

Strengthening Public Hospital Governance

A Special Commentary by

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FROM

Dynamic Governance

AN ANALYSIS OF BOARD STRUCTURE AND PRACTICES IN A SHIFTING INDUSTRY

THE GOVERNANCE INSTITUTE'S 2011 BIENNIAL SURVEY
OF HOSPITALS AND HEALTHCARE SYSTEMS



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Executive Summary



SINCE WE LAST REPORTED ON GOVERNANCE STRUCTURE and practices in 2009, the healthcare industry looks drastically different, due to the passage of the Patient Protection and Affordable Care Act in March 2010, an increase in hospital mergers and consolidations, and the nation's continued struggle to recover from the Great Recession. The Affordable Care Act is in the earliest stages of implementation, with much of the potential benefits yet to be realized. However, the law's future may be at stake as many states are refusing to participate in certain reform programs including insurance exchanges and loss ratios, not to mention the various lawsuits challenging the constitutionality of the individual mandate (and/or the law in its entirety). Adding to this uncertainty is the federal budget crisis and the delicate position of Medicare and Medicaid in Washington budget conversations.

These factors have created a time in history like no other, both for our country as well as for the directors who oversee the nation's non-profit hospitals and health systems. Thus, our list of "recommended practices"—fundamental board activities necessary to fulfill the fiduciary responsibilities and ensure proper oversight of the charitable mission—continues to evolve in order to help boards frame their work more effectively and enhance their ability to respond to a dynamic marketplace. This year's survey included new questions relating to both governance structure and practices, in an effort to reveal subtle shifts connected to how organizations may be beginning to respond to these unprecedented marketplace dynamics.



Governance Structure

Governance structure is an essential component of the effectiveness of a board. Without the proper structure, boards cannot easily or effectively perform the essential practices to fulfill their duties. Thus, the first portion of our survey focuses on how the board structures itself. Board size and composition, committees and committee meeting frequency, board meeting frequency, and allocation of board meeting time all are fundamentally related to overall board performance. And, significantly, the size and composition of the board overall, are important ingredients in accomplishing the board's work. This

year we added governance structure questions specific to the makeup of the quality committee (which is becoming an essential arm of the board), more specific information about who sits on the board, and the use of a board portal or other online tool for communication between board meetings.

Governance structure has remained relatively consistent over the past few surveys, with boards moving towards the optimal size and structure for their needs. A few differences this year are briefly summarized below.

Board composition: Overall board size increased only slightly. Health system board size decreased slightly, while board size for all other organization types increased slightly. The most significant change is an increase in average physician representation on the board (employed physicians and "outside" physician representation increased across all organization types). However, most respondents indicated that there has been no change in physician representation on the board as a result of employing physicians. We asked this year about nurse representation on the board; subsidiary hospitals have the highest average number of nurses on the board (0.51).

Committees: The average number of committees increased significantly (7.6 vs. 5.1 in 2009); it is possible this is due to an increase in board activity in response to market changes. The percentage of organizations reporting audit and compliance committees (separate) increased by 6 percentage points compared to 2009. With the exception of health systems, there has been a significant increase in the number of organizations with a community benefit committee; there is a higher percentage of investment committees this year. And the percentage of organizations with a quality committee has increased again. The makeup for the quality committee for most respondents is primarily non-physician board members, physicians (either board members or medical staff physicians), and nurses.

The executive committee has less authority than it did in 2009. The percentage of respondents indicating that the executive committee has full authority to act on behalf of the board decreased from 51% to 45%. The percentage of respondents noting activities for which the executive committee is responsible has decreased for each activity, with the exception of board member selection. And more respondents noted that all executive committee decisions must be ratified by the full board (28% vs. 23% in 2009).

Board meeting time: Boards continue to devote about half of their meeting time to hearing reports from management and board committees (49%). Meeting time spent for board education increased slightly from 15% to 16%; however, time spent discussing strategy and setting policy remained the same at 32% (well below recommendations from governance experts). This year's analysis shows a positive correlation between the amount of meeting time spent on strategy and overall board performance (the more time spent on strategy, the higher the performance).

Board member compensation: This year marks the first significant increase in the overall percentage of organizations that compensate their board chair and other board members. Twelve percent (12%) of respondents said their board chair is compensated (up from 10% in 2009), and 15% said all or some other board members are compensated (up from 10% in 2009). For most respondents, the amount of compensation is less than \$5,000.

Use of board portal or similar online tool: Fifty-four percent (54%) of respondents either use a board portal or are in the process of implementing a board portal or similar online tool for board members to access board materials and for board member communication. Forty-four percent (44%) said the most important benefit of using a board portal is the reduction of paper waste and duplication costs.



Governance Practices

This year, we increased the number of recommended practices to 95. This list has slowly been growing from a list of 50 practices in 2003. Some practices have been updated; others were added—most notably practices related to compliance (duty of obedience) and new provisions within the Affordable Care Act. As the list of practices grows and becomes more complete, we are careful to maintain consistency over reporting years for the sake of comparison, while still having the ability to reflect market changes and new governance responsibilities. Thus, the list includes both fundamental governance practices that are not likely to change, as well as leading-edge practices that reflect priorities for boards given the current environment.

This year's results show that adoption of our list of recommended practices is, for the most part, widespread. However, this is the first year that we do not see a significant increase in adoption of most practices compared to our last reporting

year (2009), nor have we seen an increase in boards' ratings of overall performance in most of the oversight areas covered in the survey. The leap in adoption and performance from years 2007 to 2009 was significant, and in 2011 we see a slight leveling-off, which could be related to two major factors: 1) trend lines often grow in a linear fashion for only so long before there is a natural stasis and, 2) it is possible that this year survey respondents are expressing some degree of doubt or uncertainty as to how their organizations will be able to respond to the many changes soon to come.

Health systems and subsidiary hospitals again show a stronger consistency of adoption compared to independent hospitals and government-sponsored hospitals.

Financial oversight continues to be rated first in board performance and the practices in this area are most widely adopted. The duties of care and loyalty also rated high in performance. Quality oversight performance was rated higher this year than in 2009 (the performance score itself remained the same, but its ranking compared with other oversight areas was slightly higher this year), although adoption of practices did not increase significantly. Board self-assessment/development and advocacy remain the two weakest areas in both performance and adoption of practices.

Thus, the survey data reveal opportunities for hospitals and health systems to enhance their performance in ways that support all other board responsibilities. Board self-assessment/development activities include a regular performance assessment of the board, which boards can use to develop an action plan for performance improvement, and ongoing education programs on industry trends and governance information that can be tailored to the board's areas of weakness identified in the self-assessment. There has been increased attention in the industry on the importance of conducting individual board member assessments both to improve overall board performance and also to provide data to assist in the board member reappointment process; this is not reflected in the adoption scores this year. More focus on board self-assessment and development can help boards perform better in all areas, helping them to better anticipate obstacles to achieving board goals and identifying gaps in oversight responsibilities and practices.

Advocacy has long been an area of low performance, and with the current uncertainty in the industry regarding reimbursement levels and new payment models, advocacy efforts and fundraising should be top of mind for boards in helping their organizations have the financial means to continue to provide quality healthcare for the community.

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THIS YEAR'S BIENNIAL SURVEY SHOWS A CONTINUED PARADOX with respect to the boards of hospitals in the "government-sponsored" category. Such boards show relatively weaker governance effectiveness and responsiveness to their communities than the boards of non-profit community hospitals (and have shown such weaker performance over previous surveys as well). Government-sponsored hospital boards' overall scores were lower on all three fiduciary duties and all six core responsibilities in the 2009 study, and again in this year's analysis. (See [Appendix 3](#) for detail.)

To a certain extent, this paradox can be explained by the political nature of the boards that govern the hospitals in this category. The members of such boards typically serve either by virtue of being elected directly by the public or appointed by elected politicians. Most of the 164 government hospitals in this survey are directly owned and operated by city or county governments, or they are taxing districts or authorities directly controlled by state or local governments.

Elected officials are often unable to focus all of their attention on their hospitals. They are usually responsible for many other governmental programs and services. Even where separate politically appointed boards exist, they often have relatively little independence or autonomy compared to the boards of community non-profit hospitals. Many of the boards of these hospitals were established in the 1950s and '60s to protect the public's interest and oversee public hospitals with access to tax-based revenues to support hospital operations and retire debt from the federal Hill-Burton financing program. Where their governing bodies were to serve the broader public good, over the years many seem to have slipped into performance patterns that lag behind the boards of other community not-for-profit hospitals.

In part, this is because some of the important elements of effective governance are often subject to rules and regulations that were intended to apply on a government-wide basis, not only to hospitals. For this reason, many governmental hospitals have reformed their governance and legal structure in recent years. They have converted to structures with governing boards that have considerably more independence and autonomy, including freestanding authorities, public benefit corporations, and even non-profit corporations.¹

In sum, the very nature of the structure of such hospitals may make it more difficult for such board members to perform at the same level as the boards of community non-profit hospitals. However, that does not



¹ Larry Gage, "Why Do Public Teaching Hospitals Privatize?" (book chapter), *The Privatization of Health Care Reform* (Stuart Altman, Editor), Oxford University Press, 2003.

make effective governance any less important to governmental hospitals, particularly at a time when all hospitals are facing pressures to reform the way healthcare is delivered and financed. There are many areas where even elected or appointed directors can strengthen the governance of their hospitals and health systems.

In order to understand the areas in which the boards of governmental hospitals can strengthen their governance, it is informative to review the exhibits in this report that compare these hospitals to all others, by specific dimensions of good governance:

1. Government-sponsored hospitals tend to have smaller boards, with fewer physicians and less CEOs with vote (see [Exhibit 1](#)).
2. While there has been a modest increase in the use of term limits by public hospitals to refresh board talent, they are still (often due to statutory requirements) used less frequently than all other organization types (see [Exhibit 5](#)).
3. Fewer public hospitals use committees (see [Exhibit 7](#)), instead tending to rely more on working as a committee of the whole. This may be due to the smaller size of the overall board. They also rely less on executive committees than all other hospital types (see [Exhibit 9](#)). The small scale and less frequent reliance on committees may frustrate these board members from developing enhanced depth of understanding in selected functional areas of governance, and generates a substantial time burden on the amount of meeting hours board members must endure throughout the year.
4. Public hospital respondents tend to meet more often throughout the year (see [Exhibit 11](#)). This can create a persistent drag on the time and focus of their executive teams away from operations and strategic initiatives to the challenge of preparing for, going to, and writing up the activities and discussions of these many meetings.
5. The efficiency of their meetings may lag behind other hospital boards as public hospitals rely less on consent agendas (see [Exhibit 12](#)).
6. The effectiveness and quality of public hospital board meetings can be affected by their common requirements for meetings open to the public, media, and employees. This aspect of the public hospital governance ironically has been known to frustrate serving the public good rather than protect it in the original enabling legislation for many public hospitals. An overzealous application of open meetings can restrict the free and candid exploration of strategic challenges and opportunities that could strengthen the long-term vitality of the organization.
7. Instead of fostering a board culture that hungers for strategic and long-range thinking and planning, too many public hospital boards spend more time in meetings listening to reports, rather than on creative conversations about strategic challenges and opportunities. The



quality of board member dialogue can also be enhanced with their access to fresh insights and information about local and national trends that affect the performance of their hospitals. Great governance calls for great board education. Public hospitals have less of their meeting time devoted to education than other hospitals (see [Exhibit 15](#)). They also have the lowest budgets available for board member education (see [Exhibit 18](#)).

8. A pattern of governance that is particularly difficult as we move into an era of accountable care and receive increased calls for more transparent hospital performance reporting is the observation that over 84% of the public hospitals spend less than 40% of their meetings on strategy and policy, lowest among all types (see [Exhibit 16](#)).
9. While the above observations reflect concern with today's performance, the survey also provides insight into a factor that suggests future governance improvement and efficiency of public hospital boards may continue to lag behind other governance models as they have the lowest reliance on modern digital board portals (see [Exhibit 19](#)).

The challenges facing our nation's public hospitals in the coming decade demand that they be governed as wisely and efficiently as possible. The persistence of the governance patterns reflected in this survey, coupled with

the ever-increasing complexity of our nation's health system, will make it more difficult for elected officials whose focus is inevitably shared among many governmental priorities. Where dedicated hospital boards exist, the failure to provide such boards with sufficient

independence and autonomy will also make it increasingly challenging to attract strong board members to serve on these public boards. And ultimately the patients and communities these hospitals exist to serve may be disadvantaged.

Today, there are dozens of examples of governmental hospitals that have successfully addressed many of these concerns through the creation of new legal structures or the appointment of a new governing board. However, it is essential that such new organizations or boards be given real operating autonomy and be permitted to exercise it. Where restructuring has failed to solve problems or meet expressed goals, it frequently has been due to elected officials withholding too much explicit authority or interfering too often in the ability of the new board to exercise their authority.

In the process of creating a new board, hospitals should establish a process to recruit and retain highly qualified board members, both initially and over time. As in the private sector, a government hospital board should be composed of successful individuals who possess the range of experience

and skills to govern an organization effectively during a crucial transformational period. No less than in the private sector, a public hospital board must fully understand that their primary allegiance when they sit in the boardroom is to the viability of the hospital or health system (not to an external constituency). And once such a board has been recruited, even a governmental entity must provide board members with education and ongoing information, structure their committee and board meetings to permit them to govern effectively without wasting their time, and provide them with sufficient “job security” to enable them to make tough decisions with confidence. 🦋

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