most board members sitting on non-profit hospital and health system boards are volunteers. America's great tradition of voluntarism supports the idea that people can willingly band together for a common purpose. Thus, outstanding citizens freely devote time and energy serving on boards of hospitals and health systems from which they derive no tangible gain. For the most part, directors serve because of a genuine interest in the quality of healthcare and a sense of service to their community.

The legally constituted governing board of directors holds the healthcare organization in trust. In order to fulfill this trust, it must be the ultimate source of authority—and it must have overall responsibility—for the institution. In the eyes of the law, directors have a fiduciary obligation that cannot be divested through delegation. Directors are held to a very high standard of conduct. They are charged with safeguarding the assets of the organization, protecting the patient from harm, and not receiving any personal gain from their relationship.

The 21st century hospital or health system board is overseeing a much more complex organization than in years previous, and the market dynamics facing healthcare are unprecedented. This makes the job of non-profit directors more important and complex, emphasizing the need for a strong orientation program and ongoing education to remain at the forefront of challenges and issues facing the organization the director serves.

This orientation manual gives you important points about governance. Some of the information may be elementary to you, but overall, the manual offers a comprehensive guide to your responsibilities and roles. It also offers tips you can take with you into the boardroom, and outlines governance trends that may affect you in the next one to three years of your tenure. Finally, it gives you specific questions you will want to have answered as your organization puts you through its board orientation program.

Many new healthcare directors come from outside the world of healthcare. For this reason, we have also included basic background information on hospital organizational structure and some key dynamics that have influenced and continue to influence the direction of healthcare.

On Leadership

You have been selected as a board member because you bring a specific set of skills and experience to the healthcare organization's boardroom. This probably results from your demonstrated abilities to organize and lead others. Leadership in the healthcare boardroom setting has specific attributes. We want you to feel comfortable that, after reading this manual and attending your organization's board orientation program, you will have added these leadership attributes to your own. For this reason, we present The Governance Institute's Leadership Criteria, some of which are necessary for board members to possess prior to coming on board; others can be learned during the board member's first term:

Knowledge

- Has the knowledge to help the board understand the market and competition
- Is highly informed in financial planning, bond issues, debt, and budgets
- Is fluent in the history and heritage of the institution
- Has an understanding of labor-management challenges
- Develops an understanding of the organization's services
- Understands the importance of asking, "Does each decision and each action move us toward our goals?"
- Seeks opportunities for director education and leadership development
- Is well versed on the needs of the community and stakeholders
- Understands the board's fiduciary duties and core responsibilities
- Educates himself/herself regarding legal requirements and regulations governing the board's actions
- Understands healthcare legislation and implications for the organization
- Is knowledgeable about national quality and safety initiatives
- Understands quality improvement theories and frameworks
- Understands the physician credentialing process and related issues, including medical malpractice and professional liability
- Has a working grasp of health economics and financial matters, including payer relationships
- Has an understanding of appropriate governance structure to facilitate board effectiveness
- Is knowledgeable about the current healthcare environment, including systems issues, community health issues, and trends
- Understands public policy matters and legislative and advocacy processes, including the appropriate role of the board in this area
- Understands the consequences of unethical actions
- Understands the difference between the appropriate role of the board versus the role of management and the medical staff in decision making
- Understands the importance of effective measuring and reporting
- Understands how an organization's culture affects its effectiveness

Skills

- Has "people skills" and understands how to build and develop administrative, board, and physician leadership
- Is a collaborative and communicative leader
- Has credibility among his/her peers and subordinates
- Can think on both macro and micro levels
- Is a strategic and forward-thinking leader
- Has the ability to employ comparative analysis strategies
- Seeks to build consensus among stakeholders, but is still able to make a clear recommendation when needed
- Can develop effective relationships with physicians in support of the mission, vision, and strategic plan
- Can approach problem solving by seeking and using input from a broad range of people
- Is guided by the organization's mission, vision, and values in his/her decision making
- Is able to facilitate and mediate a discussion, appropriately managing group dynamics
- Does not get involved in the daily operations of the organization
- Advances the mission of the organization
- Is willing/able to be a mentor to new board members
- Establishes appropriate and timely goals
- Operates with a particular sense of urgency and importance

Attitudes

- Prepares for, attends, and participates in committees and meetings
- Is a good listener who takes into account all parties
- Is diplomatic
- Is mission-driven and values-based
- Perceives the physicians and executive leaders as partners and not adversaries
- Possesses a flexibility to change when needed
- Possesses a high level of integrity
- Maintains objectivity regarding his or her comments
- Demonstrates composure and resilience in times of crisis
- Offers professional expertise when appropriate
- Asks questions and doesn't feel he/she has to have all the answers
- Places a high premium on building and maintaining good relationships
- Has an inclusive nature
- Is sensitive to cultural differences concerning issues related to communication and behaviors
- Is open to constructive feedback and willing to provide constructive feedback to others

What's Involved in Serving on the Board?

It is important to begin your position as director with a basic set of information regarding your fundamental duties, roles, and responsibilities as a member of your board.

Fundamental Fiduciary Duties

Boards have legally mandated fiduciary duties to their organizations. Although the term "fiduciary" has become synonymous with "financial" responsibilities, it actually means that boards have been given a trust to uphold. These duties describe the manner in which board members are required to carry out their roles and responsibilities.

The director's fundamental duty to manage the corporate enterprise by delegation to full-time managers is referred to as the "duty of oversight." This duty is central to everything a director does. It obliges directors to exercise reasonable and prudent oversight with respect to corporate officers, agents, and employees to whom such affairs are delegated. To adequately discharge the duty of oversight requires the director to give attention to such matters as:

- The current business and financial performance of the organization
- The principal activities of senior management
- The effectiveness of, and senior management's commitment to, the corporate compliance plan
- Achievement of the charitable mission of the organization
- The presence of an effective reporting system to the board
- Selection of competent senior management
- Establishing institutional norms and procedures (e.g., compliance programs)
- Reviewing and having input into management-formulated strategy
- Management of institutional investments and access to restricted gifts
- Monitoring the performance of the enterprise and of senior management

The related duties of care, loyalty, and obedience describe the manner in which directors are required to carry out their fundamental duty of oversight of the organization.

Duty of Care requires board members to have knowledge of all reasonably available and pertinent information before taking action. The board member must act in good faith, with the care of an ordinarily prudent businessperson in similar circumstances, and in a manner he or she reasonably believes to be in the best interest of the organization.

Duty of Loyalty requires board members to candidly discharge their duties in a manner designed to benefit only the corporate enterprise, not the individual interests of the board member. It incorporates the duty to disclose situations that may present a potential for conflict with the corporation's mission, refrain from discussing confidential board business with others, as well as a duty to avoid competition with the corporation.

Duty of Obedience requires board members to ensure that the organization's decisions and activities adhere to its fundamental corporate purpose and charitable mission as stated in its articles of incorporation and bylaws.

fi•du•cia•ry: To hold something in trust for another…to assume responsibility or ownership of property to keep, use, or administer for another's benefit. It encompasses *all* oversight responsibilities of the board, not just financial.

In healthcare systems with tiered governance structures, there can be both legally constituted governing boards as well as advisory boards. Legally constituted governing boards bear sole and ultimate responsibility for the affairs of an organization. They serve as the *fiduciary* agent of the organization's owners (whether they are shareholders or stakeholders) and possess legally mandated responsibilities and functions. *Advisory bodies* (alternately called community boards, local boards, and so forth) are non-fiduciary entities created by the health system for the purpose of providing advice and counsel to the system board, the management of the subsidiary itself, or both.

How Boards Accomplish Work

The best way for boards to meet and fulfill their responsibilities is to take on three key roles: policy formulation, decision making, and oversight.

Board roles are the *how* of governance—the things the board needs to do:

- Policy formulation
- Decision making
- Oversight

Policy Formulation

Boards formulate policy to give the organization direction. Policies are statements of intent that guide and constrain further decision making and action and limit subsequent choices. Policies provide a framework for the decision-making role. Policies influence three key areas:

- ***Statements of board responsibility*** describe the nature and scope of board obligations.
- ***Board policies*** provide direction and convey board expectations of management and the medical staff as they go about accomplishing the organization's work.
- ***Operating policies*** are those responsibilities and authorities the board delegates to the organization's management and medical staff. If boards formulate a lot of operational policies, management and medical staff have less authority over operations. Conversely, fewer board-initiated operational policies result in more authority over operations by management/medical staff. Each board has its own management and governance "culture," and boards typically walk a fine line between their own role and that of their executives.

Decision Making

This is considered to be the most important role of governance, since much of what boards do eventually comes down to making choices. Decisions are based on policy. A board can choose to retain authority with respect to an issue related to one of its responsibilities, or the board can delegate decision-making authority to management or the medical staff.

Oversight

This is central to everything boards do. Boards engage in oversight by monitoring decisions and actions to ensure they conform to board policy and the organization's strategic plans and budgets, and produce intended results. Management and the medical staff are accountable to the board for the decisions they make and the actions they undertake. Proper oversight ensures this accountability.

Board Responsibilities

Hospital and health system boards must assume responsibility for organization oversight in six key areas: quality, finance, setting strategic direction, board self-assessment and development, management performance, and community benefit and advocacy.

Responsibilities are the *what* of governance—the things that require the board's attention:

- Quality of care oversight
- Financial oversight
- Strategic direction/mission oversight
- Board self-assessment and development
- Management oversight
- Community benefit and advocacy

Quality Oversight

"Quality" is the degree to which health services for individuals and populations:

1. Increase the likelihood of desired health outcomes as defined by patients, families, the community at large, physicians, employees, and payers
2. Prevent and decrease the likelihood of undesirable outcomes
3. Are consistent with current but constantly changing professional knowledge (i.e., evidence-based)

The Institute of Medicine defined quality of care in its 2001 landmark report, *Crossing the Quality Chasm,* using the STEEEP acronym, which is still widely used today:

- **Safe:** the patient's safety comes first.
- **Timely:** care should be delivered in the timeliest manner possible.
- **Effective:** care is based on the best scientific knowledge currently available.
- **Efficient:** care is not wasteful of time, money, and resources.
- **Equitable:** care does not vary in quality because of patient characteristics, such as ethnicity, ability to pay, or geographic location.
- **Patient-centered:** care is respectful and responsive to individual preferences, needs, and values.

It is important for each hospital or health system board to routinely review its own interpretation of quality and have a strong voice in its definition.

Hospitals and health systems across the country are now being charged to deliver not only high quality but also *value.* As part of the new "value equation," healthcare leaders are evaluating their care delivery systems to assess whether they are able to provide care that 1) enhances the patient experience (i.e., accessible and affordable care centered on the needs of the individual patient); 2) enhances the overall health of a population; and 3) simultaneously reduces the per-capita cost of care.[1]

1 Institute for Healthcare Improvement's Triple Aim. For more information, see www.ihi.org.

The board's responsibility for quality comes from a variety of sources, including the hospital or health system's mission statement and corporate bylaws, requirements by various accrediting bodies, and legal mandates. The board has a moral and ethical obligation to guarantee that the organization is doing everything it can to keep patients safe and provide them with the highest-quality care. It is a legal obligation as well—the landmark court case *Darling v. Charleston Community Memorial Hospital* (1965) placed responsibility for quality care on the hospital board.

Boards have ultimate responsibility for ensuring the quality of patient care and patient experience. This responsibility is enhanced due to value-based payment models tying reimbursement to quality outcomes, and the increasing need to address quality and cost simultaneously. This includes:

- Credentialing (appointing, reappointing, and determining privileges of the medical staff)
- Ensuring that an efficient and effective quality program is in place and operating as charged, in all care settings where the organization's patients may receive care
- Ensuring that quality and cost are appropriately related and that the organization's culture and strategy support the need for all staff and physicians to understand and focus on efforts related to increasing quality, improving the patient experience, and reducing cost

Credentialing

Quality monitoring includes credentialing physicians and granting privileges to practice medicine in the hospital. It has been argued that nothing contributes to the quality of care in a hospital as much as effective credentialing. Credentialing is a process to determine whether a practitioner is competent and meets the hospital's high standards of clinical skill and professional conduct. Basically, this means deciding which doctors may join the medical staff, which procedures each may perform, and which conditions they may treat. It is a responsibility of board members to ensure that the credentialing process is rigorous and that the safety and well-being of patients is the priority.

Credentialing involves the board and its quality committee, management team, the medical executive committee (MEC), clinical department chairs, and other medical staff leaders. The board is responsible for the process as well as the outcome of the process. The basic steps are as follows:

1. Establish appropriate credentialing policies and criteria (MEC, governing board).
2. Collect and summarize information about applicants for membership and privileges (management, medical staff leaders).
3. Evaluate applicants and recommend membership and privileges (department chairs, credentials committee, MEC).
4. Review, grant, deny, or approve (governing board or designated agent).

An important component of credentialing involves setting the organization's criteria to hold particular privileges. These criteria are developed to ensure practitioners have current competence to perform clinical tasks, and they may differ from organization to organization, or be modified from time to time within the organization. Criteria for specific privileges will be recommended by the medical staff but must be approved by the board. Once the criteria are established (and they should be periodically reassessed), the credentialing process ensures that practitioners are only assigned privileges for which they are competent and meet the established criteria. Privileging typically enumerates requirements for education, training, and evidence of current competence.

Governing boards will sometimes adopt policies to "close" the medical staff in particular specialties. Policies can also be adopted that require applicants to show how they will advance the mission of the hospital. Sometimes boards adopt physician conflict-of-interest policies, which might restrict access to the medical staff under well-defined circumstances.

Medical staff participants in the credentialing process must be educated carefully in best credentialing practices. It is the duty of the MEC to make formal recommendations to the board regarding requests for medical staff membership, the assignment of specific privileges to practitioners, and the appropriateness of any policies and procedures that should be adopted.

The *final* step is the board's review of the MEC's recommendations and its action to grant, deny, or restrict the membership and/or specific privileges being sought. In general, board members will give the greatest scrutiny to the 5 to 10 percent of practitioners who have some type of unusual event in their past.

Although the board is directly involved in the first and last of these credentialing steps, it has oversight over the entire process and must ensure that all steps are carried out diligently, in compliance with the requirements of the medical staff bylaws, and consistent with the board's own policies.

> Credentialing is a critical board responsibility because the practice of medicine in the organization has the single greatest impact on the quality of care provided.

Quality Measurement

Much of the board's quality oversight work involves measuring indicators of quality, and setting appropriate goals and targets for improving those metrics. Determining the right metrics to measure, and accessing the information in a meaningful way, is an ongoing and evolving process. Most of this work is done by the board-level quality committee, in conjunction with the management team. The full board is then charged with ensuring it has a realistic picture from the quality committee of the quality metrics being measured and why, and where and how to focus improvement efforts to target the priority areas of concern.

Quality metrics typically include clinical outcomes, service outcomes (including patient experience/HCAHPS scores), specific quality problems, and a comparison of the organization's performance with like organizations across the country. Most importantly, the metrics include a comparison against the organization's own historical performance.

Clinical outcomes. These are also labeled as quality indicators or quality outcome indicators. A quality indicator is a measure of some aspect of quality of care or service that a board deems important enough to track. Some typical quality outcome indicators include:

- National Quality Forum (NQF) "never events" and sentinel events from The Joint Commission[2]
- Hospital-acquired conditions (e.g., patient safety conditions such as pressure ulcers; device-associated infections)
- Surgical wound infections
- Overall hospital/system mortality
- Neonatal mortality
- Perioperative mortality
- Cesarean section rate
- Heart failure "appropriate care" measures
- Pneumonia "appropriate care" measures
- Unplanned readmissions to the hospital (and/or overall hospital readmissions)
- Unplanned transfers to a special care unit
- Unplanned returns to the operating room

Many organizations are taking a population health approach to care delivery to address both health outcomes and costs for at-risk/high-utilization populations. To do this boards also need to look at outcomes data on groups of patients with chronic diseases (e.g., diabetes, obesity, cardiovascular disease), and patient groups that have insufficient access to necessary care.

Service outcomes focus on the patient's experience in the hospital. These measures (many of which are included in the HCAHPS surveys, which hospitals are required to conduct and report to the Centers for Medicare and Medicaid Services) include length of wait in the emergency room, ease of pre-admit procedures, staff responsiveness, doctor communication, nurse communication, hospital environment, etc.

Specific quality problems. For example:

- Too much care—excessive use of diagnostic tests or unnecessary surgery
- Too little care—clinical consults not ordered, patients discharged prematurely, mammograms and immunizations do not occur, or treatable conditions like depression go undiagnosed
- Inferior care—patient safety issues, surgical accidents or preventable drug interactions, under-qualified staff

2 Since 2007, the Centers for Medicare and Medicaid Services (CMS) identified several of the NQF "never events" that it considers to be so egregious that they are no longer being reimbursed for Medicare patients. This list is updated on a periodic basis. See http://bit.ly/3cadVhc for a list of such events. Also see http://bit.ly/2wd1a5a.

Benchmarking. Beyond determining the organization's performance in relation to similar organizations, the board should monitor the organization's own historical performance on a selected list of quality indicators against agreed upon quality goals that challenge the organization but are realistic. At the very least, some of the quality goals should be based on the "theoretical ideal" (e.g., zero sepsis, zero infections, etc.). The goal of benchmarking is to identify a minimum performance standard and work to exceed it.

Financial Oversight

The healthcare industry is moving to a value-based business model from a volume-based model that has been in place since the 1960s. As this transition occurs, hospitals and health systems are facing critical strategic, operating, and financial challenges. The combined impact of environmental forces has been significant for all types of providers, industry-wide. Forces include declining payments, rising costs, increasing price sensitivity, emergence of nontraditional competitors, declining inpatient utilization, and a shift of care focus to ambulatory and other non-acute settings.

The speed of the transition to value/risk-based payment and population health management varies from market to market. Hospitals and healthcare systems that wish to serve their communities over the long term must develop reasonable plans for making the transition, and navigate the gap in between.[3] Whether the organization proceeds slowly or rapidly with fee-for-value arrangements, it must have in place the leanest-possible cost structure and the capabilities required to assume clinical and financial risk for managing the health of a defined population through provision of defined services. Capabilities include clinical alignment, care management infrastructure, clinical and business analytics, and data collection and reporting infrastructure, among others.

A hybrid of payment has emerged. It is critical for new board members to understand both a) how the fee-for-service payment system works, and b) how value-based payment models differ and affect care delivery and revenue. Hospitals and health systems are learning how to manage the old and new systems concurrently.

Boards and executive teams should be discussing what it will take to move their organizations toward success under the value-based system. How fast the organization wants to move, or may be forced to move, and how much the transition might cost are important considerations. Organization-wide strategic cost reduction and integrated strategic-financial planning are required. Associated risk and scenario analyses might appropriately include variables such as: the expected proportion of patients covered under various payment mechanisms; revenue projections by payer; and capital and cash flow requirements for value-based infrastructure, including physician strategies, analytic resources, case management, and other major initiatives. The planning process enables healthcare leaders to determine the financial risks associated with various levels and speeds of organizational transformation.

3 See J.H. Sussman and B.R. Kelly, *Navigating the Gap Between Volume and Value: Assessing the Financial Impact of Proposed Health Care Initiatives and Reform-Related Changes,* Health Research & Educational Trust and Kaufman, Hall & Associates, June 2014 (http://bit.ly/2Tmeqwg).

Uncertainty is prevalent in the current environment, and unforeseen circumstances—such as the emergence of a new market competitor or an economic downturn—may intervene to disrupt even the best-laid plans. Given this situation, financial oversight of hospitals and health systems by boards and executive teams is more important now than at any point in the experience of most industry leaders.

Financial Principles

In the evolving new era, hospital or health system leaders must reposition the organization through an integrated strategic-financial planning process. This process maintains a single financial perspective. As articulated for the past 30 years, that perspective is that "financial performance must be sufficient to meet the cash flow requirements of the strategic plan and, at the same time, maintain or improve the financial integrity of the organization."[4]

The nature and magnitude of required challenges and change to organizational cost structure may be unprecedented. Pursuit of traditional opportunities to improve the efficiency of existing operations or services in the areas of labor costs, non-labor costs, and revenue cycle management is imperative, but business restructuring initiatives offer the biggest opportunities for major savings. These include redefinition of businesses and services offered and right-sizing of the distribution of services and required facilities across an organization's service area. Capital investment and expenditure savings can be significant.[5]

Boards must ensure that senior leadership is tracking trends and issues with financial implications closely and putting in place effective plans to address the challenges. To project and monitor performance improvement organization-wide, high-quality costing and planning tools are required. Board financial oversight duties often now include master planning for strategic cost management, the alignment of strategic, capital, and financial plans, debt and investments comprising the organization's capital structure, auditing and compliance functions, and other activities. Finally, in an era of increasing uncertainty, boards must be informed of and understand the trade-offs involved in pursuing a strategic objective that puts the organization's financial position at risk.

Specific Board Duties

Boards must protect and enhance their organization's financial resources, and must ensure that these resources are used for legitimate purposes and in legitimate ways. Specific practices that are part of core financial oversight responsibilities include:[6]

- Being sufficiently informed and discussing the multi-year strategic/financial plan before approving it
- Being sufficiently informed and discussing the organization's annual capital and operating budget before approving it

4 Kenneth Kaufman, *Best Practice Financial Management: Six Key Concepts for Healthcare Leaders* (Third Edition), Health Administration Press, 2006.

5 See J.H. Sussman and M.E. Grube, *Strategic Cost Transformation for Post-Reform Success* (white paper), The Governance Institute, Summer 2014.

6 K.C. Peisert and K. 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.

- Annually reviewing and approving the investment policy
- Reviewing the financial feasibility of projects before approving them
- Monitoring financial performance against targets established by the board related to liquidity ratios, profitability, activity, and debt, and demanding corrective action in response to under-performance
- Ensuring that the finance and quality committees work together to improve quality while reducing costs and setting value-based performance goals for senior management and physician leaders

At a minimum, the financial information presented to the board includes:

- A *balance sheet* as of the last day of the reported month
- A *statement of operations,* including the operating and non-operating revenue and expenses for the month and year-to-date, as compared to the budget and prior year
- A *statement of sources and uses of cash* for the year-to-date
- A *statistical report* reflecting the levels of patient activity across the full range of services provided

Many hospital and health system boards examine considerable financial information beyond these documents. For example, financial detail on key operating units, such as physician practices or ambulatory sites, may be increasingly important to board financial oversight as the level of investment expands in the outpatient and physician space.

The Financial Package Used to Monitor Performance

Standard monthly reports developed by the executive team and provided to the board cover information on the hospital or health system's activities and performance. These include:

- Activity statistics
- Statement of operations, also called the income statement
- Balance sheet
- Statement of sources and uses of cash, also called the cash flow statement

A brief description of each follows.[7]

7 To understand how board members use these reports in monitoring activity, see Felix Kaufman, Ph.D., *Hospital Accounting and Finance* (Fourth Edition), Elements of Governance®, The Governance Institute, 2015.

Activity Statistics
This statistical report typically includes such data as inpatient discharges, average length of stay, average daily census, case mix index, and outpatient, clinic, ambulatory surgery, and emergency room visits. Data typically are provided for the month and year-to-date, showing variance between actual and budgeted for each. Data reported should be expanded to include all major services provided, regardless of location. (See sidebar for more details.)

Activity Statistics

Activity statistics show the level of patient activity for the month and year-to-date by types of service (medical) and by payment method. Some of the key elements in this report are:

Total number of patient discharges from the hospital
Number of Medicare patient discharges from the hospital
Number of non-Medicare patient discharges from the hospital

Average length of hospital stay (total)
Average length of hospital stay (Medicare)
Average length of hospital stay (non-Medicare)

Outpatient visits (total)
Outpatient visits (emergency room)
Outpatient visits (other)
Outpatient visits (physician)
Surgeries (inpatient and outpatient, in hospital and off site)
Key service line volumes

Utilization by payer (by patient days and, separately, by percentage of revenue)
Medicare
Medicaid
Blue Cross
HMO/PPO contracts
All other
Total

Staffing and occupancy
Full-time equivalents
Full-time equivalent per adjusted occupied bed
Occupancy rate based on staffed beds

The Balance Sheet

The balance sheet is the statement of the organization's financial condition as of a specific date. On that date, various resources (assets) are available for use in the organization's operations. Opposed to these assets are the claims (liabilities) against them. The "fund balance" or "net assets" is the not-for-profit organization's term for net worth ("net worth" or "equity" is used in for-profit businesses).

The values by line and by totals change on consecutive balance sheets because of many factors:

1. The flow of resources from one monthly balance sheet to another as patient activity takes place
2. Surpluses and deficits (profits and losses)
3. Investing and divesting
4. Incurring debt and reducing debt
5. Pension funding and other items that do not impact the income statement

Statement of Operations (Income Statement)

This financial report shows the organization's performance in terms of revenues, expenses, and income or losses, for the month and year-to-date, and how these results are better or worse than the current budget and, generally, the prior year. Best practice reporting includes volume adjustments to the budget to account for actual results to cancel out the "noise" due to variations in actual versus projected volumes. This statement includes the operating income/loss as well as the excess of revenues over expenses (or overall net income/loss).

Statement of Sources and Uses of Cash

Equally important to understanding the organization's profit or loss is understanding its "unrestricted cash position." This statement, sometimes called the cash flow statement, identifies cash flows from operating activities, investing activities, and financing activities. When reviewing it, keep in mind:

1. If the organization doesn't have enough cash, monitoring cash is the highest priority.
2. A growing, profitable venture may have cash problems.
3. Increasingly, rating agencies and lenders are looking for large and growing cash positions.
4. The organization should establish a targeted cash position. This will create the parameters for managing balance between capital investment and cash flow requirements.

It also is important for boards to understand the restrictions placed on some cash balances, such as those specified by bond covenants, compliance requirements, and donors.

Using Ratio Analysis to Monitor Performance

Dozens of factors are relevant to financial performance; the challenge for an organization's board and management team is to select those factors most indicative of the organization's financial strengths and weaknesses and closely monitor these on a regular basis. A ratio analysis, which draws data from the financial statements described above, is helpful in this regard, enabling the board to identify organizational trends and comparative performance. Key ratios used in many effective financial analyses appear below.

Ratio	What It Shows	Formula	Comment
Days in Accounts Receivable	Measures the time (in days) that the organization processes claims and receives payment from insurers/patients.	Net patient accounts receivable (from balance sheet) x 365 / net patient revenue	An increase of days in A/R suggests challenges in the hospital's business operations. A lower ratio is preferred, reflecting that the time period for collection is reasonable.
Days Cash on Hand	Measures the number of days the organization could continue paying its operating expenses from existing unrestricted liquidity balances in the absence of any future cash inflow.	(Unrestricted cash and marketable securities + unrestricted board-designated funds) x 365 / operating expenses – depreciation – amortization	Rating agencies are increasingly focused on this ratio. The median days cash on hand for an A-rated hospital in 2018 was 215 days.* This ratio changed in 2011 to exclude bad debt as an expense, which has increased the median. The finance committee should establish a target for the current year and five years into the future.
Operating Margin	Shows whether the organization made or lost money on its patient care and related operations.	Operating revenue – operating expenses / operating revenue	This excludes non-operating revenue/expense and focuses on the core activities of the hospital or system. Operating margin is a widely used metric to demonstrate the ability to make money on operations.
Operating EBIDA Margin	Shows whether the organization made or lost money on its core operations excluding the impact of capital decisions.	(Operating revenue – operating expenses) + interest + depreciation + amortization / operating revenue	Operating EBIDA margin is a key measure of overall financial health and is the primary driver of the organization's ability to invest in capital projects and maintain financial viability.
Debt Service Coverage	Measures the ability of an organization's cash flow to meet its debt-service obligations.	(Total revenue – total expenses) + depreciation + interest + amortization / annual debt service	The higher this ratio, the lower the risk lenders are incurring.
Debt-to-Capitalization	Shows how highly leveraged, or debt-financed, the organization is.	Long-term debt (less current portion) / (unrestricted net assets + long-term debt less current portion)	A lower ratio is preferred as it reflects less reliance on debt/external borrowing to support the organization's asset base.
Cash-to-Debt	Shows the ability of the organization to pay off its existing debt.	Unrestricted cash and marketable securities + unrestricted board-designated funds / long-term debt + short-term debt	This ratio is becoming increasingly important to rating agencies and lenders. A higher ratio is preferred.
Average Age of Plant	Indicates the average age of physical facilities and equipment.	Accumulated depreciation / depreciation expense	It is important that the average age of plant be at or below the median, especially among regional competitors. An older average age of plant ratio portends the need for major capital investment.
Capital Spending Ratio	Assesses capital spending as a percentage of depreciation expense.	Capital expenditures (additions to property, plant, and equipment) / depreciation expense	This ratio provides an indication of an organization's level of investment in its facilities and other strategic initiatives for long-term competitive performance.

Note: Bad debt is treated as a "contra-revenue"—a deduction from gross revenue similar to charity care—rather than an expense. Of the metrics above, this impacts days cash on hand, operating margin, operating EBIDA margin, and days in accounts receivable.

For more information on key creditworthiness ratios and their impact on credit ratings and capital access and costs, see Kenneth Kaufman, *Focus on Finance: 10 Critical Issues for Hospital Leadership,* 2nd Edition (signature publication), The Governance Institute, 2016.

*Moody's Investors Service, "Medians - Revenue growth rate inches ahead of expenses as margins hold steady," September 3, 2019.

Budgeting versus Planning

Is budgeting planning? Yes. However, the terms "long-range financial planning" and "strategic planning" are different. A budget has a one-year time horizon. It reflects objectives to be achieved in the short term. Strategic plans and long-range financial plans, best accomplished through an integrated planning process, have longer time horizons—three to five years, at least—and reflect desired future positioning. How are the budgeting and planning processes connected? A strategic financial plan outlines the expected financial impact over the planning time horizon of investing and implementing strategic initiatives. This includes multi-year projections of balance sheets, statements of operations, and cash flow statements. The current budget is a step toward accomplishing the objectives established by the strategic financial plan and should be tied closely to the first-year projection included in the plan.

Given the current operating environment, the strategic financial plan should include analysis of the investments required for value-based positioning, including physician integration strategies and infrastructure investments, as well as the risk to revenues associated with payment pressures, including reductions in inpatient utilization and payment levels tied more closely to quality outcomes.

Income Statement vs. Balance Sheet

The income statement is related to the balance sheet: for any two consecutive balance sheets, and if all other things are equal, the organization's change in unrestricted net assets mirrors the surpluses (profit) or the deficits (losses) generated during the period. The balance sheet category "net assets" is similar to what is generally called equity in a for-profit corporation.

Strategic Direction/Mission Oversight

Boards are responsible for envisioning and formulating the overall strategic direction of the organization. This is done through confirming the organization's mission, articulating an achievable future vision, identifying clear metrics by which the organization can measure its strategic progress, and specifying key goals and strategies to guide implementation. The board's primary focus is on mission, vision, strategic metrics, and goals. And, as described above, the strategic plan and planning process must be integrated with the financial plan. Guiding and participating in the development of the organization's strategic plan remains an integral part of this process.

At the outset of the process, it is important to understand and agree on how the organization is positioned today. Creating a foundation of objective information on your starting position helps to ensure that the strategic plan is realistic. To establish this foundation, the board should:

1. Know the organization's history—where it has been, what has worked, what hasn't worked, how the mission has changed over the years, and some of the main forces of change that have affected your organization.
2. Understand how healthcare is changing nationally, regionally, and in your local market, and agree on what changes you believe are most likely to impact your organization over the next three to five years.
3. Evaluate your organization's strengths and weaknesses—what it does well now, what it needs to improve—and how these fit with the organization's history and future market demands.
4. Evaluate external opportunities and threats—this is especially important given the rapid pace of change in healthcare. The board should be educated about those dynamics most shaping your market and how you are positioned to respond.
5. Involve your constituents—including physicians, partners/affiliates, community organizations, government, and the community at large.

Mission. Articulates the fundamental purpose of the organization. Answers "why" we exist.
Vision. Describes your desired future state in five to 10 years, including how the organization will be positioned and function. Answers "where" we are going.
Values. Express the behaviors that everyone in the organization is expected to demonstrate, every day and in every situation. Values are the heart and soul of the organization. Answers "how" we do what we do.

Once you have agreement of where your starting point is, the process of planning for the future starts. Essentially, there are six steps to the process:

1. **Reaffirm or change your mission.** Your mission is the foundation of all that you do. As part of the planning process, the board should review the mission statement to identify whether it is still relevant or needs any changes.
2. **Articulate your future vision.** The board should be actively involved in identifying your desired future positioning, five to 10 years from now. The resulting vision statement should be short, memorable, directional, and aspirational but realistic.
3. **Identify strategic metrics or a strategic balanced scorecard.** Strategic metrics—sometimes referred to as a balanced scorecard—are high-level measures of strategic success, with annual targets for each year of the planning horizon. They enable the board to monitor progress in plan implementation.
4. **Set goals.** Goals are broad statements of intent to accomplish your mission, vision, and strategic metrics. You will want to set goals to correspond to the organization's needs. To achieve your goals, you establish strategies that drive concrete actions that you can monitor and evaluate.
5. **Implement the plan.** Once the plan is completed and approved, the board turns it over to management for implementation. The board will expect management to provide progress reports on performance against the strategic metrics and implementation timetable laid out in the plan.
6. **Evaluate.** Routinely examine progress and evaluate what worked and what did not work. You will use your evaluation results in modifying direction, as needed, and shaping your subsequent plan(s).

The planning steps, as outlined here, appear to have a firm start and finish. However, in practice, good strategic planning is an ongoing cycle that is always being reshaped and improved as the environment changes, goals are achieved (or not), and the organization's needs change. Your strategic plan should be dynamic, and revisited at least annually at a board retreat to confirm or modify your strategic direction and determine whether any goals need to be changed.

Here are some helpful planning guidelines:

- Create time on your board calendar for planning tasks. It takes time to plan successfully.
- Involve all appropriate parties, both inside the organization and in the community.
- Always keep your organization's mission in mind.
- Remember that your culture and your strategic direction must be compatible. "Culture eats strategy for breakfast."[8]
- Take time to consider various strategic options, even if the "right" option seems obvious.

8 This quote is often attributed to management consultant, educator, and author Peter Drucker, and was popularized by Mark Fields of Ford Motor Company in 2006.

- Make sure your plan is flexible enough to accommodate a rapidly changing healthcare environment.
- Plan three to five years out, not just for the next year. And the organization's vision may involve a 10-year horizon.
- If you have tasked management to develop the plan, the board still needs to stay involved at the levels of mission, vision, strategic metrics, and core goals. Your organization's strategic plan reflects the board, and board approval is required.
- Make sure that your plan is realistic and focused.

During times of rapid change, strategic planning is more critical than ever. Boards should consider the following "pitfalls" and strive to avoid them:

- Don't assume that the future will be a continuation of the past.
- Don't avoid facing reality. Issues tend to hang around whether you like them or not. Use scenario planning to help the board think through "what would happen if…."
- Don't deny important trends. Trends reflect changes in the attitudes and behavior of consumers or users of services, and we ignore them at our risk.
- Don't plan wearing rose-colored glasses. It is easy to be over-optimistic. Good planning requires a grasp of reality rather than a bias toward optimism.

One final note on planning: Strategic planning involves the preparation of long-range financial projections that reflect the financial requirements and outcomes of the organization's aspirations. Frequent changes over the period of the strategic plan typically produce results that differ from the initial financial projections. The organization can track these changes in a more detailed manner through its annual budget—a step toward the fulfillment of the strategic plan.

Board Development

A board must assume responsibility for itself—its own effective and efficient performance. To discharge its stewardship responsibilities to its "owners," the board is responsible for its own development, job design, discipline, and performance.

Boards must evaluate themselves to determine their own effectiveness. Successful board evaluation results in specific action plans to improve performance in areas that need improvement. Being effective as a board comprises several key elements, including:

- Appropriate board structure (e.g., board size and composition, member terms, board budget and staffing, officers, committees, and recruitment, selection, and orientation of new members)
- Continuous governance improvement through regular board evaluation, rigorous orientation for new board members, and ongoing education
- Efficient and effective board meetings
- Meeting its legally mandated fiduciary obligations

Intentional Governance is a framework developed by The Governance Institute to help boards address their effectiveness in key areas and perform at their highest level of potential. The Intentional Governance Spectrum shown here can serve as the foundation for continuous board development.

Using a rigorous and valid board self-assessment tool is essential to develop an action plan for improvement. The Governance Institute also recommends conducting individual board member assessments and using the results of those assessments to determine reappointment to the board.

With an understanding of the overall duties, some of the issues, and a code of conduct, boards can work on specific responsibilities and effectively monitor their own performance.

Intentional Governance Spectrum

Management Oversight

A key responsibility of the healthcare board involves management oversight and review, accomplished through routine CEO performance evaluation. The Joint Commission mandates routine assessment of chief executive performance, and observers clearly view this activity as a primary indicator of good governance. This is not a responsibility many board members enjoy, but it is fundamental to governance. It aligns organizational mission, values, goals, and objectives with organizational and CEO performance.

Both the board and the CEO need a clear vision of where the organization should be. The vision helps delineate an overall plan to guide the CEO's activities. As the CEO executes the plan, the board needs assurance that the CEO's leadership and direction remain compatible with the organization's vision and goals. Performance evaluation gives both the board and the CEO the opportunity to measure and guide progress.

Boards must ensure high levels of executive management performance. The CEO is the only employee who reports directly to the board. Tasks related to this responsibility include:

- Recruiting and selecting the CEO
- Specifying CEO performance expectations
- Evaluating the CEO's performance
- Determining the CEO's compensation and benefits, and tying CEO compensation to financial and quality performance metrics where appropriate
- Terminating the CEO's employment relationship with the organization, if the need arises
- Maintaining a current, written succession plan for the CEO, top senior executives, and key physician leaders

The relationship between a board and a CEO is delicate and critically important. This person is generally both a colleague and a subordinate. In most health systems and hospitals, the CEO is a member of the board (and also reports to it). Because the CEO is in the organization on a full-time basis and significantly influences the type of information the board receives, the CEO is often the board's most influential member.

Community Benefit and Advocacy

Community benefit and advocacy, an increasingly integral part of the board's overall imperative, is not limited to fund development and philanthropy. It encompasses a full range of efforts to reinforce the organization's grounding in the community, and to truly understand and meet the community's needs.

The Affordable Care Act of 2010 mandates that boards conduct a community health needs assessment every three years, and implement action plans based on the needs assessment. Hospitals and health systems are partnering with many different types of community organizations to improve the health status of their communities, increase access to healthcare services, and better coordinate care. While these issues are related to improving quality of care, they are also essential to the organization's obligation to benefit the community. Addressing these needs require going beyond providing clinical care and addressing other social determinants of health that are

barriers to care, including safe environments, access to healthy foods and exercise, health education, and the ability of patients to get to doctors' appointments.

Boards need to focus on community benefit efforts and advocacy for other public policy issues such as labor relations, nurse staffing ratios, medical malpractice, niche-provider competition, effective policies for managing the uninsured, and so forth. This requires board members to take an activist role in telling their stories.

Key activities that underpin advocacy efforts include:

- Conducting a community health needs assessment to understand the health issues of the communities served, and creation of an action plan to meet these needs (at least every three years)
- Ensuring that the organization is appropriately and effectively addressing social determinants of health impacting its patients
- Clearly explaining during new member orientation the expectation that board members advocate on behalf of the organization
- Developing a policy on community benefit that includes a statement of the organization's commitment, a process for board oversight, a definition of community benefit, a methodology for measuring community benefit, and measurable goals for the organization
- Developing a board policy that delineates the board's role in fund development and philanthropy efforts
- Determining board goals for public advocacy
- Tying community health goals and programs to the strategic plan

Some hospitals and health systems are now including information in their board orientation manuals such as a comprehensive description of the organization's community health commitment, policies, and programs, as well as questions boards can ask about these activities and potential ways to create community partnership opportunities.

Committees: The Workhorses of the Board

Board committees exist to enhance the effectiveness and efficiency of the full board when it meets. They do this by performing serious work for the board, in addition to directing work done by others on their behalf. This makes the volume of work more manageable.

Committees contribute to the overall effectiveness of a board in the following ways:

- They help an organization take complex issues or tasks and break them down into manageable projects.
- They accomplish much of the groundwork needed for the full board to make informed decisions.
- They ensure the board and the organization that an issue was discussed thoroughly and not given short shrift by being one of a dozen items the board had to address at its meeting.
- They allow their members to substantively contribute to the organization—more so than these members may be able to do at full board meetings.

Committees do not replace the work of the board, but rather aid the full board in fulfilling its responsibilities. The full board, however, must ensure that committees function properly.

We advise keeping the number of committees to a minimum, and setting up *ad hoc* work groups or task forces, with limited duration, for topical and/or timely issues. Boards typically allocate work to eight "standing" committees (finance, audit and compliance, executive compensation, quality/safety, strategic planning, community benefit, governance, and executive). In addition, systems often have investment and research and education committees. A summary of these committees' charges and procedures appears in the following table. This table is for representative purposes only and is generic to hospital or system-level committees; boards may vary the number and titles of committees, the committees' purposes, responsibilities, etc., to fit the needs and values of their individual organizations and governance structures.

Board Committee	Purpose	Responsibilities	Composition	Meeting Schedule
Finance *(including investment for independent hospital boards; large system boards often have a separate investment committee)*	To oversee all significant financial matters affecting the hospital/system (and its affiliates), including setting financial policy; evaluating financial performance; reviewing assets, transfers, and debt; reviewing financial matters concerning the retirement program; and undertaking financial planning and analysis, including establishing capital and operating targets	• Receive, review, and make recommendations to the board regarding the annual operating and capital budgets and all other fiscal budgetary matters affecting the hospital/system and its subsidiary corporations • Monitor financial results of the hospital/system and its subsidiary corporations • Advise the board on the financing of any long-range plans (e.g., debt strategy) • Review and recommend approval of major capital expenditures • Advise the board on capital financing strategy • Advise the board concerning acquisition, construction, utilization, and divestiture of real property/facilities/information technology • Oversee the financial plans and results of joint ventures, acquisitions, and other strategic arrangements of the hospital/system and its subsidiaries • Oversee managed care contracting, pricing, and revenue management • Oversee risk management strategies and exposure • Oversee the organization's investment portfolio and policies (if no investment committee) • Oversee the organization's pension plans, including funding and investment policies	Usually five to seven members including the CFO of the system/hospital, and the treasurer (if a different person than the CFO); the treasurer, if a board member, is usually the chair; CFO is staff to the committee	Independent hospital: monthly Health system: four to six times a year
Investment	To provide fiduciary oversight of the funds in the investment program, which includes the retirement fund, the endowment fund, the long-term fund, and the operating fund; also to review performance of and retain consultants and investment managers	• Recommend an investment policy • Select asset classes as well as establish targets and ranges for each asset class with regard to diversification • Evaluate the asset allocation and manager structure • Retain, review, and assess performance of appropriate experts to support staff and committee (e.g., investment advisor, investment managers, and institutional trustee) • Provide annual report and periodic updates to the board on the performance of the investments	Usually five members including the CEO, the CFO, and some board members	Independent hospital: not applicable Health system: four times a year
Audit and Compliance	To provide principal oversight for the accuracy and integrity of financial reporting systems, internal controls, and the internal and external audit processes; overseeing and monitoring the compliance program	• Oversee the independent audit of the hospital/system (and its subsidiary corporations) • Hire and direct the work of the independent auditors, who shall report directly to the committee • Oversee the internal audit function by setting priorities and reviewing reports and recommendations • Oversee the organization's compliance program by ensuring the establishment and maintenance of effective policies, procedures, leadership, and staffing • Review and recommend approval of the annual compliance plan • Oversee compliance with conflicts of interest, independence, and ethics policies governing the boards, medical staff, and employees of the hospital/system (and all of its entities) • Review annually with management and the full board the IRS Form 990(s) filed by the hospital/system (and its entities)	Usually five to seven members including the general counsel and the corporate compliance officer, who are staff to the committee; subject to state law, this committee should strive for the highest practical level of members who are independent under standards adopted by the board with the advice of counsel	Usually meets two to four times per year

Board Committee	Purpose	Responsibilities	Composition	Meeting Schedule
Executive Compensation *(includes oversight of all highly paid employees including employed physicians)*	To oversee matters pertaining to the employment, review, and compensation of the CEO, and reviewing the total compensation program for "highly compensated" executives and employed physicians to ensure they are both competitive and compliant with IRS and other regulatory agencies	• Establish compensation philosophy statements regarding "highly compensated" employees (executives and employed physicians) base pay, incentives, and benefits • Review and recommend compensation for "highly compensated" employees in a manner that qualifies for the rebuttable presumption of reasonableness under the IRS intermediate sanctions rules • Establish a plan for CEO succession • Monitor the CEO's plan for senior management development and succession for key executives • Work with the CEO to jointly set the CEO's performance goals and conduct annual evaluation of CEO performance against those goals • Ensure the CEO conducts performance assessments of senior executives • Monitor the employed physicians' performance evaluation process • Ensure that compensation information is fully and fairly disclosed on the IRS Form 990(s)	Usually three to five members, including the board chair (note: this cannot include any physicians who are on the active medical staff); must be composed of 100 percent independent board members according to IRC 4958; the CEO is a non-voting member or may attend meetings, but should not be present when his/her compensation is discussed, except to hear results of the committee's evaluation	Usually meets twice a year, periodically in executive sessions (outside the presence of the CEO) with independent advisors, and annually for the purpose of the executive compensation and performance review
Quality/Safety *(includes clinical quality, patient safety, and service/satisfaction/experience)*	To oversee the delivery of quality patient care and a patient-centered experience throughout the hospital/system	• Oversee patient care, clinical quality, patient safety, and satisfaction (of patients, physicians, employees, and payers) for the hospital/all entities in the system • Develop hospital/system-wide board-level policies regarding patient care and quality • Set hospital/system-wide quality goals, parameters, and metrics • Oversee quality improvement systems, priorities, and plans • Work with medical staff to set criteria and processes for credentialing and ongoing quality monitoring of clinicians • Make recommendations to the board on medical staff appointments, reappointments, and privileges • Monitor performance against policies, goals, systems, and plans • Review sentinel events and recommend corrective action as appropriate • Review management's plans to address negative performance and serious errors • Oversee compliance with quality and safety accreditation standards • Monitor medical staff credentialing and privileging; may be able to approve "clean" physician credentials • Ensure physician credentialing procedure is disciplined, consistent, and effective	Usually seven to nine voting members including some board members and physicians/clinicians; for a hospital, may include the chief of the medical staff, chief nursing officer, and senior-most quality executive, as well as three directors from the hospital board, and at least three physicians	Independent hospital: monthly Health system: four or six times a year (depending on how credentialing is handled)
Strategic Planning *(some boards prefer to do strategic planning at the full board level)**	To recommend to the board and review performance toward overall long-range strategic plans, as well as provide advice on urgent corporate strategic issues (includes oversight of strategy regarding all technology)	• Provide advice on corporate policy, strategic issues, management, long-range plans, and, in general, overall strategic direction of the corporation and its subsidiaries and/or affiliates • Review proposals and recommend new business ventures and new technology • Review and recommend the annual update of the strategic plan • Address other matters relating to corporate strategy • Review present information systems and recommend systems to more fully integrate corporate-wide clinical, financial, and managerial functions, and to more fully support strategic business objectives and operational needs • Monitor implementation of the strategic plan and major strategic initiatives • Ensure that the strategic plan reflects and furthers the organization's mission, vision, and values • Ensure that physicians and other key stakeholders are included in the strategic planning process	Usually seven to nine members including board members and non-board members; vice president of strategy is staff to the committee	Meets two to four times a year

*For more insight on whether to create this committee or use the full board, see *Board Committees* (Second Edition), Elements of Governance, The Governance Institute, February 2016, p. 9.

Board Committee	Purpose	Responsibilities	Composition	Meeting Schedule
Community Benefit *(including mission fulfillment and advocacy)*	To ensure the hospital/system executes its mission and provides benefit to the communities it serves based on an assessment of community health needs	• Ensure focus on the mission • Assess community health needs at least every three years • Ensure results of community health needs assessments are used in setting organization's strategies and plans • Develop community benefit goals, parameters, and metrics • Monitor community engagement plans and programs that serve to strengthen ties to the communities served • Engage with other organizations to foster improvements in community health and well-being, especially regarding behavioral health • Oversee the organization's annual community benefit reporting • Coordinate with the community outreach staff to identify and address important and relevant community issues • Oversee educational programs to help the community understand behavioral health issues and to reduce stigma • Advocate for the hospital/system and the communities served • Assist with public policy initiatives (as requested by management) • Keep abreast of major state and national issues relating to healthcare	Usually seven to nine members; the senior-most person in charge of mission is often staff to the committee; should include non-board members with connections to the community and needed expertise	Meets two to four times a year
Governance and Nominating	To ensure that the governance of the hospital/system is effective and efficient and consistent with "best practices" and legal and regulatory guidelines	• Maintain well-functioning governance structure, practices, and documents • Define competencies needed on boards and committees • Cultivate potential board and committee candidates • Recruit and recommend new board and committee members • Orient and mentor new board and committee members • Review the performance of board members prior to reappointment • Plan for continuing board education and ensure adequate funding • Evaluate board, committee, and subsidiary board performance annually • Develop and monitor achievement of annual goals by board, committees, and subsidiary board(s) • Support board chair in board and board officer succession planning • Develop and update board policies and procedures on a regular basis • Periodically initiate a comprehensive review and recommend enhancements to the organization's governance structures, practices, and documents (e.g., bylaws and committee charters)	Usually five to seven members, including the board chair and vice chair; often chaired by the vice chair and general counsel is usually staff to the committee	Usually meets four times a year
Executive *(this committee requires special care regarding the level of authority it is given to make decisions between board meetings)**	To transact the business of the full board in the interim between meetings	• Act on matters that cannot reasonably await action by the full board • Provide a vehicle, if needed, for timely decision making and advice to the CEO or board chair	Usually five to seven members, including the board chair (who is the committee chair), the CEO, the vice chair, and sometimes the chairs of each committee	As needed, ideally only in emergencies

*See *Board Committees* (Second Edition), Elements of Governance, The Governance Institute, February 2016, p. 10.

Board Committee	Purpose	Responsibilities	Composition	Meeting Schedule
Research and Education *(for health system boards, if part of the mission)*	To ensure the clinical research and medical education missions of the system are achieved	• Oversee clinical research for all entities in the system, in coordination with the university/medical school(s) • Develop system-wide board-level policies and procedures regarding clinical research • Set system-wide clinical research plans, goals, parameters, and metrics • Monitor management's implementation of the plans, policies, and procedures • Oversee the medical education for all entities in the system, in coordination with the university/medical school(s) • Develop system-wide board-level policies and procedures regarding medical education • Set system-wide clinical research plans, goals, parameters, and metrics for medical education • Monitor management's implementation of the plans, policies, and procedures for medical education	Usually five to seven members including both researchers and educators; the senior-most executive for research often staffs the committee; it often also includes the dean of the School of Medicine or equivalent university executive	Independent hospital: probably not applicable Health system: four times a year

Notes:

1. Usually, the voting board members do *not* include the employees/staff to the committee; they are ex-officio, non-voting members (e.g., CFO staffs the finance committee as a non-voting committee member).
2. The exception is that usually the CEO and the board chair are ex-officio, voting members of each committee (except the CEO would be a non-voting member of the executive compensation committee). They attend committee meetings as they choose. Often they are not included in the total number of members for the committee.
3. Most committees should include non-board members to add needed expertise and develop a pool of potential candidates for the board. The exceptions are usually the executive committee, executive compensation committee, and sometimes the governance committee. Another exception is committees that have been delegated decision-making authority; they often must be composed entirely of board members.
4. Committees should all be chaired by a board member and most states require at least two other board members. The committee chairs should be appointed by the board chair and approved by the full board.
5. These descriptions have almost all been written under the assumption that none of the committees have been delegated final decision-making authority for any responsibilities. The board should determine whether or not it will delegate any final decision making to any of its committees, and if so, include that in the bylaws and committee charters.
6. Each committee should include at least one expert in that topic (e.g., audit and compliance committee should include a CPA).

Loose Ends: Other Important Information for New Board Members

Keeping on Track: The Distinction between Management and Governance

The board must represent and balance the interests of those to whom the organization belongs, and thus must decide and act as their constituents would if they had the time, energy, experience, and knowledge to do so on their own behalf. This is best accomplished by focusing board efforts on governance—the area where the board is best positioned to add value to the organization.

Directors need to have a clear sense of the fine line between management and governance. Although not absolute, there are differences between the two. Governance means *setting* policy and strategy. Management means *implementing* policy and strategy as set forth by the governing body. The distinction, however, is obscured by the complexity and dynamic nature of healthcare organizations.

Ideally, governance and management is a joint endeavor. The future of the organization depends on the effectiveness of their mutual efforts. Nevertheless, it is the healthcare organization's governing board that is ultimately responsible, legally and morally, for the institution and all services it provides. So both the board and the CEO must diligently support their respective roles in the organization.

The board should expect specific things from its CEO and executive managers:

- A cooperative and open relationship—fully receptive to advice and counsel regarding the overall direction of the organization
- Guidance on policy and strategy
- Sufficient amounts of the right kind of information, in a timely fashion, to enable directors—individually and collectively—to fulfill their duties
- Management's best interpretation of reports, performance indicators, etc., including implications
- A realization that a director has assumed a responsibility to all stakeholders and expects the organization to be a good corporate citizen with respect to its many publics
- An openness and receptivity to searching questions by the directors
- Distribution to directors of all communications by management to the organization's various publics, including reports to funding sources, presentations to analysts, pertinent press releases

The CEO also has expectations of the board:

- Directors will show up (on time) for board and committee meetings, well prepared to discuss agenda items.
- They will express their views on the quality, quantity, and timeliness of the information they receive from management.
- They will seek additional information when they need it.
- They will exercise an active skepticism, articulate nagging doubts, and volunteer viewpoints.
- They will be available to the chairperson and CEO on an *ad hoc* basis for advice and counsel.
- They will confine their activities to their role as directors, and not allow themselves to drift into the management domain.

Key Points about the CEO's Role and the Board's Role

- Board members are not policemen—or even objective critics. They must have a positive, optimistic view that the organization will succeed.
- Both the board and the CEO should exert influence and have input in creating value.
- The board should focus on unlocking its full potential to contribute by:
  - » Being involved without micromanaging.
  - » Challenging the CEO but also being supportive.
  - » Being patient but not complacent.
- The CEO has the right to demand that the board be an open-voice forum, a source of counsel, and a check on his/her own judgment.
- The CEO should try very hard to:
  - » Share information without feeling vulnerable.
  - » Seek advice without appearing weak.
  - » Solicit input without appearing to relinquish control over operational decisions.
- Essentially, boards and CEOs are accountable to each other and pursue the same goals.

Legal Liability as a Board Member

Most organizations provide Directors' and Officers' (D&O) liability insurance. It protects board members from lawsuits by paying defense costs, settlements, and judgments in some suits that challenge decisions they have made. However, it does not completely protect directors because of limitations and exclusions of coverage. D&O insurance premiums have been increasing in the past few years in response to increased risk for litigation, particularly in relation to hospital/health system finances and major business transactions.

Board members have liability protections other than D&O liability insurance. For example, some organizations have indemnification provisions in the corporate bylaws. These provisions ensure that board members will be compensated by the hospital for lawsuit judgments against them. Directors are also protected to some extent by state statutory immunity, although limitations and loopholes make this protection variable and debatable.

Additionally, board members are required to complete a conflict-of-interest disclosure statement that is updated on an annual basis. This statement should include any and all business relationships, either direct or indirect (through family connections), the board member may have with the hospital or health system. Failure to disclose this information constitutes grounds for stepping down from the board, and the director is individually responsible for fully disclosing this information.

The board must always strive to do its best. Worrying about its performance, however, should be tempered with reason and judgment. Past scrutiny of board actions by the judicial system has focused on practical approaches to governance such as:

- Judicial examination of a board's oversight emphasizes the board's decision-making process and whether the board acted in a deliberate and knowledgeable way.
- Perfection is not needed; directors are not required to know everything about a topic, and courts defer to directors about choosing which materials to study or ignore.
- Boards must be attentive to obvious signs of financial or regulatory problems and of employee wrongdoing.
- Boards must use the amount of care an ordinarily careful and prudent person would use in similar circumstances.
- Directors will not be held liable for a decision made in good faith, where the director is disinterested and reasonably informed, and believes the decision is in the best interest of the organization.

Healthcare is very big business, and must measure up to very stringent and onerous regulations. The board is ultimately responsible for the efficacy of the organization's compliance plan. Here are a few regulations to be aware of:

1. Hospitals and healthcare organizations must be licensed to protect the health, safety, and welfare of the public. Licensed facilities are subject to periodic inspections and review activities.
2. Certificate-of-need (CON) legislation, enacted by Congress, requires that providers get approval based on community need for construction and renovation projects. (CON regulation still exists in many states in order to regulate entry of very expensive new services.)
3. Cost-containment through rate review.
4. Regulation of mergers and acquisitions through antitrust laws.
5. Regulation of health plans through federal and state agencies and commissions.
6. Professional liability for malpractice suits.
7. Many other forms of regulation including pharmacy services, radiology services, food safety standards (patient meals and employee cafeterias), employee safety regulations, infection control standards, regulations governing the operation of laboratories, etc.
8. Accreditation agencies that report organizations' progress in meeting standards. Accreditation makes the difference between receiving and not receiving certain types of federal and state funding.
9. The IRS Form 990 report includes an expanded section for hospitals to file, known as Schedule H. This worksheet requires not-for-profit hospitals and health systems to describe and document vast amounts of information on how

the organization and its board of directors run the business. Community benefit calculations and conflict-of-interest disclosure are included on this form, as well as policies and compliance issues. If the IRS finds the information to be lacking, the IRS may question the validity of the organization's tax-exempt status.

Code of Conduct

Some boards have established a "code of conduct" to help guide their members through the political and bureaucratic quagmire of board activity. Here is a sample—addressing director, management, and physician conduct—that may be helpful:

- Board members, physicians, and administration will function as partners in serving the community's health needs.
- Board members, physicians, and administration will hold themselves accountable for maintaining and improving partner-like relationships among themselves.
- Physicians will be involved in making major strategic-level decisions that affect them, but will do so as part of the governance and management process.
- Physicians will be actively involved in the governance of the system and adhere to their fiduciary obligations.
- Board members, physicians, and administration will make decisions and solve problems jointly using open communication and positive approaches to conflict resolution.
- Board members, physicians, and administration will not tolerate dysfunctional relationships among themselves.
- Board members, physicians, and administration will commit to learning healthcare issues together.

Ground rules for behavior also set the tone for effective board meetings:

- Be honest and kind.
- Use good listening skills (e.g., clarify and paraphrase).
- Speak one at a time.
- Avoid side conversations.
- Keep all conversations confidential.
- Use consensus decision making.
- Encourage full participation.
- Summarize all decisions reached.

Finally, each board member should "internalize" the following maxims:

- Know and remember why you are on the board.
- Be careful but act decisively.
- Serve the organization's/stakeholders' interests.
- Do your homework.
- Show up and pay attention.
- Keep your eyes on the organization but your fingers out.
- Disagree in productive ways.
- Don't surprise the board chairperson and/or CEO with unexpected and potentially divisive topics. If there is a need to address something like this, inform the chair and CEO prior to the meeting.

Gaining Perspective to Serve Effectively

A typical board orientation program will be organized into sections specific to your hospital or health system. Each section should answer basic questions you may have about your organization, its structure, key managers, financial and legal issues, etc. We offer a sample orientation format, with 100 focused questions for your convenience. This is probably more than you expected you would have to know, but we believe it will provide you with a basic background to your organization.

100 Things to Know about Your Organization

The following table lists questions that are typically answered/covered in the board manual and board orientation program.

What You Need to Know

- Your organization and its structure
- Board structure
- Organizational planning
- Program services
- Funding
- Financial management
- Public relations and organizational spokesperson
- Personnel

Main Topics	The Section Should Answer the Following Questions:
Mission	1. Why do we exist? 2. What is our mission and has it changed recently? If so, why? 3. What are the communities we serve? Who are the "owners"?
Vision	4. Where do we want to be as an organization? 5. Has our vision changed recently? If so, why? 6. Does our strategic plan reflect our vision?
Values	7. What are our core values? 8. Has our value statement changed recently? If so, why? 9. Do the medical staff and management accept and promote these organizational values?
Board of Directors	10. Who is on the board (should include director and CEO names, addresses, work and home phone numbers, length of tenure)? 11. Who are the "independent" directors? "Non-independent" directors? 12. What board committees do we have? 13. Which board members are assigned to what committees? 14. What is the physician representation on the board? 15. What are the provisions/terms of our D&O insurance?
Board Meetings	16. What is the board's meeting schedule? The committee meeting schedules? 17. How long are board meetings? Committee meetings? 18. Who provides staff support to the board? How do we contact him/her? Where is the board "office"? 19. What does a standard board meeting agenda look like? 20. How do we submit agenda items for the meetings?
Organization Structure	21. What are the primary phone numbers for the organization? 22. Who is the primary administrative support person we should contact? What is his/her direct phone number? 23. How is the organization set up (parent, subsidiaries, special programs/units, etc.)? 24. How is management set up (organizational chart)? 25. Who is the senior administrator on call?
Strategic Plan	26. What is our primary direction over the next three to five years? 27. Who developed the plan? 28. Where are we in its implementation? 29. What are the plan's problems, if any?
Type of Organization	30. What is our legal status (not-for-profit corporation, division/branch of a not-for-profit corporation, subsidiary of a for-profit corporation, etc.)? 31. Do we have for-profit subsidiaries? If so, what are they and how does this work? 32. Do we have non-profit subsidiaries? If so, what are they?
"Direct Reports" to the CEO	33. What departments/services report directly to the CEO? 34. Who else reports directly to the CEO?
CEO Responsibilities	35. What are the CEO's responsibilities? 36. What is the difference between what the board does and what the CEO does (i.e., where is the line between the two functions)? 37. Is the CEO a voting member of the board? 38. Who handles the media?
Medical Staff	39. Who is the chief of the medical staff? How long has he/she had that position? Is this person on the board? A voting member of the board? 40. What is the composition and structure of the medical staff (how many, specialties, employed, physician groups, physician leadership, etc.)? 41. What is the responsibility of the medical staff with respect to patient care and the board? 42. How is the medical staff organized (including committees)? 43. Is there an updated medical staff manual? 44. What is the credentialing and reappointment process? 45. What medical staff committees exist to ensure quality patient care? 46. Does the medical staff leadership provide the board with routine reports on quality of care?

Main Topics	The Section Should Answer the Following Questions:
Operations	47. Do we have a customer service program? If so, what are its components and who is in charge? 48. Do we have a patient handbook? If so, has it been recently updated? 49. Do we have a continuous quality improvement/performance improvement initiative? If so, how is it working and who is in charge? 50. What is The Joint Commission and how does it affect our organization? 51. When was our last Joint Commission (or other accrediting organization) visit? Were we accredited? If not, what have we put in place to ensure we will be accredited at the next visit? When is the next visit? 52. What programs do we have that reach out into the community?
Finance	53. Who is our chief financial officer and what are his/her responsibilities? 54. Who conducts internal audits? 55. Who conducts external audits? 56. What was our inpatient/outpatient activity over the past year? Has it increased or decreased? What are the implications? 57. What was our revenue and expense position over the last year? What are the implications? 58. What is our payer mix? How does this affect our revenue? 59. What are our key financial indicators? 60. What is our bond rating? 61. What are the trends in patient activity, reimbursement, technology, and in the market?
Nursing	62. Who is our director of nursing and what are his/her responsibilities? 63. How are patient care services organized (e.g., Ambulatory Care, Med/Surg, Intensive Care, Maternity/OB, etc.)? 64. Who is the "house supervisor" and what does this mean? 65. What are the current issues regarding our Emergency Department? 66. What are the inpatient statistics (e.g., how many beds per unit, occupancy, number of surgeries, etc.)? 67. What are the outpatient statistics (e.g., how many ambulatory visits, how many emergency room visits, etc.)? 68. Do we have case managers?
Other Clinical Services	69. How many labs do we have and where are they located? 70. How many lab tests are done each month? 71. How many radiology sites do we have and where are they located? 72. How many radiographic studies are done each year? 73. Do we have rehab services? What are the specifics? 74. Do we have cardiopulmonary services? What are the specifics? 75. Do we have a palliative care team? Who is on it? 76. How is our social service/social work effort organized? What are the specifics? 77. What are the specifics about our pharmacy services?
Corporate Compliance/ Strategic Planning	78. Who is in charge of corporate compliance and strategic planning? 79. What are the responsibilities associated with monitoring corporate compliance? 80. What is the specific role of the person in charge of strategic planning? How does this activity relate to board responsibility?
Legal	81. Who is our counsel? 82. Do we have outstanding lawsuits against us? What is the status? 83. Who handles our contracting? 84. What major contracts do we have outstanding? 85. What are our most pressing legal issues?
Physician Recruiting/ Integration	86. Do we employ physicians? 87. How do we recruit physicians? 88. What are our current physician needs for the organization? 89. How are we progressing in our recruitment and integration efforts?
Human Resources	90. How many employees do we have? 91. What are our employee statistics (e.g., males vs. females, number of FTE, part-time, average age, average length of employment, turnover, etc.)? 92. How many nurses? Do we have a shortage? What are some of the key issues and efforts? 93. What is the employee benefit package? 94. How does employee compensation compare with our competitors and with the industry? 95. Do we have in-house education programs? 96. What are the components of human resources that merit attention of the board (e.g., changes to administrative policies such as benefits and wages, Joint Commission, employee satisfaction, etc.)?
Materials and Facilities	97. Who is in charge of materials and facilities management? 98. What are some of the key responsibilities of this position? 99. How does this function relate to capital purchases and the capital budget? 100. If we have large construction projects underway, what has been our progress and what can we expect in the next three to six months?

Overview of the Healthcare Industry

A healthcare organization mobilizes the skills and efforts of a number of widely divergent groups of professional, semi-professional, and non-professional personnel to provide a highly personalized service to individual patients. Its principal product is medical, surgical, and nursing services to the patient, and its central concern is the life and health of the patient. Hospital-centric organizations are facing the need to transition more care to outpatient settings and focus on keeping patients healthy and preventing them from needing to go to the hospital in the first place.

A healthcare organization has several objectives, for example:

- Its own maintenance and survival
- Organizational stability and growth
- Financial solvency
- Possibly medical and nursing education and research
- Community outreach, education, and health services to the uninsured/underinsured

Characteristics of a Healthcare Organization

- The main objective is to provide personalized service—care and treatment to individual patients. However, in today's value-based population health environment, the organization must also improve the health of populations, while also providing the right care at the right time for individual patients.
- It depends upon and must respond to its surrounding community.
- The demands of much of the work are of an emergency nature and non-deferrable.
- The nature and volume of work are variable and diverse.
- The principal workers in the hospital—doctors and nurses—are professionals, and this entails various administrative and operational challenges for the organization.
- The CEO has much less authority, power, and discretion than his/her managerial counterparts in other industries because the healthcare organization is not and cannot be organized on the basis of a single line of authority.
- It is a formal, quasi-bureaucratic and quasi-authoritarian organization that relies on conventional hierarchical work arrangements and rather rigid impersonal rules, regulations, and procedures.
- It is also highly departmentalized, highly professionalized, and highly specialized, and could not function effectively without relying heavily for its internal coordination on the motivations, actions, self-discipline, and voluntary, informal adjustments of its many members.
- The organization shows a very great concern for efficiency and predictability of performance among its members and for overall organizational effectiveness.

To do its work, the healthcare organization relies upon an extensive division of labor among its members. Work is greatly differentiated and specialized, and carried out by a large number of people whose backgrounds, education, training, skills, and functions are as diverse and heterogeneous as can be found in any of the most complex organizations in existence.

Everyone working in the organization depends upon some other person or persons for the performance of his/her own organizational role. Work is mutually supplementary, interlocking, and interdependent. Consequently, healthcare organizations have developed intricate and elaborate systems of internal coordination which, without concerted effort, continuity of care could not be ensured.

Organization of a Hospital/Medical Center

A hospital typically offers a wide array of services, both inpatient and outpatient, on its campus, and its organizational structure varies. In general, it is organized with a chief executive officer directing all aspects of operations except those that are assumed by the medical staff.

The board of directors has two direct reports: the CEO and the leader of the organized medical staff. This may be changing in the 2020s as hospitals become ever more similar to other large corporations and the professional medical staff becomes increasingly employed. Historically, the medical staff does not get involved in operations. However, in the 21st century there is an increasing recognition of the need to get doctors involved in operations in order to redesign care delivery to achieve the Triple Aim. For this expertise, most hospitals and health systems now directly employ physician leaders (CMOs, CIOs, CQOs, medical directors, and so forth) to manage operations as part of the administrative/management team under the CEO.

Few CMOs are voting board members, though they frequently attend board meetings as part of the C-suite representation at those meetings. Chiefs of Staff attend board meetings to provide reports from the medical staff, but are often not voting board members (this position typically is a non-voting, *ex officio* board member). This allows the Chief of Staff to be a true advocate and representative of the medical staff without the conflict of also being a fiduciary board member.

Thus, the board of directors works in collaboration with its two key partners—the CEO/senior executives and the medical staff. The three comprise the organizational "triad." But the board has ultimate authority and overall responsibility for the institution.

Administration

Although the organizational structure varies, generally the hospital or medical center's CEO is responsible for the organization's administration, which includes myriad professional and non-professional patient care services. Here are just a few of the specialized departments:

- Nursing and nursing units (for example, regular patient units such as med/surg, OB/maternity, labor and delivery, cardiac unit, intensive care units, intermediate care units, trauma, and all outpatient nursing in clinics, same-day surgery centers, etc.)
- Radiology
- Laboratories
- Pharmacy
- Social work
- Respiratory therapy
- Occupational therapy
- Physical therapy
- Nuclear medicine
- Housekeeping
- Nutrition and dietetics
- Operating rooms
- Dialysis
- Ambulatory services
- Emergency department
- Other specialized services

Administrative support services include:

- Finance: this includes hospital admitting, patient billing, authorizations, budgets, as well as all aspects of financial performance
- Information technology
- Medical staff relations
- Communications
- Public relations
- Marketing
- Human resources
- Education, training, certification
- Legal
- Regulatory/compliance
- Quality monitoring
- Strategic planning
- Community outreach
- Supplies and materials management
- Linens
- Physical plant maintenance
- Management and administrative support
- Waste disposal
- Other support services

The Medical Staff

The board delegates the day-to-day management to the CEO. In turn, the CEO delegates authority to the heads of the various departments. The heads of these departments, in turn, have varying degrees of authority over the affairs of their respective departments and personnel. The independent medical staff, its officers, and its members usually do not have any direct-line responsibility; they are outside of the administrative line of authority. (However, this is swiftly changing with the increase in employed physicians, many of whom are taking on these leadership roles.)

Yet, as is well known both within and outside the hospital, physicians exercise substantial influence throughout the hospital structure at nearly all organizational levels, enjoy very high autonomy in their work, and have a great deal of professional authority over others in the organization. And although the board of directors is in theory the ultimate source of authority, the board actually has very limited *de facto* authority over the medical staff. Independent physicians are subject to very little organizational authority partly because they are not employees of the hospital,

they enjoy high status and prestige, and they have almost supreme authority in professional–medical matters (the recent trend towards employing and integrating physicians alleviates some of these issues among the employed physicians).

The physicians most commonly employed by the hospital are hospital-based specialists such as anesthesiologists and pathologists, hospitalists, intensivists, and the chief of staff or chief of a specific medical service, who coordinates medical care for that service. Patient care services that have a physician "chief " can include surgery, orthopedics, obstetrics/gynecology, cardiology, etc. Hospitals and health systems are employing increasing numbers of primary care physicians and non-hospital based specialists, and/or engaging in integrated relationships with such physicians so that there can be more control over the quality of care provided and adherence to standardized care protocols in line with the hospital/health system's efforts to prepare for new payment models.

Nursing

Nurses provide the vast majority of hands-on care in hospital and outpatient settings. Nurse-dependent services include surgery, labor and delivery, emergency and trauma care, all acute inpatient care, all facility-based long-term care, outpatient dialysis, and licensed skilled homecare. Nurses do clinical assessment on admission, the majority of IV care and related medications, most treatments and procedures and discharge evaluation, and evaluate other nurses.

Because of both their importance and professional requirements, they are governed through a lead nursing executive who usually reports directly to the CEO. Nurses are assisted by a variety of professional and semi-professional people including technicians, administrative clerks, aides, therapists, social workers, infection control specialists, discharge planners, quality monitoring specialists, utilization review specialists, and care coordinators. There are also nurse specialists fully integrated into most patient care settings including nurse practitioners, midwives, and clinical nurse specialists.

Ancillary Services

Patients usually need more than a bed, a doctor, and a floor nurse when in the hospital. They require services that are "prescribed" by the physician and administered or processed by other healthcare professionals. These "ancillary" services include respiratory therapy, blood work from a laboratory, X-rays from radiology, dialysis, physical therapy, occupational therapy, resuscitation teams, special diagnostic procedures such as magnetic resonance imaging (MRI), and oncology treatment such as chemotherapy.

In addition to these clinical services, the hospital also must feed its patients and employees, keep rooms and hallways clean, instruments sterile, linens fresh, everything well stocked, equipment calibrated, and emergency transport certified and running well.

National Context for Hospitals and Health Systems

Today's healthcare organization looks quite different from its early 20th-century counterpart. The hospital, a major institution in the healthcare delivery system, is complemented and enhanced by a variety of structural and virtual relationships that expand its influence, and risk, far into its many communities.

Healthcare today involves aspects we never used to consider, including advancements in information technology and data management, virtual/mobile health and telemedicine, and specialty and disruptive competition from alternative (and unlikely) providers. More and more patients are being treated in an outpatient setting, which is greatly affecting care delivery in hospitals. What used to be considered a complex industry has surpassed its own complexity.

But providing healthcare services has become more expensive than ever imagined. Since the middle of the 20th century, healthcare has consumed an increasingly large—some believe disproportionate—share of U.S. resources. However, some progress in slowing healthcare costs is beginning to show. National health spending in 2012 was $3.8 trillion, and this remained level by the end of 2019. But projected spending by 2027 is $6 trillion, due to higher expected enrollment growth in Medicare as the population ages.[9]

> Soon, the cornerstone of healthcare will no longer be the hospital.

From a care delivery standpoint, two major structural changes are affecting hospitals and health systems, and as such, the role of their governing boards. First, the unsustainability of the marketplace and reimbursement pressures have caused a wave of hospital consolidations across the country. More and more governing boards are overseeing multiple hospital sites, and many are overseeing local and regional boards as well. Governance structures are changing, as some systems are choosing to remove boards at the local level, or changing the role of the local boards to that of advisory rather than fiduciary. Standalone hospitals that wish to remain so are looking to physician groups and other local community organizations with which to integrate or affiliate to increase their strength and expand their reach in the market.

Secondly, population health (focusing on the health outcomes of a group of individuals) has become a major focus in changing care delivery in order to prevent illness, enhance quality and access, and reduce costs. Accountable care organizations (ACOs) are being created across the U.S. in order to better manage the health of populations through care coordination, while keeping costs in check. These ACOs have their own governing board, with its own structure (representative governance, with a majority of board members being physicians in the ACO) and its own set of

9 Centers for Medicare and Medicaid Services, National Health Expenditure Projections 2018–2027 (forecast summary). Available at https://go.cms.gov/2vgDnBj.

priorities, many of which may be different from a hospital or health system board. CMS has several different ACO programs involving varying levels of payment risk, from shared savings and shared risk to full risk/capitation.[10] In addition, private payers are working with providers to develop their own ACO-like arrangements. This has created an emphasis on primary care and the development of patient-centered medical homes, as primary care physicians become the "gatekeepers" of ACO patients.[11]

As healthcare organizations take on more value-based payment contracts from both private payers and Medicare/Medicaid, the financial implications will be ever changing, and board members will need to analyze and understand financial scenarios that may look very different from before. The percentage of Medicare payments tied to value-based care reached 34 percent in 2017, up 23 percent from 2015.[12] Each year providers are expecting to have a higher percentage of value-based contracts from all payers, eventually phasing out fee-for-service contracts all together.

Market pressures to reduce the unsustainable cost of healthcare have also caused an increase in physician integration and employment (meaning an evolving medical staff structure, which has changed the board's relationship with the medical staff). Implications and considerations for hospital and health system boards include:

- Prevention and wellness efforts mean fewer patients filling hospital beds.
- There will continue to be an increase in outpatient care and a decrease in inpatient care.
- Payments are reflecting this and thus the financial indicators of a healthy organization are being measured differently.

10 For more information, see https://go.cms.gov/39bPXAu.
11 For more information, see https://pcmh.ahrq.gov.
12 Health Care Payment Learning & Action Network, *Progress of Alternative Payment Models: Methodology and Results Report, 2018.*

Bon Voyage and Good Luck!

Well done! You have completed this brief orientation manual—which means you have an earnest and inquiring approach to your new role as board member. These attributes will serve you well, and will serve your organization even better, because today's healthcare organization needs diligent, curious, critical thinkers to help guide it through the upheavals it will undoubtedly experience in the next three years.

There is much more to learn about healthcare and about governance. You now have a basic mastery of your key responsibilities, roles, key issues, and what sorts of questions you need to think about during your formal orientation. You also know how you and your colleagues should relate to one another and to your managers, how to work together in tense settings to accomplish great things in short periods of time, and how to support one another for the good of your community. Rely on your CEO and chairperson for assistance.

The Governance Institute has in-depth publications on each of the topics covered in this manual, as well as on other timely governance and healthcare issues crucial for your continuing education efforts. We also provide customized research services, answer special requests, and respond very well to unique suggestions about publication and conference topics. We publish a bimonthly newsletter, *BoardRoom Press*, E-Briefings online newsletter (also bimonthly), toolbooks, and white papers. We have video programs, Webinars, e-learning courses, and an online education series, Elements of Governance®.

Recommended Resources

Below is a list of recommended resources to learn more about what has been presented in this manual. Governance Institute members may download these at www.governanceinstitute.com:

On Board Kit: Online Multimedia Toolkit for New Board Members

Sample Board Job Descriptions:
Freestanding Hospital Board
Health System Board
Hospital Board within a System
Individual Board Member

Meeting Agendas and Board Calendars:
Board Calendar
Board Meeting Agenda

Elements of Governance®:
The Board's Role in Quality, 2nd Edition
Hospital Accounting & Finance, 4th Edition
Integrated Strategic Direction Setting and Planning
Board Self-Assessment: A Core Responsibility
Board Committees, 2nd Edition
Governance Development Plan, 2nd Edition
Board Education, Goal Setting, & Work Plans
The Distinction between Management & Governance, 2nd Edition

Best wishes for a challenging and rewarding experience serving on your board!

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