CRITICAL QUESTIONS

Every Hospital Board Needs to be Able to Answer

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Board service has never been more challenging, the future less certain and the range of board responsibilities so broad and complex. Complexity, transparency, and demands for a greater level of governance accountability require motivated, knowledgeable trustees who understand how to think and lead strategically in today's challenging environment.   Developed by The Walker Company, GovernWell™ builds on over two decades of experience working with small and large hospitals and health systems, hospital associations and other health care organizations.

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Introduction

According to the American Hospital Association, there are over 2,800 nongovernment not-for-profit community hospitals in the United States, and just over 1,000 state and local government community hospitals. The nation's hospitals employ over 5.4 million people for a wide range of skill levels and are one of the largest sources of private sector jobs. Hospitals in the U.S. contribute much more than clinical care. They play an integral role in what's right with America's health care system, acting as centers of innovation and education, working outside their walls to improve community health, providing free and discounted care to uninsured and underinsured patients, and contributing significantly to their local economies.

America's health care system is undergoing significant transformation, and hospitals are seeking new ways to deliver value-based care, improve the health of their patients and communities and ultimately elevate "what's right with health care" to a new level. Many hospitals and health systems are aligning and integrating services across the continuum of care, but at the same time are confronting significant financial pressures as they seek to cross the chasm from a fee-for-service based system to a value-based payment system.

Trustees play a significant role in the transformation of health care and must demonstrate strong leadership to navigate through the challenges their organizations are confronting. Board service has never been more challenging. The future of health care is still largely unknown, and the range of board responsibilities is broad. Hospitals and health systems need dedicated and knowledgeable individuals who are willing to commit their time, experience, expertise and leadership to the hospital, its mission and the community.

This document has been developed as a resource for trustees seeking to ensure their board discussions, deliberations and decisions are well-informed and evidence based, as they lead their organizations into the future.

Q: What is the board's fiduciary responsibility?

In any venue, fiduciary responsibilities have to do with issues of trust and confidence. In the realm of hospital governance, it is imperative that hospital governing boards understand their particular fiduciary role as it pertains to accountability, financial responsibility, confidentiality and integrity.

Fiduciary: (1) of, relating to, or involving a confidence or trust; (2) held or founded in trust or confidence.

For hospital governing boards, fiduciary responsibilities and their related issues of accountability and trust are complex. Boards have a two-way responsibility: they must act in the best interests of both the hospital and the communities their hospital serves.

In these days of economic insecurity, it is particularly important for hospital governing boards to earn and keep the public trust. In the handling of hospital finances, the oversight of hospital quality, patient care and safety, and the assessment of hospital programs and services, governing boards can and must be held accountable to the people of the communities they serve. There can be no room for question of integrity or credibility of board members. Especially now, trust is an asset no board can do without.

What are "Fiduciary Responsibilities?"
Legally, board members must take particular care to become thoroughly informed before making a business decision; they must put the needs of the hospital first when taking responsibility for its operations; and they must abide by laws, regulations and standards of hospital operations.

These three main responsibilities are usually referred to as the Duty of Care, the Duty of Loyalty, and the Duty of Obedience. Each may be applied in a court of law to determine whether or not a trustee has acted improperly. They are to be taken seriously by every person accepting a position on a hospital board.

Duty of Care. When engaging in hospital business, trustees must use the same level of judgment they would use in their own personal business activities. The tenets are mostly common sense:

- Obtain necessary and adequate information before making any decisions;
- Act in good faith;
- Make decisions in the best interest of the hospital; and
- Set aside personal interests in favor of those of the hospital.

Individual state courts often further define board members' fiduciary duties, as does the U.S. Internal Revenue Service (IRS). The IRS, in recommendations for trustees, encourages putting policies and procedures in place to ensure that each trustee is totally familiar with the hospital's activities, that every activity promotes the mission of the hospital and helps it achieve its goals, and that each trustee should be fully informed about the organization's financial status.

Duty of Loyalty. The duty of loyalty bars trustees from using their board positions to serve themselves or their businesses. It requires that when acting in their fiduciary capacity, trustees place the interest of the hospital before all else. It demands that board members be:

- Objective and unbiased in their thinking and decision-making;
- Free from external control and without ulterior motives;
- Free of any conflict of interest when discussing issues and making decisions; and
- Able to observe total confidentiality when dealing with hospital matters.

The Board's Fiduciary Responsibility: Putting the Community's Trust into Action

To identify potential conflicts of interest, trustees and staff should annually disclose, in writing, any known financial interest with any business entity that transacts business with the hospital or its subsidiary businesses.

The IRS recommends creating written procedures for determining whether a relationship, financial interest or business affiliation results in a conflict of interest, and outlining a course of action in the event that a conflict of interest is identified.

Duty of Obedience. The duty of obedience requires board members to be faithful to the hospital's mission, and to follow all state and national laws, corporate bylaws, rules and regulations when representing the interests of the hospital.

Board members, in carrying out their duty of obedience, will protect the limited resources of the hospital to ensure optimal services and benefit to the community. They will ensure legal compliance with all applicable laws and regulations.

The IRS recommends several board actions to promote good governance practices related to the board's duty of obedience:

- Develop both a code of ethics and whistleblower policies;

- Adopt and monitor specific fundraising policies;

- Carefully outline and determine compensation practices; and

- Develop and strictly adhere to document retention policies.

Two Roadblocks to Fiduciary Effectiveness

Strong boards are independent-minded, curious, and able to focus on what matters most. Their members are willing to challenge status-quo thinking and stretch themselves intellectually. Weak boards are complacent and submissive. Their members do not ensure that all sides of issues are considered, or that "conventional wisdom" is challenged. Such weak boards are not likely to successfully carry out their fiduciary responsibilities.

There are two true roadblocks to any board's ability to maintain fiduciary effectiveness. These are 1) a tendency toward "rubber stamping;" and 2) a tendency toward micromanagement. Both are most likely to occur when a majority of members lack interest, drive or the ability to speak from the shadow of one or more overbearing board members.

Carrying Out the Board's Fiduciary Duties

The Duty of Care is fulfilled by...

- Consistent attendance at board and committee meetings

- Attentive and introspective preparation for board meetings

- Obtaining and reviewing relevant data and information before voting to ensure evidence-based decisions

- Exercising independent judgment

- Periodic examination of the performance of the executives and trustees who lead the organization

- Meaningful review of the organization's finances and policies

The Duty of Loyalty is carried out by...

- Full disclosure of potential conflicts of interest

- Compliance with the organization's conflict of interest policy

- Avoidance of the use of corporate opportunities for personal gain or benefit

- Maintaining confidentiality when required

The Duty of Obedience is carried out by...

- Strict adherence to the by-laws of the board and the mission of the hospital

- Compliance with all regulatory and reporting requirements

- Understanding of all documents governing the board and its operation (by-laws, articles of incorporation, board and committee job descriptions, charters, etc.)

- Ensuring that decisions further the organization's mission and comply with the scope of its governing documents

Rubber Stamping. Members of rubber-stamping boards fail to ask pertinent questions or engage in deliberative dialogue on solutions to challenges, and do not work successfully together to arrive at independent-minded decisions. They accept recommendations with little questioning or debate, and fail to explore alternatives and scenarios that may reveal the weaknesses of arguments or positions.

Rubber-stamping boards are often a result of overly dominant individuals and weak board chair leadership. A strong board chair will ensure that every board member is meaningfully engaged in constructive thinking and deliberation on the important issues that come before the board.

The Board's Fiduciary Responsibility: Putting the Community's Trust into Action

From a legal standpoint, individual members of a rubber-stamping board may be considered negligent and liable for their actions or inactions, and may be held personally liable for a lack of adequate oversight.

Micromanagement. It's often a challenge for board members to see the fine line between management and governance. Board members must understand that they are expected to be leaders and overseers, not managers and implementers. They should be concerned with the "what," not the "how." Micromanagement is a term generally applied to boards that pay too much attention to details, and not enough attention to the "big picture" strategic issues and implications.

It's up to everyone on the board to guard against micromanagement. The board chair should ensure that its members understand their roles, and consistently adhere to them. In addition, the CEO needs to be willing to candidly discuss problems of micromanagement with the board chair to work out board-driven solutions to this problem.

Maintaining the Public Trust

Whether a board member is serving for the first time or has been in the role for a number of years, it behooves the organization to have each trustee review these fiduciary responsibilities. This is a time in our nation when demonstrated personal accountability and acceptance of responsibility are key. No board can afford to lose the public trust.

The bottom line is that board members must act in such a manner that protects both hospital operations and the community's trust. There is no other way to success.

Sources and Additional Information

1. The Excellent Board: Practical Solutions for Health Care Trustees and CEOs, edited by Karen Gardner. AHA Press. 2003.
2. Knowledge Center. BoardSource. www.boardsource.org
3. Vicki Z. Lauter. Preparing for the Future. Hospitals and Health Networks. November 14, 2006.
4. Horikawa, Saori and Hempill, John. Serving on a Nonprofit Board in the Post-Enron World. Morrison & Foerster, LLP. San Francisco, CA.
5. IRS Publication 4221, *Compliance Guidelines for 501(c)(3) Tax-Exempt Organizations,* available at www.irs.gov.

Q: What is the difference between the hospital's mission, values and vision?

Too often hospital leaders develop mission, values and vision statements, and then don't make meaningful strategic use of these critical statements. Successful governing boards know that these statements, when properly developed and used, are the primary driver for every governance discussion and decision.

The board must ensure that the hospital has meaningful, unique, market-specific and compelling mission, values and vision statements that inspire and lead employees, physicians, trustees, volunteers and others to the highest levels of achievement.

The board must ensure that the entire hospital family, from top to bottom, sees its role and value in achieving the hospital's mission and vision. Every single person plays a vital role, and each person should hold him or herself accountable for understanding that role and playing their part in the attainment of the mission and vision. That culture of commitment is created and inspired by the board.

Finally, the board plays a unique role in motivating and inspiring hospital leadership to excel as strategic change leaders, individuals who can coalesce their colleagues in a strategic movement unified by purpose, committed to excellence, and rewarded for outstanding performance.

Mission, Values and Vision - The Gears that Drive Organizational Success

The board of trustees is ultimately responsible in every way for the hospital's long-term success in meeting the health care needs of the people it serves. It's incumbent upon the board to ensure a tight strategic fit and linkage between the hospital's mission, vision and values.

These three statements are the foundation of a solid strategic plan. The board of trustees, more than any other group of leaders, is responsible as the "keepers" of these critical success factors.

The board must ensure that these statements are unique, meaningful, powerful and compelling, and that they help solidify organizational thinking when confronted with a multitude of potential pathways to the future.

Once solid mission, vision and values statements have been agreed upon by the board, these statements should be the forefront of board decision making, and at the top of trustees' minds as they develop strategic plans, recruit physicians, plan for programs and services, determine community needs, and advocate for legislative and regulatory change that will benefit the community.

The Mission

The mission is the core purpose of the hospital. It should be a unique description that clearly defines the hospital's distinctiveness and differentiation.

Great mission statements are short, memorable, highly focused and enduring. They are able to capture in a few words the uniqueness of the organization and what it strives to accomplish. In addition, they clearly, boldly and vividly define the hospital's distinctive uniqueness - what sets it apart from other hospitals, and makes it a valuable asset to patients and the community.

Great mission statements use words and phrases that are compelling and passionate, and that inspire dedication and commitment. They are the foundation of everything the hospital does, and they inspire the hospital's vision and the strategies and objectives that underpin it. Great mission statements are used at board meetings to help frame critical discussions and stimulate deliberative dialogue and decision-

Building the Foundation for Success: Developing Powerful and Purposeful Mission, Values and Vision

making. They are a focal point for ensuring that every employee, physician, board member, volunteer or other member of the hospital family understands his or her unique role in helping the hospital to carry out its most important work.

Keeping the Mission Alive. Simply having a great mission statement doesn't guarantee that it will be consistently carried out with passion and with purpose. In order to keep the mission alive it should be printed at the top of every board meeting agenda. Having the mission front and center on the agenda will help to ensure that it's thought about and referred to during the course of governance dialogue and decision-making.

The board should take time during its board meetings for "mission moments," opportunities to reflect on some of the ways in which the hospital is carrying out its most important work. These mission moments can serve as an inspiring reminder of the importance of the hospital to patients, families and the community, and the importance of the governing board's work in ensuring constancy of purpose in achieving the mission

The board of trustees faces many situations in which it has very difficult decisions to make. When making these difficult decisions, one important question should always be asked: "how will this action, activity or decision further our ability to achieve our mission?"

Finally, at the end of every meeting take a moment to reflect on this question: "has the work we've done today on behalf of the hospital and the people we serve advanced our ability to achieve our mission?"

How Does Your Mission Measure Up?

Consider the following questions to determine how your hospital's mission measures up to "great mission" criteria:

- Is your mission dynamic, memorable, compelling, passionate and meaningful to everyone in the hospital family?
- Does it resonate with patients, consumers, payers, and community leaders?
- Does your mission clearly differentiate the hospital from all others in the market? Does it describe your competitive difference and distinctiveness?
- Does everyone in your organization know what the mission is? Can they relate the essence of it to patients, consumers and others? But more importantly, do they "live the vision" through the way they act and serve?

Based on your answers, should your mission be changed to better reflect your hospital's true core purpose and value?

The Vision

The vision is a vivid description of what the hospital seeks to become in the future. It considers future challenges, possibilities and choices, and serves as a "high bar" for organizational success. Like the mission, creating a vision with passion and purpose takes time, innovative thinking, and an ability to think into the future.

The vision should be inspiring, unique and visual; it should be written in a way that creates a mental image of the hospital at a future point in time. It should be enduring, and able to stand the test of time. It should be hopeful, empowering and measurable, providing purpose and focus in a dynamic, rapidly-changing environment. And while it should be a "stretch," and be very challenging to achieve, it should also be realistic and attainable with hard, focused work by everyone in the organization.

The vision should inspire enthusiasm and commitment in every corner of the organization, articulating what the hospital's hard work and investment is seeking to achieve, and prepare leadership thinking and resources to meet future challenges. It should be powerful and empowering. Finally, the vision should encompass the "big goals" that drive strategies, objectives and action plans.

The Dynamics of Creating a Vision. The key components of a vibrant vision are straightforward. They consist of the now - where the hospital is today; the future - an assessment of where the environment is headed; the focus - the responses the hospital intends to undertake to be successful in that future; and the future reality - where the hospital anticipates it will be when it's successful in achieving its prioritized strategic initiatives.

Elements of a Value-Based Vision. Many believe that a vision should be a simple, short and concise statement. That view often leads to a very general goal that doesn't truly describe the future the hospital seeks to achieve.

Instead, a successful, high-value, strategically usable vision is one that describes what the hospital seeks to become in the future in several critical organizational success areas. For example, what is the hospital's vision for improvement in the community's health? What does the board want to be able to say about the level of quality and patient safety in five years? How will the hospital adopt, implement and secure new information technology, such as electronic health records, and mobile and wearable technology in five years? What is the hospital's vision in the area of finance, patient and customer loyalty and satisfaction, and overall corporate culture?

Building the Foundation for Success: Developing Powerful and Purposeful Mission, Values and Vision

How Does Your Vision Measure Up?

Think about the hospital's vision. How does it measure up?
- Have you defined the areas in which your future success is most critical?
- Is your vision a powerful statement of the hospital's future in the areas most important to its success?
- Does your vision connect with the mission and values?
- Is your vision realistic, while at the same time an organizational "performance stretch?"
- Is your vision relatable to every area and every person in the organization?
- Does your hospital measure progress in achieving the vision?

In order to successfully achieve the mission, what other organizations will the hospital seek partnerships with, and what will those partnerships look like? What new services will the hospital develop and excel in as a center of excellence? What changes in governance and leadership will be in place in five or 10 years, and how will those changes benefit the organization?

These are the types of questions that should be asked by the board in the process of developing a value-focused strategic vision. They establish an agenda for strategic change that must be supported by clearly-defined strategies, initiatives and measurable objectives.

An Ideal Vision. An ideal vision is challenging, but at the same time realistic and attainable with diligence, commitment, and intelligent leadership. It's powerful, hopeful and empowering, and it inspires enthusiasm for the future and a commitment to achieving the hospital's mission.

An ideal vision provides purpose and focus during challenging and uncertain times. It takes into account the hospital's current and emerging challenges and opportunities, provides purpose and focus, and describes a future that has successfully dealt with them. In addition, it drives creative strategic thinking, and provides leadership with an "end point" that serves as the foundation for the hospital's strategies and objectives.

Values

Values are the principles and beliefs that drive organizational behavior at every level throughout the entire organization. The values are inspirational guideposts, the ethical compass that inspires people to live their professional lives in a certain way, and relate to patients, families, visitors, competitors, and others by exhibiting certain organizational and personal qualities and characteristics.

Values are not simply a collection of high-sounding words on a wall in the hospital lobby. They are the "rules of the road," the aspects of personal and professional behavior that signify what the hospital is and what it believes. They should be communicated and demonstrated through action – every day, in every way.

Good Values Create Better Organizations. Good values can create better organizations if they are more than just platitudes. Truly meaningful values are the unchangeable, bedrock core principles and ethics that guide the actions and belief structure of the organization. They serve as "cultural cornerstones," a blueprint for organizational, employee, and medical staff behavior. They are the fundamental beliefs and truisms that guide organizational behavior and decision making. They set the organization apart from its competitors, and establish its unique organizational culture.

In addition, values limit operational freedom and constrain behavior in order to ensure compliance with all laws and regulations, and set a high ethical bar. Finally, they demand constant vigilance to keep them at the forefront of organizational behavior and expectations.

Putting the Hospital's Values to Work. Having values is important, but embedding them into the hospital's culture is critical, and the board can help make that happen. The hospital's values should be integrated into every employee-related process – hiring, performance evaluation, criteria for promotion and awards, and dismissal. They should continually remind everyone in the hospital family that the values form the basis for every decision the organization makes, particularly the most difficult ones.

They should be promoted at every opportunity, and become infused in the organization's behavior. One way to highlight and instill the values is to tell stories about how employees,

How Do Your Values Measure Up?

Do a quick values check. How do your hospital's values measure up?
- How distinctive are your values?
- Do your values make a positive difference in the way people act, serve and relate to one another?
- Do your values support the mission, vision and strategies?
- Does your hospital use the values when evaluating employee performance?
- Does your hospital showcase examples of living the values?
- Does your hospital enforce its values, even when it's uncomfortable?

physicians, volunteers, trustees and others exemplify the hospital's values in their work. Finally, demonstrating the values should be celebrated at employee meetings, board meetings, community meetings and other venues.

Making Your Mission, Vision and Values More Than Words on Paper

To ensure success in living their values and achieving their mission and vision, governing boards can take several simple steps.

First, ensure that the mission, values and vision are prominent elements of decision making at all board meetings. Not only should they be prominently displayed with every board meeting agenda, but items should not appear on the board agenda unless they are directly connected to the mission, values and vision. And when considering any decision, boards should always discuss how the decision will contribute to fulfilling the organization's mission.

When considering policy and strategy decisions, boards should put them to the mission, values and vision alignment test. Do they fit? Can their rationale be explained? Is an investment in them an investment in furthering mission, values and vision success?

In addition, boards should regularly examine their strategic progress by reviewing the indicators that tell them whether they're on the right strategic course, and continually probe the value of their initiatives in helping them achieve their mission and vision. They should also ensure that a well-defined board-approved system is in place to measure progress toward

achieving the mission, vision and strategies, and take timely corrective action when necessary.

What Do We Know Today that We Didn't Know Then? One vital question that should be regularly asked by the board of trustees is this: "What do we know today that we didn't know when we developed our vision for the future? And if we had known then what we know now, would our assumptions change? Would our strategies change? What would we be doing differently?"

It's important that the mission, values and vision be reviewed on a planned, predictable basis, such as at the board's annual retreat. These should not be static statements. Instead, they evolve as the environment evolves. Assumptions should be challenged, and developing realities should be factored into the hospital's thinking about what it is and where it's headed. The only way to ensure that that occurs is through a continual flow of new information, new ideas, and new knowledge that drives new assumptions.

Seek Leadership Involvement, Particularly From the Medical Staff. Defining the hospital's mission, values and vision is not the exclusive job of the board. It's one of the primary responsibilities of the board, but to do it right requires involvement and buy-in across the organization.

The medical staff is one of the principal groups whose input and involvement is critical to success. In addition, the board should always depend on well thought-out options and alternatives from management to help shape the mission, values and vision course.

Q: How does the board ensure that quality is truly job one?

Boards of trustees are responsible for ensuring the quality of care and patient safety provided by their organization, and must take strong, organized action to establish and ensure an organizational culture that continually strives to improve quality and patient safety at every turn.

While there has been a much-heightened awareness about quality and patient safety in health care, errors still occur in hospitals every day. These errors are not always large and egregious; they may instead be small or unnoticed acts of commission or omission. Regardless of the nature or scope of the problem, quality and patient safety errors have great consequences on an organization's payments, patient satisfaction, medical staff and employee morale, and reputation.

The Problem: Inadequate Systems

The health care system is fragmented, with patients seeing several different providers for any number of health issues. Each provider has only limited access to patient information, and care is often poorly coordinated amongst the providers. This has resulted in no clear lines of accountability, and oftentimes poor communication between all levels of care providers.

With today's changing reimbursement that incentivizes increasingly coordinated care and alignment across the care continuum, boards must ask: "how can we better align care, increase communication, and eliminate fragmentation in the system?" According to the Institute of Medicine, there are many behavior choices that health care organizations make that can lead to patient injury or death, including:

- Not adhering to protocols/requirements;
- Inadequate investment in systems;
- Inadequate staffing;
- Lack of, or poor provider qualifications;
- Communication inefficiencies and ineffectiveness; and
- Failure to learn and change.

Boards must commit to changing these behavior issues by setting the tone or "culture" for the hospital, including setting patient safety guidelines and priorities and dedicating the resources necessary to provide appropriate, effective, safe care.

Quality and Patient Safety are Job One

Too often boards of trustees assume that quality and safety problems are not an issue in their hospital unless they hear otherwise. Instead, boards should ask specific questions to identify the hospital's current performance and pinpoint areas with the greatest need for improvement. Questions boards should be asking include:

- How good is our quality? How safe is our hospital? How do we know?
- What is our "culture" of quality and safety? Does everyone in the hospital family understand and embrace it?
- How can we improve?
- What should we be measuring?
- What does the public expect from us?
- How ready are we to publicly disclose our quality and safety performance?

Boards of trustees should be concerned about patient safety for moral, ethical, legal and financial reasons. Board members must understand that they are liable for the care provided at the hospital; that poor quality significantly

> "Board seats in American hospitals have traditionally been relatively honorific positions...it is time for hospital boards of directors – along with executives and physicians – to rise from slumber and view safety as an urgent matter."
> -Donald M. Berwick, Former Chief Executive, Institute for Health Care Improvement

impacts health care costs and reimbursement; and that patient safety is a key component of "staying on top" in a highly competitive environment. In addition, quality outcomes, such as 30-day readmissions and patient satisfaction, directly impact hospital reimbursement. And as hospitals increasingly employ physicians and forge partnerships and alliances in outpatient settings, hospital and health system boards of trustees must equally understand and be responsible for outpatient quality and patient safety.

Board Liability. It is ultimately the board's responsibility to ensure that the hospital is taking clear, appropriate measures to provide the safest health care in the most efficient and effective manner. As a result, trustees need to be aware of and proactive in addressing patient safety in their hospital, and seek continuing education about current trends and implications. Boards should regularly review key quality indicators, and take corrective action when necessary.

Competition. Quality has traditionally been a matter of perception on the part of patients, but emerging transparency efforts are allowing patients to make more evidence-based decisions. The growth in quality transparency combined with insurance decisions about who to include "in network" have the power to significantly direct market share. Hospitals that do not put protocols in place to increase quality and patient safety and improve patient satisfaction risk not only lower reimbursement, but also losing consumer confidence and market share.

Quality Leaders and Standard-Setters

Media scrutiny is increasingly shaping the public's opinions about health care quality and patient safety. People's opinions will be shaped by the stories they read and hear, but more importantly, by the "word of mouth" outcomes of those stories.

Hospitals and lawmakers are increasingly looking to national leaders such as the Institute of Medicine (IOM) and National Quality Forum (NQF) for quality measurements and benchmarks and suggested action steps. The Joint Commission patient safety standards are aligned with these recommendations, and underscore the importance of organizational leadership in building a culture of safety.

Institute of Medicine. In 1996 the Institute of Medicine launched its effort focused on assessing and improving the nation's quality of care. The first phase included research and documentation of the nation's overall quality problem, resulting in the now well-known report, *To Err is Human*. The

	Questions Trustees Should Ask About Quality and Patient Safety
1	What quality and patient safety measures should we be collecting and closely monitoring?
2	What are the top five quality and safety issues at our facility?
3	What is our organization's plan for quality and safety improvements?
4	What should we hold the executive team responsible for this year to improve our quality and patient safety?
5	Is it easy and safe to report errors at our hospital? What is the process?
6	What steps have we specifically taken to address the IOM's Six Aims?
7	If we were paid today on the basis of quality, not procedures, how would we do?

study brought national attention to the seriousness and frequency of health care errors, reporting that:

- 44,000—98,000 Americans die each year due to medical errors;

- Medical errors are the 8th leading cause of death in the U.S.;

- The annual cost of medical errors is as much as $29 billion;

- The majority of problems are systematic;

- Many Americans are injured by the health care that is supposed to help them;

- Less than five percent of these injuries are due to individual errors; and

- Errors can be reduced, but not eliminated.

To Err is Human was followed by a second phase of research and the publication of *Crossing the Quality Chasm*, a report describing broader quality issues and defining the "six aims" of care, stating that care should be:

- *Safe*, avoiding injuries to patients from the care that is intended to help them;

- *Effective*, providing services based on scientific knowledge to all who could benefit, and refrain from providing services to those not likely to benefit;

- *Patient-centered*, providing care that is respectful of and responsive to individual patient preferences, needs values

IOM: Simple Rules for the 21st Century Health Care System

The Institute of Medicine's 2001 *Crossing the Quality Chasm* report included specific recommendations for ways health care organizations can improve quality, including the ten rules for care delivery redesign outlined below.

Current Approach:
- Care is based primarily on visits
- Professional autonomy drives variability
- Professionals control care
- Information is a record
- Decision-making is based on training and experience
- Do no harm is an individual responsibility
- Secrecy is necessary
- The system reacts to needs
- Cost reduction is sought
- Preference is given to professional roles over the system

New Rules:
- Care is based on continuous healing relationships
- Care is customized according to patient needs and values
- The patient is the source of control
- Knowledge is shared and information flows freely
- Decision-making is evidence-based
- Safety is a system property
- Transparency is necessary
- Needs are anticipated
- Waste is continuously decreased
- Cooperation among clinicians is a priority

Source: Crossing the Quality Chasm: A New health System for the 21st Century. Institute of Medicine. 2001.

and ensuring that patient values guide all clinical decisions;

- *Timely*, reducing waits and sometimes harmful delays for both those who receive and those who give care;

- *Efficient*, avoiding waste, including waste of equipment, supplies, ideas and energy; and

- *Equitable*, providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.

Crossing the Quality Chasm included specific ideas of ways to make health care safer, including: 1) health care organizations' purpose should be to continually reduce the burden of illness,

injury and disability; 2) purchasers and health care organizations should work together to redesign health care processes; and 3) purchasers should examine current payment methods and remove barriers that impede quality improvement.

The recommendations made in this document, and continuing research and recommendations by the IOM, have become the new standard for health care safety. It is critical that trustees understand the key components of this research and develop strategies to address these issues in their hospitals.

The Joint Commission. Aligning with the IOM's reports on improving patient safety in health care, Joint Commission patient safety standards underscore the importance of strong organizational leadership in building a culture of safety. Such a culture should strongly encourage the internal reporting of medical errors, and actively engage clinicians and other staff in the design of remedial steps to prevent future occurrences of these errors. The additional emphasis on effective communication, appropriate training and teamwork found in the standards draw heavily upon lessons learned in both the aviation and health care industries.

A second major focus of the standards is on the prevention of medical errors through the prospective analysis and re-design of vulnerable patient care systems (for example, the ordering, preparation and dispensing of medications). Potentially vulnerable systems can readily be identified through relevant national databases such as the Joint Commission's Sentinel Event Database or through the hospital's own risk management experience.

Finally, the standards make clear the hospital's responsibility to tell a patient if he or she has been harmed by the care provider. The Joint Commission now requires organizations to develop a policy for informing patients when they have received substandard care or their outcome varies from anticipated results. Those organizations that fear that this will increase litigation may be surprised to learn that the Association of Trial Lawyers of America have stated that this could reduce litigation because "people appreciate honesty and being told what is happening to them or what might happen to them. The more

The IOM Definition of Quality: "The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

IHI: Characteristics of High-Achieving, Rapidly Improving Hospitals

Through review of literature, research evidence and best practices, the Institute for Healthcare Improvement identified 15 specific governance behaviors that increase the odds of rapid quality improvement throughout hospitals. The IHI recommends that observing these fifteen actions is the best place for boards to start in their quest to improve quality and patient safety. Best practice characteristics of high-achieving boards include:

1	They set a clear direction for the organization and regularly monitor performance
2	They take ownership of quality problems and make quality an agenda item at every board meeting
3	They invest time in board meetings to understand the gap between current performance and the best in class
4	They aggressively embrace transparency and publicly display performance data
5	They partner closely with executives, physicians, nurses, and other clinical leadership in order to initiate and support changes in care
6	They drive the organization to seek the regular input of patients, families, and staff, and they do the same themselves
7	They review survey results on culture, satisfaction, experience of care, outcomes, and gaps at least annually
8	They establish accountability for quality-of-care results at the CEO level, with a meaningful portion of compensation linked to it
9	They establish sound oversight processes, relying appropriately on quality measurement reports and dashboards ("Are we achieving our aims/system-level goals?")
10	They require a commitment to safety in the job description of every employee and require an orientation to quality improvement aims, methods, and skills for all new employees and physicians
11	They establish an interdisciplinary Board Quality Committee, meeting at least four times a year
12	They bring knowledgeable quality leaders onto the board from both health care and other industries
13	They set goals for the education of board member about quality and safety, and they ensure compliance with these goals
14	They hold crucial conversations about system failures that resulted in patient harm
15	They allocate adequate resources to ongoing improvement projects and invest in building quality improvement capacity across the organization

Source: 5 Million Lives Campaign. How-to Guide: Governance Leadership. Institute for Healthcare Improvement. www.ihi.org.

people know about their condition, the more favorably they view their doctor."

The Centers for Medicare and Medicaid Services. The Centers for Medicare and Medicaid Services (CMS) began by reporting hospital quality using "pay for reporting" on its Hospital Compare website. That has since transitioned to "pay for performance" and value-based purchasing, an ever-changing process that hospital boards of trustees must understand and incorporate into decision-making. Examples include hospital acquired conditions, readmission payment penalties, value-based purchasing, bundled payments and accountable care organizations.

- *Hospital Acquired Conditions (HACs)*—For discharges beginning on or after October 1, 2008, CMS stopped paying for certain HACs. To identify applicable conditions, hospitals are required to report "present on admission" (POA) information on diagnoses for discharges. Under the new rule, hospitals do not receive the higher payment for cases when a HAC is acquired during hospitalization (meaning it was not present on admission). Hospitals are paid if the secondary diagnosis is not present. In April 2011, CMS began to publish hospitals' HAC performance on the Hospital Compare website, and are proposing to add new conditions to the list for non-payment. Beginning in FY 2015, under the ACA, Medicare payments (base DRGs) to hospitals in the lowest-performing quartile for HACs will be reduced by one percent. This payment reduction applies to all Medicare discharges.

- Readmissions— In FY 2013, CMS reduced its payments to hospitals with "high rates" of readmissions in an effort to improve quality and reduce costs. Whether a hospital's payment is cut depends on how well the hospital controls its preventable readmissions. The reduction, which applies across all discharges, was limited to one percent in FY 2013, two percent in FY 2014 and three percent in FY 2015 and thereafter.

- *Value-Based Purchasing (VBP)* —Value-Based Purchasing is payment for actual performance rather than payment for just reporting hospital performance. With reporting, the Medicare payment was the same whether the hospital's performance is good or bad. Under VBP, CMS keeps between one and two percent of hospitals' payments – and hospitals will have a chance to earn back the withheld depending on the quality of their care.

- *Bundled Payments*—the "Bundled Payments for Care Improvement Initiative" was rolled out by CMS under the requirements of the ACA. Designed to improve quality and control costs, a bundled payment is one single payment for multiple services received by a patient from one or more providers during an "episode of care." According to CMS Administrator Marilyn Tavenner, "The objective of this initiative is to improve the quality of health care delivery for Medicare beneficiaries, while reducing the program expenditures, by aligning the financial incentives of all providers."

- *Accountable Care Organizations*—For hospitals participating in Accountable Care Organizations (ACOs), additional rules apply for quality incentives and disincentives. In its program analysis after issuing the final rules, the CMS describes the goal of shared savings to "reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first."

National Quality Forum. The National Quality Forum (NQF) is a not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting.   It was developed through a combination of public and private leaders committed to bringing about national change in health care quality on patient outcomes, workforce productivity, and health care costs.

In response to the IOM report, the NQF identified several events that should never happen in a hospital and that can always be prevented.   Examples of these Serious Reportable Events (SREs) include:

- Operating on the wrong body part or the wrong patient;

- Performing the wrong procedure;

- Leaving foreign objects in a patient;

- Contamination, misuse or malfunction of products and devices;

- Wrong discharge of an infant;

- Patient disappearance or suicide;

- Death or disability due to a medication error;

- Death or disability associated with a fall, burn or use of restraints;

- Care ordered by someone impersonating a doctor or nurse; and

- Abduction or assault.

The NQF works to promote a common approach to measuring health care quality, and is known as the "gold standard" for the measurement of health care quality.

The Institute for Healthcare Improvement. The Institute for Healthcare Improvement (IHI) was established in 1991 to lead the improvement of health care across the world. The IHI estimates that nearly 15 million instances of medical harm occur in the U.S. alone every year – a rate of over 40,000 instances per day. The IHI is striving to achieve health care for all patients with:

- No needless deaths;

- No needless pain or suffering;

- No helplessness in those served or serving;

- No unwanted waiting; and

- No waste.

One of the IHI's twelve interventions is to "get boards on board…by defining and spreading the best-known leveraged processes for hospital boards of directors, so that they can become far more effective in accelerating organizational progress toward safe care."

In an effort to accomplish these aims, the IHI launched its "100,000 Lives Campaign", with the goal of reducing 100,000 preventable deaths in the U.S. Over 3,000 hospitals participated in the campaign, and in 18 months an estimated 122,000 lives were saved. The combination of the campaign's success and the desire to address medical errors that may harm patients in addition to preventing avoidable deaths led to the IHI's launch of its "Five Million Lives Campaign." It expanded the focus of the 100,000 Lives Campaign, with the goal of dramatically accelerating efforts to reduce non-fatal harm, while continuing to fight needless deaths. The Five Million Lives goal was to protect patients from five million incidents of medical harm over a two-year period, from December 2006 – December 2008.

The campaign included twelve interventions for hospitals to reduce infection, surgical complication, medication errors, and other forms of unreliable care in facilities. While the IHI can't quantify if a total of five million instances of harm were prevented, according to the IHI, the campaign raised awareness about critical quality initiatives, and brought

unprecedented commitments to quality and patient safety with significant results from more than 4,000 hospitals across the country.

Quality Reporting and Measurement

The increasing push for improved quality and patient safety has resulted in a number of publicly available quality reporting websites. The challenge of reporting hospital quality performance is daunting: hospitals perform a wide variety of services and procedures, and each patient case is unique due to the patient's individual circumstances and co-morbidities. Nonetheless, these sites are the first attempt to capture and compare hospital quality performance.

As the health care reimbursement and delivery landscape changes and patients are increasingly responsible for paying a greater portion of their health care costs and making their own health care decisions, the availability of easily understandable hospital quality data will increasingly influence patient care decisions. In addition, public and private payers are moving toward "pay for performance," utilizing standardized hospital quality performance measures to influence hospital reimbursement.

While new websites are continually emerging, examples of well-known quality reporting sites include the CMS Hospital Compare website, the Leapfrog Group, HealthGrades, and the Joint Commission's Quality Check website. Hospital boards should know how their hospital's quality measures on these pages, how they compare to their competitors, and what the hospital is doing to improve in its quality performance indicators.

Hospitals and Physicians Can't Do It Alone

Quality improvement requires an understanding and acceptance of mutual responsibilities between all key stakeholders, including employers, clinicians and staff, and patients. Implementing quality and patient safety improvements is an opportunity for board members to be leaders in the community, coalescing all the key stakeholders together around a common purpose.

Employer Involvement. Employers have the opportunity to be champions for patient safety, promoting the need for safety reform and providing leadership in action toward the definition, measurement and improvement of quality and patient safety.

Nine Potential Causes of Medical Errors

1 Fundamental difficulties in medical care
- Balancing act of over-testing and under-testing
- Too much information – impossible to stay up-to-date
- Lack of time

2 Medical industry system problems
- Under-funded care
- Inefficiency of use of funds
- Over-worked physicians
- Slow adoption of technology
- Failure to report medical errors for fear of lawsuits
- Unnecessary medical tests for fear of lawsuits

3 Physician mistakes
- Human mistakes
- Alcohol or drug abuse
- Poor handwriting
- Poor dosage instructions

4 Patient mistakes
- Failure to report symptoms
- Delay in reporting symptoms
- Failure to report medications
- Non-compliance with treatment plans
- Dishonesty: Fraud, hypochondria
- Fear: Legal, social
- Patient pressure on physicians

5 Pharmacist mistakes
- Wrong medication
- Similar labels and packaging
- Similar medication names
- Wrong dosage
- Failure to communicate instructions

6 Pathology laboratory mistakes
- Errors in sample labeling
- Cross-contamination during testing
- Inherent risks in tests – false positives and negatives
- Limitations of tests for certain patients
- Human error in examining slides

7 Pharmaceutical industry mistakes
- Naming similarities
- Inadequate safety testing

8 Hospital mistakes
- Nosocomial infections
- Surgical mistakes
- Errors in transferring and re-labeling of medications
- Medication errors: Wrong medication, wrong dosage, wrong patient, wrong time

9 Surgical mistakes
- Wrong surgery
- Right surgery, wrong site
- Medication error before, during or after surgery

Source: Causes of Medical Mistakes. www.wrongdiagnosis.com/mistakes/causes.

Clinician and Staff Involvement. Accountability for quality and safety should be incorporated into every employee's job description. Regardless if employees have direct contact with a patient, every employee has a role in patient safety, from keeping the facility clean, to arranging the room in the safest manner possible, to ensuring the patient is checked in and registered correctly. Employees should be educated about the quality and safety expectations they are required to meet, as well as how to report safety concerns and errors. These concepts should be ingrained in the workplace culture, and effectiveness and success in meeting specific goals should be recognized and rewarded.

To ensure accountability, employees should work in teams that share responsibility and check one another to ensure protocols are followed. Individuals and groups should be recognized for disclosing errors, near misses and safety concerns, rather than punished.

Patient Involvement. Patients play a critical role in quality and patient safety as well. Without patient honesty and clear communication, health care providers may misunderstand a patient's needs, desires or abilities. Patients must be clear with doctors about medications they are currently taking, and they should take ownership in learning about their conditions and the best places to seek care for their unique medical needs. And patients should not be afraid to speak up—for example, to confirm that a provider has washed their hands, to ensure that discharge instructions and treatment plans are understandable, or to ask questions about follow-up care.

The Board Role. Boards must recognize that quality and patient safety is the backbone for everything the board does. Meeting agendas should include regular review of reports on quality and patient safety, as well as discussions of errors and near misses, and the steps taken as a result. The board should set performance goals for quality and safety improvement, and hold managers accountable for achieving those goals. Quality and safety expectations should be a major factor in board discussions about services, facilities, medical staff development and workforce development.

A Call to Responsibility: Improving Patient Safety at Your Organization

While no board or individual trustee sets out to govern low performance, boards can be "unsafe" or perform "governance malpractice" simply through lack of knowledge or understanding about key issues, not talking about quality and patient safety measures and their implications, lack of involvement, or focusing in the wrong areas. A "culture of

safety" should be ingrained in the hospital, beginning with the board. The board is responsible for setting the tone for the hospital, providing the tools necessary for employees to carry out the quality and patient safety vision, and encouraging a safe environment by regularly measuring and monitoring quality measures.

Creating a Culture of Safety. The term "culture of safety" is used often, but the definition can be ambiguous. Boards must define what a culture of safety means to their hospital. They should define what the leadership's commitment is to continual improvement in quality and patient safety, and how that will be carried out throughout the organization. Boards and hospital leaders should define how quality errors and near misses will be addressed, engraining in the culture the critical role that each employee plays in ensuring high quality and patient safety.

Building Physician Partnerships for Quality and Patient Safety. The medical staff is responsible for delivering the best possible quality to patients in the safest manner, working collaboratively with the board to identify clinical issues that prevent quality and patient safety improvement. Despite this shared quality goal, an eroded sense of shared vision can occur due to competing agendas, economic stress, regulatory pressures and leadership problems.

But working with the medical staff and medical executive team is essential in ensuring a patient safety plan is successful. Physicians don't want to be micromanaged by the board, and trustees don't want to overstep their bounds. But the quality of care provided at the facility is ultimately the board's responsibility, and increasing involvement will help the board better understand the issues and recognize the resources and technology necessary to achieve greater patient safety.

Some trustees may be uncertain about voicing their opinions around members of the medical staff. Trustees who lack medical expertise may be hesitant to challenge members of the medical staff. But to successfully improve quality of care, the board and medical staff must work as a team. That requires the medical staff to translate complex medical issues into "plain English" that trustees can understand, and requires trustees to ask questions and stand up for what they believe is right.

The contrasting cultures of physician independence and autonomy and board shared-decision making may be difficult to overcome, but can be achieved through board-medical staff communication, relationship-building and mutual respect. The board sets the tone for the hospital by creating a culture that is acceptable to both the board and physicians, creating a "practice friendly environment" through strategic

understanding of the issues, ensuring adequate staffing, quality employees, efficient and effective processes, and providing adequate resources.

Board/medical staff relationships can also be enhanced through additional efforts, such as retreats and workshops, one -on-one meetings or focus groups that allow both groups to understand one another's viewpoints. Conducting a medical staff needs assessment can also help the board to understand physician needs, and physician involvement in strategic planning allows mutual understanding of long-term issues and a shared long-term vision.

Maximizing Employees' Quality Improvement Commitment. The workforce is responsible for riveting its attention on improving quality and safety within the scope of their jobs, and employees are an integral part of the quality and patient safety improvement team. According to an article in *Hospitals & Health Networks*, to ensure that employees understand their critical role and maximize employees' quality improvement commitment, boards should:

- Demonstrate patient safety as a top leadership priority;

- Actively promote a non-punitive environment for sharing information and lessons learned;

- Routinely assess risk to positive patient outcomes;

- Determine ways employees can learn from one another and share information;

- Involve staff in analyzing causes and solutions to errors and near misses;

- Reward and recognize safety-driven decisions and reporting;

- Foster effective teamwork, regardless of authority, through team training and simulation;

- Implement care delivery processes that avoid reliance on memory;

- Implement care delivery processes that avoid reliance on vigilance; and

- Engage patients and caregivers in the design of care delivery processes.

Implementing a Quality Dashboard

One effective method for monitoring the hospital's quality performance is to implement a quality dashboard. The dashboard should be reviewed regularly at board meetings, ensuring that trustees are aware of the hospital's actual quality performance, and are empowered to make decisions based on hard facts and evidence rather than anecdotal opinions.

What is a Dashboard? Dashboard reports are useful tools that help hospitals convey large amounts of information in a concise manner. A concise display of clinical performance information is an ideal way for board members to monitor clinical aspects of care – similar to how a board scrutinizes financial information. Dashboard reports are easy-to-read updates of progress on those indicators important to the community and to hospital administrators, caregivers and boards.

Quality dashboards help hospitals accomplish the goal of regular trustee review and assessment of patient quality and safety measures.   Dashboards are presented in the same easy-to-read format at every board meeting, ensuring that all trustees understand the reports and can make informed decisions about whether the hospital is "on track" with its quality and patient safety goals.

Because each hospital has its own unique goals and progress indicators to track, every organization's quality dashboard will look slightly different. The key is that boards of trustees determine the type of reporting that works best for them to quickly review and interpret their organization's quality performance.

General Implementation Principles. Quality dashboards should be simple and concise. The information should be presented in a language easily understood by everyone, avoiding and/or defining acronyms and technical terminology when possible. The best model provides a quick way to report the status of hospital measures. Dashboards should lead with problems identified, followed by areas of progress.

Choosing Dashboard Measures. When deciding on measures to present, consider the list of potential measures as a "menu" for board selection. Keep in mind that not all measures are appropriate for all dashboards. Some measures may be fitting for some hospitals to follow and others may be applicable to track only occasionally. Work with the quality and safety committee to determine which measures to report.

Governance Accountabilities in the Quest for Quality

Key Questions for Trustees When Implementing a Quality and Patient Safety Program

The board's responsibility in patient safety is simply to monitor performance and demand accountability. Governing bodies should hold themselves accountable for patient safety just as they are accountable for financial performance. According to the American Hospital Association, boards should begin by:

- Asking to see regular reports on quality and patient safety from the facility or organizational managers;
- Requiring root-cause analysis of all errors that lead to injury;
- Setting performance goals for quality and safety improvement; and
- Holding managers accountable for achievable quality and patient safety improvement goals.

In addition, when selecting measures to include, align them with the hospital's strategic priorities. Consider measures that reflect issues determined to be most critical for review by hospital board members. Start with high risk, problem-prone areas. Also, include the hospital's publicly reportable measures, such as the indicators provided on the Hospital Compare website. This ensures that the board sees the same information that the general public sees.

Presenting Performance Data. Presenting performance data in a format that everyone understands is critical. The following three steps can help ensure that the dashboard is understood equally by all trustees:

- First, bring attention to the status of the indicators selected. For example, color-coded metrics allow trustees to see the status of quality and safety measures at a quick glance.
- Second, select the "lightning rods," or major areas of concern, for discussion at board meetings. In addition, follow-up on progress from previous meetings. Celebrating quality improvement successes are equally important to addressing current and emerging quality challenges.

Framework, Benchmarks, and Targets. It is important to have a common framework across the organization for understanding and communicating information in your quality and safety dashboard (for example, a balanced score card based on the Institute of Medicine's Six Dimensions of Care: Safe, Effective, Patient-Centered, Timely, Efficient, and Equitable). The measures should be reported to the board at the same time as they are reported at the department/service and practitioner levels. Although the metrics may be provided in much greater level of detail at the department and committee level, reporting the same indicators to all

Does Your Board Practice These Quality Best Practices?

1	*Goal Achievement and Compensation.* Tying executive goals and performance to compensation is critical practice. Achieving certain quality goals should be a part of not only the CEO's performance evaluation each year, but of every employee's performance evaluation. Ensure that achievement is rewarded by linking a meaningful percentage of compensation to quality goal achievement. The entire organization should be focused on quality progress, and goals should cascade through all levels of the organization.
2	*Adequate Budget.* Ensure that quality improvement plans and goals are incorporated into budgets. Identify the resources needed to help guarantee success well enough in advance so they may be incorporated into the hospital's annual budget process. And if budgets need to be reduced, ask what impact those cuts may have on quality.
3	*Quality Expertise on the Board.* Evaluate the diversity of your board. Do you have members with quality expertise? That expertise might be clinical and it might be an individual with quality performance improvement experience from an outside industry.
4	*Board Self-Assessment.* Does your annual board self-assessment include an evaluation of board and individual quality expertise and practice? Have you considered those findings as you develop quality and patient safety education for the board?
5	*Quality Dashboard.* Does your board have a well-defined quality dashboard, which is reviewed regularly at board meetings? The dashboard should continually be updated, and should ensure that board members have the information necessary to make informed decisions.
6	*Just Culture.* Boards should be familiar with the concept of a "just culture," which recognizes that people make mistakes—however, organizations can have systems in place to prevent those errors before they occur. And if they do occur, employees feel safe identifying an error or bad choice so that the system can be improved and prevent future events.

stakeholders at the same time ensures that the key players are "on the same page," operating with consistent information and working toward the same shared goals.

Reports should also include benchmarks and/or targets for each measure where feasible. Measures should be compared to past performance, benchmarks at state and national levels, or data from published literature.

The Goal: "Quality Literacy"

A critical tool for advancing quality is continuing governance education and knowledge building. The goal is to build the board's "quality literacy."

To start, new trustee orientation should emphasize quality and patient safety. It should include help in understanding quality reports and dashboards, information about quality trends, a summary of legal and regulatory quality mandates, an explanation of quality terms and acronyms, and a review of your hospital's quality program, initiatives, challenges and issues. In addition, hospitals may consider assigning new trustees to the Quality Committee to provide them with a deeper understanding of the hospital's quality commitment and efforts. And, very importantly, quality and patient safety education and awareness not be a one-time event that ends with new trustee orientation. In today's rapidly changing environment, quality education should be an ongoing process for all board members.

Sources and Additional Information

1. Rowland, Christopher. Hospital Trustees Shift Their Focus to Medical Safety. *Boston Globe.* March 5, 2007.
2. Mycek, Shari. Patient Safety: It Starts with The Board. *Trustee Magazine.* May 2001.
3. To Err is Human, Building a Safer Health System. Institute of Medicine. www.iom.edu.
4. Causes of Medical Mistakes. www.wrongdiagnosis.com/mistakes/causes.
5. Harvard School of Public Health/Kaiser Family Foundation. Medical Errors: Practicing Physician and Public Views. *The New England Journal of Medicine.* December 12, 2002.
6. Sarudi, Dagmara. A Commitment to Safety: A Toolkit for JCAHO's new Patient Safety Standards. *Hospitals & Health Networks.*
7. Runy, Lee Ann. Quest for Quality: Lessons Learned, Challenges Met. *Hospitals & Health Networks.* November 2002.
8. Wilson, Nancy J. Creatures of Culture. *Hospitals & Health Networks.* May 2001.
9. Hospital Governing Boards and Quality of Care: A Call to Responsibility. National Quality Forum. December 2, 2004.
10. Agency for Healthcare Research and Quality, www.ahrq.gov.
11. American Hospital Association, www.aha.org.
12. Institute for Healthcare Improvement, www.ihi.org.
13. Institute of Medicine, www.iom.edu.
14. The Joint Commission, www.jointcommission.org.
15. National Patient Safety Foundation, www.npsf.org.
16. National Quality Forum Principles. National Quality Forum, www.qualityforum.org.
17. 5 Million Lives Campaign. Getting Started Kit: Governance Leadership "Boards on Board" How –to Guide. Cambridge, MA: Institute for Healthcare Improvement; 2008. www.ihi.org.
18. Arianne N. Callender, Douglas A. Hastings, Michael C. Hemsley, Lewis Morris, Michael W. Peregrine. Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors. United States Department of Health and Human Services Office of Inspector General and American Health Lawyers Association. September 2007. http://www.oig.hhs.gov/fraud/docs/complianceguidance/ CorporateResponsibilityFinal%209-4-07.pdf.
19. OIG Report on Board Oversight and Quality of Care: What it Means for Health Care Boards of Directors. Foley & Lardner LLP. October 16, 2007. www.foley.com/publications/pub_detail.aspx?pubid=4515.
20. Alice G. Gosfield, J.D., James L. Reinertsen, M.D. Avoiding Quality Fraud. *Trustee Magazine.* September 2008.
21. Joanna H. Jiang, Carlin Lockee, Karma Bass, Irene Fraser, Robert Kiely. Board Engagement in Quality: Findings of a Survey of Hospital and System Leaders. Journal of Healthcare Management. March-April, 2008. www.entrepreneur.com.
22. Jim Roberts, M.D., Steve Durbin. The Board's Role in Quality and Safety, 7 Key Governance Questions. July 9, 2007. Providence Health & Services.
23. Hospital Governing Boards and Quality of Care: A Call to Responsibility. National Quality Forum. December 2, 2004.

Q: How does the board ensure the right issues are discussed in the right way at the right time?

Hospital leaders must navigate through a complex health care environment that continues to come under increasing examination and debate. The lingering effects of the economic recession, calls for increased transparency, scrutiny of health care costs and quality, changing reimbursement systems and the uncertainty of health care transformation mean that boards today, more than ever, must focus their time and attention on the most critical issues confronting their organizations. Board meetings should begin with prepared participants, follow a meticulously-planned agenda, and include respectful, friendly exchanges of ideas and calm deliberations. Meetings should be conducted by a procedure-savvy chair, maintain clear direction and decisive votes, and end on time. If this does not quite describe your board's meetings, read on…

The truth is, the time a governing board spends together in its meetings can make or break its effectiveness. Great board meetings set the tone for hospital success.. Everyone arrives having done their homework, they know the issues they'll be discussing and voting upon, they're committed to treating one another in a civil manner, and they deliberate calmly. If the discussion should ever get boisterous, their chair skillfully brings them back to order, refocuses the discussion, and calls for a vote. When the gavel signaling adjournment falls, board members clap one other on the back and congratulate themselves on another productive meeting.

It may sound like a dream, but it's a fact that your governing board meetings can move just as smoothly and productively.

Best Practice Number One: The Meeting Starts Before the Meeting

Board members should arrive at meetings well-prepared, having received their board packet – including the agenda, previous meeting minutes, board reports, and supporting materials – at least a week ahead of the board meeting. As committed board members, every trustee will have read and studied the entire packet, prepared ideas to propose during discussion periods, and arrived at the board table on time.

Too often, board members arrive five minutes early (or late!) and try to speed-read their packet information before discussions begin. This practice makes it nearly impossible for them to be equipped with the background information they need to discuss agenda items intelligently, and their lack of detailed knowledge can cloud any vote they may cast during the meeting's progress.

Takeaway tips: Read and study the board agenda several days prior to the board meeting. If you have questions, call the board chair for clarification. Clarify your thinking on each scheduled agenda item and arrive prepared for discussion and deliberation. And always be sure to arrive on time.

Best Practice Number Two: A Great Agenda Sets the Stage

Sketchy agendas, or agendas with catchall phrases such as "New Business," "Old Business," or "Other Business" do no one any favors. A well-planned agenda can keep a meeting focused and on time. It can keep discussions from derailing and keep your members on task.

Here's what a clear agenda contains:

• Time, date and location of the meeting.

- Items being considered, with brief notation of action expected, such as "discussion only," "information only," or "vote to be taken."

- A suggested time for each item's discussion (in minutes).

- Items of greatest importance placed at the beginning of the meeting; items of lesser importance near the end.

Use of a consent agenda preserves limited board meeting time for the most important issues and helps to keep meetings on track. A consent agenda is an "agenda within an agenda," containing items that rarely need discussion. Most consent agendas include approval of minutes, approval of agenda, the chief executive's report and various committee reports. On occasion, a consent agenda might include legal documents such as leases or contracts that have already been agreed upon, but need formal approval. A consent agenda gathers all of these "low or no discussion" items into a group, and a vote is taken at the meeting's outset either giving "consent" to unilaterally approve the entire group of items, or to pull one or two items out for clarification and discussion. It's assumed that all board members have read the items included in the consent agenda prior to the meeting.

Takeaway tips: Pay close attention to your agenda. Note the items that will be discussed and the time allotted for discussion. Come to the meeting with your ideas and thoughts prepared. Expect to spend more time on items of greatest importance, and little time on administrative tasks. Expect to approve the consent agenda, or be ready to ask that one or more items be removed from it for further discussion.

Best Practice Number Three: Treat Others as You Want to be Treated

The cardinal rule of boardroom etiquette is: Treat your fellow board members as you want to be treated. Learn to agree – and disagree – courteously. Speak up, stating your opinions and ideas concisely. Don't interrupt and be mindful not to dominate a discussion. Be willing to listen to others' opinions, and perhaps even change your mind if you hear a reasonable alternative to a tough issue. If you feel yourself getting hot under the collar, remember your mission to serve the hospital and the community.

Boardroom etiquette and courtesy are often "taught" in board orientation. In addition, a tremendous aid to keeping the meeting discussions and deliberations civil is for each board member to have a working knowledge of parliamentary procedure.

While reviewing etiquette may seem trivial, it helps set the stage for meaningful deliberation and dialogue, and for building positive working relationships between and amongst trustees. Great boards also conduct ongoing member performance evaluations, which may bring to light bullying or disruptive behaviors that must be addressed.

Takeaway tips: Respect others' right to speak, and listen to their ideas. Expect others to do the same for you. Be calm. Be collaborative. Keep your temper. If you disagree with someone, discuss the idea, don't belittle the person. Learn the basics of parliamentary procedure. It can help keep your meeting friendly, respectful and focused.

Best Practice Number Four: Elect an Organized and Focused Leader

A skillful board chair can bring efficiency and order to the most chaotic of situations. If emergency action is needed on a particular issue, a skillful board chair will concisely state the challenge, the background to the issue at hand, and signal the beginning of deliberation. If one board member is dominating a discussion, a skillful board chair will remind the group of the importance of all voices being heard and call upon others for their opinions. If a board member consistently remains silent and does not offer ideas or opinions, a skillful board chair can draw them out, urge their participation, and ask for their thoughts on an issue. If a discussion veers off course, a skillful board chair will bring it back into focus and keep tabs on the timing of the discussion.

Some boards may find they spend more time discussing past accomplishments or the "good old days" than they do deliberating over more pressing and difficult issues. A skillful board chair may remind them of health care planner and futurist Ian Morrison's words, "If you don't think systematically about the future, you run the risk of not participating in it."

Takeaway tips: Elect, appreciate and support a skillful board chair. Expect to participate equitably in meetings, or receive a phone call from the chair asking you to either tone it down or step it up. Expect the chair to keep discussions focused, on time, and strategic.

Best Practice Number Five: Know Your Deliberative and Decision-Making Processes and How they Work

Deliberation is one of the key roles of a governing board—it's where decisions are formed before decisive votes are taken.

Excellent deliberation always begins with a written definition of the challenge before the group, stated in neutral words with key points highlighted. The issue or challenge should tie directly back to the hospital's strategic plan and will be of importance to the hospital and/or the community. The chair details what the deliberation should accomplish, re-stating the objectives. He/she keeps the discussion on target, making certain every person shares opinions and is heard from. Solutions are proposed and alternatives are suggested, leading to a vote being taken or scheduled for the next meeting.

There are several models of decision-making, and board members must understand how their particular board utilizes each method. In the consensus model, agreement is reached after all alternatives are on the table, and the group arrives at one opinion. In some instances, the "majority rule" model is employed, where a simple majority decides the issue. In other instances, the board calls for a decision to be made by a super-majority, in which at least 51 percent of participants carrying the motion. Other forms of majority rule are a 2/3 requirement, and on occasion, 3/4. Sometimes, the full board simply approves decisions reached by the executive committee, although "rubber-stamping" of all such opinions is not a good practice.

Takeaway tips: Know how the deliberative process works, and be prepared to participate. Help ensure that all members are heard from. Know which decision-making models apply in various situations within your board. Do not abstain from voting unless a conflict of interest applies.

Best Practice Number Six: The First Five Minutes After the Meeting Count Too

Many boards pack up and leave the moment adjournment is announced. If you knew your board meetings could become more energized and effective if you gave just five more minutes of your time, would you offer them?

Even boards that conduct the most efficient and effective meetings fine-tune their meeting work through the use of individual board meeting evaluations. These evaluations are designed to be completed in five minutes or less, and include yes/no questions with room for suggestions. Simple questions might include: Did the meeting follow the agenda? Was the agenda focused on the most critical or strategic issues? Did we start and end on time? Were all members participating in an active manner? Did the board chair lead the meeting skillfully? Comments could also be sought regarding the helpfulness of board packet materials, meeting direction and focus, issues as they relate to the strategic plan, fairness of deliberations, and a

Overview: Six Best Practices for Building Better Meetings	
1	The meeting starts before the meeting
2	A great agenda sets the stage
3	Treat others as you want to be treated
4	Elect an organized and focused leader
5	Know and practice deliberative and decision-making processes
6	The first five minutes after the meeting count too

sense of whether each member left the meeting believing it was a valuable use of their time.

Takeaway tips: Prepare a short meeting evaluation for every board member to anonymously complete prior to leaving. The board chair and the CEO will utilize information from the evaluations to fine-tune the board's meeting process.

Many of the reminders presented here are common sense solutions and known by most, but practiced by few. By implementing the six best practices of efficient board meetings, your board can achieve meetings that are highly productive, energetic, inspiring and enhance learning. Your meetings will be memorable – for the RIGHT reasons.

Critical Conversations The Board Should Have Now

Quality and Patient Safety - It's Job One, So How Well Do You Do It? The expectation of informed, engaged and active participation in quality oversight and leadership should be the foundation for every board meeting agenda. Attaching a measure to the amount of board meeting time spent on quality is one way to stimulate boards to carry out their quality accountability and raise their level of quality and patient safety knowledge, engagement and effectiveness. Being conscious of the amount of governance time spent on quality will raise its prominence on the list of board priorities. Quality should be at the forefront in board discussions and decisions on just about any subject on the agenda.

Executive Compensation: Can You Defend It? Wall Street financial executives aren't the only ones finding their compensation the subject of news headlines. Increasingly, the glare of publicity is turning on hospital executives as well.

The IRS' Form 990 is designed to provide greater transparency into executive compensation. Boards should take action to

Meetings People Remember and Critical Conversations the Board Should Have Now

make sure they carry out a sound and defensible compensation process, including:[3]

- Establishing a comprehensive, written process for evaluating executive compensation;

- Ensuring that no conflict of interest exists for trustees evaluating and approving executive compensation;

- Comparing the executive's compensation and benefits to that of other similarly situated executives using independent data, surveys and compensation consultants;

- Evaluating and accounting for executive performance against pre-established goals; and

- Documenting the board's processes, considerations and decisions.

To ensure that executive compensation reviews are rock-solid, hospital boards of trustees should engage in a critical conversation that answers these questions:

- Is the CEO's full compensation and benefits package documented in a written employment contract?

- Does the board have and adhere to a conflict of interest policy? Is that policy applied to compensation and benefit reviews and decisions?

- Does the board have a compensation committee? If so, is there a policy specifying criteria for committee selection? Do those criteria include freedom from conflicts of interest?

- Does the hospital have a written policy establishing criteria for hiring a compensation consultant, and requiring the consultant to be free of conflicts of interest?

- Have compensation evaluations included comparison with compensation and benefits offered by similar organizations?

- Could nonqualified deferred compensation and/or retirement plans offered by the organization be considered "excessive?"

- Have executive benefits been recently reviewed? Are CEO travel and other benefits governed by a written policy and monitored by the board?

- Is the CEO's compensation tied to achievement of documented performance measures?

Community Benefit - How Do You Measure Up? The lack of a quantifiable measure for community benefit has become a source of debate. At the center of the debate is whether the community benefit provided by hospitals is commensurate with the tax-exempt benefits they receive. According to Steven T. Miller, Commissioner for Tax Exempt and Government Entities of the IRS, the goal of Form 990 revisions, and specifically the creation of Schedule H, was to create transparency for hospital practices that in turn provide for a more-informed review and decision-making process regarding the community benefit standard.[1]

As allegations of excessive compensation and inequitable levels of charity care and community benefit draw scrutiny and attention, trustees need to engage in a critical conversation that seeks answers to these questions: [2,3]

- Does the hospital's mission clearly affirm the hospital's commitment to serving the community's health care needs?

- Has a community needs assessment been recently conducted? Can the organization's strategic initiatives be clearly tied to the highest priority needs identified in the assessment?

- Does the hospital have a written financial assistance and charity care policy? Is eligibility clearly defined? How do patients learn about its availability?

- Have the policy and eligibility been reviewed in response to increasing community needs resulting from economic pressures?

- Has the hospital clearly and comprehensively defined the amount and types of community benefit it provides?

- Is the hospital separating bad debt, Medicare and Medicaid shortfalls from charity care and community benefit activities?

- Does the hospital have a written bad debt policy? Has the board recently reviewed it, and is the board aware of how it's applied in the current recession?

- Will the hospital's level of community benefit stand up to public scrutiny?

- How comprehensive is the hospital's community benefit report? Does it capture all facets of the benefits provided by the hospital? Does it effectively tell the hospital's full community benefit story to the community?

The Board's Role in Difficult Economic Times. The financial effects of the economic recession and now health care transformation on hospitals are well-evident, and trustees must demonstrate strong leadership to navigate through the economic challenges of declining patient volumes, a changing reimbursement system, payment cuts, growth in expenses that outpace sluggish revenue growth, and more. [1,2]

Engaged participation in board meetings and a detailed understanding of financial issues has never been more important for trustees. Board conversations should include:

- *Constant oversight of the hospital's financial performance.* Trustees must think openly and broadly, and work together with senior leaders and medical staff leaders to find new solutions for pressing financial issues.

- *Regular review of progress on strategic plan initiatives.* The board should evaluate if strategic initiatives are being impacted by financial restraints, and if they should be adjusted or reprioritized to account for changing circumstances. Trustees should take into consideration the implications of making adjustments, and the risks of not taking action.

- *Discussion of subsidized and uncompensated care needs in the community.* The board must understand how health care needs are trending, if the organization has the resources to continue to meet changing needs, and what plans are in place to support those resources if the trend continues for the foreseeable future.

- *Continued evaluation of charitable giving levels.* Has the board developed and implemented a detailed and strategic fundraising plan? Are strategies being tracked and plans adjusted accordingly? Are new and innovative opportunities being developed? Are donor relationships being nurtured? Is hospital news shared, and are there opportunities for donors to interact with senior leaders and the board?

Hospital and Medical Staff - Partners in Care. The delivery of care is shifting from traditional structures to models that incorporate integrated approaches, continuums of care, quality outcome measures, and shared financial risk. The ability to deliver high quality care and improve health outcomes while managing costs will significantly determine hospitals' and health systems' ability to succeed in a value-based health care environment.[3] To succeed in today's changing health care environment, hospitals and their medical staffs must be closely aligned and work collaboratively to provide complete care for

patients, as well as to manage and improve the health of a population.

New structures of care and payment systems are designed to incentivize coordination of care and quality outcomes versus fee-for-service payments which have typically been viewed as payments for volume of care.[1] Early examples of value-based care delivery models in which hospitals and medical staff must succeed as collaborative partners include CMS demonstration programs which were designed to evaluate hospital/physician collaboration coupled with global payment and permitted gainsharing, or sharing of cost savings between hospitals and physicians (examples include Medical Hospital Gainsharing, Physician Hospital Collaboration Demonstration, Acute Care Episode Demonstration).[2]

New payment systems, many of which have been implemented under the Patient Protection and Affordable Care Act (ACA), include shared savings and risk, bundled and capitated payments, and penalties for low quality of care scores and high readmissions. The se payment systems, coupled with the shift in delivery of care settings from acute hospitals settings to outpatient and ambulatory settings, are also driving forces behind the need for hospitals and physicians to ensure strong collaborative partnerships.

Despite these forces, the *2014 Industry Survey: Forging Healthcare's New Financial Foundation* conducted by Health Leaders Media suggests a lack of readiness to assume risk and establish agreements based on results with care partners. Monitoring care along the continuum was found in the survey to be one of the greatest challenges to clinical quality improvement, a challenge which will require strong medical staff partnerships to overcome.[4]

More than half the hospitals and health systems responding to the survey also indicated that addressing physician-hospital alignment is among their top three priorities for achieving financial goals. However, only a third of physicians included this alignment among their top three priorities. HealthLeaders analyst, Michael Zeis, noted this may indicate difficulties for hospitals and health systems as they move forward in today's transforming health care environment.[4]

While collaboration has always been important, today hospital leadership must be a positive, collaborative, results-producing effort between the administration, the medical staff and the board of trustees. The medical staff must participate meaningfully in hospital governance, and actively contribute to strategic directions and decisions. Board members must act as catalysts for physician participation, and ensure that decisions

benefit both at-large community interests as well as the interests of the physician community. Board members must assure that discussions and analysis are mission-driven, and meet conflict of interest standards. Finally, trustees must consistently monitor strategic direction, and hold both managers and physicians accountable for achieving targeted outcomes.

Nurturing a trust-based board/medical staff relationship helps ensure the hospital's ability to respond most effectively to future issues, challenges and changing payment and care delivery structures. Consider the following suggestions for building trust between hospital leadership and the medical staff:

1. *Develop a formal hospital/physician relationship.* Hospitals can increase market share by systematically seeking physicians' input and aggressively addressing their concerns.

2. *Pursue the joint development of ancillary services.* Health care organizations and physician groups should seek opportunities to form mutually beneficial partnerships to expand or reinvigorate these services.

3. *Involve physicians in leadership.* When physicians and hospitals work in the spirit of partnership facing strategic issues, that spirit goes a long way toward ensuring mutual success.

4. *Offer physicians choice.* Individual relationships should be pursued that meet the interests and comfort levels of both specialists and primary care physicians, rather than a "one-size-fits-all approach."

5. *Stick to the basics.* Establish a foundation of trust, a demonstrated economic benefit for all parties, and a shared commitment to meeting community health needs.

A critical conversation about hospital/medical staff relations alignment may include:

- What leadership roles do physicians hold in our organization?

- What roles could or should the organization consider physicians for?

- What skills, experience or attitudes are important in physician leadership positions?

- Are physicians properly prepared to take on leadership positions?

- How can the hospital help physicians prepare for leadership opportunities? Should or can the hospital develop a physician leadership development program?[9]

- What opportunities for hospital/physician collaboration may be pursued?

- If gainsharing programs, integrated hospital/physician contracts, or similar hospital/physician opportunities presented themselves, is the organization ready to take advantage of them?

- What is the medical staff's perspective on these questions? Has the board heard and listened to first-hand accounts of physician views?

Sources and Additional Information

1. Meet Smarter. Outi Flynn. *BoardSource Publications*. 2004.

2. Orlikoff, James E. and Totten, Mary K. How to Run Effective Board Meetings. *Trustee Workbook.* April 2001.

3. *The Nonprofit Board Book.* Independent Community Consultants, 1985.

4. Helping Boards Make Good Decisions. *BoardSource.* October 2005.

Executive Compensation

1. Sen. Grassley Considers Proposing Legislation That Would Require Not-for-Profit Hospitals to Spend a Minimum Amount on Charity Care, Among Other Measures. *Kaiser Daily Health Policy Report, Capitol Hill Watch The Henry J. Kaiser Family Foundation*. December 18, 2008. kaisernetowrk.org.

2. John Carreyrou and Barbara Martinez. Grassley Targets Nonprofit Hospitals on Charity Care. *Wall Street Journal.* December 18, 2008.

3. Greis, Jason. "IRS Report Provides Insight into Community Benefit and Executive Compensation."Greis Guide Web Site. February 15, 2009. http://greisguide.com.

Community Benefit

1. Steven T. Miller, Commissioner, Tax Exempt and Government Entities, Internal Revenue Service. Full Text of Remarks Before the Office of the Attorney General of Texas Charitable Hospitals: Modern Trends, Obligations and Challenges. January 12, 2009. Austin, Texas.

2. Barbara Martinez and John Carreyrou. Minority of Tax-Exempt Hospitals Provide Most Charity Care. *The Wall Street Journal*. February 13, 2009.

3. Jennifer R. Breuer, Esq., Gardner, Carton & Douglas LLP. Illinois Community Benefits Reporting Act: Making the Case for Charitable Mission. July 2005. http://www.drinkerbiddle.com.

Economic Times

1. Moody's Investors Service. US Not-for-Profit Hospital Medians for FY2012 Show Weaker Performance, Rising Expenses. August 23, 2013. www.moodys.com

2. Letourneau, Rene. Six Revenue Pressure Create Negative Outlook for NFP Hospitals. *HealthLeaders Media*, June 30, 2014.

Medical Staff Alignment

1. Davis, Karen PhD. Paying for Care Episodes and Care Coordination. *The New England Journal of Medicine.* March 15, 2007.

2. Centers for Medicare and Medicaid Services. "Roadmap for Implementing Value Driven Health Care in the Traditional Medicare Fee-For-Service Program." http://www.cms.hhs.gov/QualityInitiativesGenInfo/downloads/VBPRoadmap_OEA_1-16-508.pdf.

3. Managing the Population Health: The Role of the Hospital. Health Research & Educational Trust, Chicago. April 2012. Accessed at www.hpoe.org.

4. Industry Survey 2014: Forging Healthcare's New Financial Foundation. *HealthLeaders Media.* January 2014.

Q: How does the board ensure strong and effective executive leadership?

Hospital CEOs and their boards must build and sustain vibrant, trust-based relationships in order to successfully navigate the opportunities and challenges in today's complex and fast-paced health care world. That trust requires leadership excellence in a number of key areas, including clear and consistent communication, adherence to well-defined roles and responsibilities, and clear CEO performance expectations and accountabilities that are appropriately rewarded using responsible compensation assessment policies and procedures.

The board/CEO relationship should be a trusting partnership, where both trustees and the CEO work together, united as a team to achieve the greatest level of organizational success. The relationship can be enhanced through a clear understanding of one another's needs and expectations, clear and consistent communication, shared goals and objectives, dialogue-rich and purposeful meetings, and a constant sharing of timely and critical information. Those are the ingredients of a successful partnership and relationship.

Good chemistry between the board and its CEO is absolutely vital to organizational success. Mutual respect, candor and absolute trust distinguish the very best board/CEO relationships. Trust, however, is the most critical component for boards and CEOs. Close communication and effectiveness are the results of trustful relations.

Building Trust
Trust plays a vital role in the ability of the CEO and trustees to communicate openly and honestly. Without trust, individuals may be hesitant to participate in discussions, raise issues, or share their viewpoints.

In order to build mutual trust, the board and the CEO must rely on one another for support, consultation and advice, and complement one another's strengths and responsibilities.

The CEO must build a positive rapport and a close professional relationship with all board members. He or she must understand clearly what motivates each trustee to be involved with the organization, and be deeply knowledgeable about the interests and needs of each individual trustee.

The CEO must also be aware of any gaps in trustees' understanding of current issues and trends, ensure that regular board education responds to trustees' needs, and encourage trustees to learn and ask questions in an open, safe environment. CEO attentiveness to individual trustees' needs demonstrates interest and support, and helps build a positive, trustful environment for dialogue and decision-making to take place.

When the board/CEO relationship is good the board has supreme confidence in the CEO's ability to lead the organization, and in the board's ability to provide encouragement, support and outside perspectives to help enable that leadership. When its good, the board and CEO are able to work together in a collaborative fashion to design clear, focused approaches to challenges and issues, because they address the right issues in the right way at the right time. Both enjoy a sense of command of the organization and a sense of fulfillment and satisfaction in the roles they play in organizational success.

On the flipside, when the relationship lapses and ends up in the "relationship ICU," persistent questions about focus, intent and appropriateness permeate board discussions and inhibit effective board decision making. Much second-guessing takes place, oftentimes behind the scenes or in the parking lot. Coalitions and factions begin to form and important decisions are tabled due to uncertainty or a lack of trust. A downward spiral of trust and confidence results.

The Board-Savvy CEO and the CEO-Savvy Board

The Board-Savvy CEO

In the *BoardSource* book, "The Board-Savvy CEO", the authors identify four characteristics of a board-savvy CEO:

- A positive, constructive attitude and well-developed emotional intelligence to work with the board. Board-savvy CEOs nurture their board as a precious asset, and they welcome and demand strong board leadership.

- Board-savvy CEOs are experts in high-impact governance. That means they not only devote significant time and attention to working with their boards, they also develop significant knowledge and expertise in the area of board leadership. They understand what it means to be a high-impact board, and how board culture, and structure and processes play into producing high-impact governance.

- The ability to play an active role in helping the board develop its capacity to produce high-impact governance. Board-savvy CEOs take accountability, along with their board, for continuous governance and leadership improvement. Good is not good enough for these board-savvy CEOs.

- Board-savvy CEOs pay very close attention to keeping their working relationship with the board fine-tuned and healthy. They recognize the highly diverse needs, emotions, governing styles and personalities present in their board, and work to ensure that board members work together collegially and with a sense of purpose. They communicate effectively with their boards to keep a healthy, trust-based relationship. And they encourage their board to undertake a thorough, rigorous annual board self-assessment in order to understand board needs and build bridges to better governance.

The CEO-Savvy Board

It's equally as important for the board to be CEO-savvy as it is for the CEO to be board-savvy. The CEO-savvy board:

- Is always "on the same page" with the CEO. Board members are careful not to become involved in hospital operations, roam the halls like a manager, discuss management issues with physicians and staff, or give any kind of direction to employees. They never engage in "behind-the-back" discussions, which only lead to an atmosphere of mistrust between the CEO and the board.

- Focuses on strategy and policy, not minutia. In addition, they deal only in evidence, not in anecdote.

- Sets clear performance expectations with the CEO and provide candid feedback on a regular basis. They want the CEO to understand where he or she is in the eyes of the board, and increase the CEO's sense of security and command.

- Understands the critical importance of confidentiality. They never share confidential hospital information with people outside the board, and understand that this is a critical piece of their fiduciary responsibility.

- Values governance participation and productivity. They recognize that what happens during the critical time that board members meet sets the stage for everything the CEO does following the meeting. They use their meeting time productively and efficiently, and focus on ensuring that steps to be taken following the meeting are clear and concise, and understood by all.

Creating Success: Mutual Needs

Establishing a successful relationship takes work on the part of the board and the CEO. There are a number of ingredients inherent in a good Board/CEO relationship, including:

- Communication is clear, concise and accurate, and candor is the order of the day;

- Both the board and the CEO are "on the same page," and display a mutual understanding of issues from their own unique perspectives;

- Roles, responsibilities and accountabilities are clear and well-expressed;

- The board has a clear understanding of its policy and strategic "place" in the leadership continuum, and egos are not allowed to suppress the important work at hand; and

- A strong sense of synergy results from a mutual understanding of what both the CEO and the board bring to play in tackling the complex challenges that face the organization.

Board Needs. The board needs to have an understanding of emerging issues that will drive organizational need and organizational success in the future. In addition, board members need to understand the nature of the barriers to success from the CEO's perspective, and understand precisely how they can be the best leadership asset to the CEO and the hospital in dealing with these issues and barriers. Crisp, clear and concise overviews assist the board in keeping their thinking at a high level, and avoid the tendency to "wander" into operational areas that are inappropriate.

CEO Needs. The CEO needs to understand the information and perspectives the board requires in order to lead with

purpose and vision. He or she needs to have a board with curiosity, and a culture of candor and commitment. This requires energetic participation, creative thinking and a willingness to challenge the status quo.

If the board/CEO relationship is not operating at a productive, high-level, there is always the looming potential for leadership to descend into a destructive spiral of mistrust, miscommunication and misunderstanding.

Purpose Wandering

Board members sometimes, knowingly or unknowingly, begin to wander into the CEO's domain, and the results of that meandering can be problematic. To avoid "purpose wandering," roles and responsibilities should be clearly expressed in writing. This helps define the fine line between strategic leadership and operational leadership. Too often roles and responsibilities are unclear and unfocused. A formal, written set of roles and responsibilities will help prevent both the board and the CEO from inappropriately trying to assume the other's responsibilities

For example, while the board is responsible for the high-level strategic focus and direction of the organization, the CEO and his or her administrative team is responsible for the day-to-day operations and details of designing action plans implementing the strategic plan. One is the "what", the other is the "how".

On a global basis, the board is responsible for the selection and evaluation of the CEO, high-level strategic planning, the development of policies and procedures and approving decisions with strategic implication - such as budgets, facility and equipment decisions and personnel policies. These specific policies or procedures are often recommended to the board by the administrative team, who rely on the board to review the information and discuss the pros and cons of each decision before coming to a consensus.

In contrast to the board's high-level focus on long-term planning and approval of budgets and policies, the CEO is responsible for ensuring the day-to-day operations fulfill the board's long-term plan for the organization. The CEO provides regular updates to the board about the organization's success in achieving its goals; informs the board about current and emerging challenges facing the organization; and presents budgets, capital purchases, personnel decisions, fees and billing and collection policies, and potential new policies or procedures to the board for review and approval.

When trustees and the CEO focus on fulfilling their respective roles, the result is an organization that is able to leverage the best resources of both of these important leadership assets.

A good idea for delineating responsibilities is to develop a matrix of responsibilities in a broad range of areas, such as hiring, budgeting, personnel policies, compliance, advocacy, community relations, quality, credentialing and more. The group or individual's specific responsibility may then be clearly defined, and gray areas can be avoided. The matrix should briefly define whether the individual or group develops, directs, reviews, provides input, and/or approves work in each area.

The Board Meeting: The Center of Communication Success or Failure

The board meeting is the center of communication and relationship success or failure. Unfortunately, board meetings are often not as effective as they should be due to poorly planned agendas, time wasted on routine reports and too much emphasis on operational issues and details, thereby frustrating the CEO.

Board meetings often focus on mundane details that have little impact on the long-term strategic direction of the organization, when instead they should focus on the vision, values, governance policies and strategic leadership issues critical to future success. It's essential that all board members be fully-informed about important issues, and that agendas be geared toward the strategic future of the organization. If boards only ensured this one single leadership focus, board and CEO relations in hospitals across America would improve dramatically.

Ensuring Effective Meetings. Effective, high-performance boards spend most of their time on important strategic and policy issues. They engage in rich discussion and dialogue, assess outcomes, and participate in ongoing education. They focus on the issues that are most critical to the organization, and where they can have the greatest impact.

One way to ensure that meetings are focused on where the hospital is headed, rather than where it has been, is to design the agenda around the "25/75" rule. According to many governance experts, no more than twenty-five percent of meeting time should be spent discussing past issues, and on retrospective reporting and analysis. At least seventy-five percent of board time should be dedicated to issues in which the board has the greatest impact: planning, setting policy, making critical decisions, and setting future direction.

Building Bonds: Pathways to Better Board/CEO Relationships

The CEO plays a major role in this area. He or she should ensure that trustees receive materials to review well in advance of board meetings to avoid grumbling abut a lack of time to become familiar with the issues. In addition, the CEO should work closely with the board chair to ensure that meetings are orchestrated to maximize meaningful dialogue and a focus on the future.

How Did We Do? The first five minutes after the board meeting count, too. Many boards pack up and leave the moment adjournment is announced.   But what if you knew your board meetings could become more energized and effective if you gave just five more minutes of your time at the close of each meeting?

Boards that conduct the most efficient and effective meetings fine-tune their meeting work through the use of individual board meeting evaluations. These evaluations can be completed in five minutes or less. Simple questions might include:

- Did we focus on the right issues?

- Did all members participate in an active way?

- Did we develop our "knowledge capital" with pinpointed board education?

Comments could also be sought regarding the helpfulness of board materials, meeting direction and focus, issues as they relate to the strategic plan, fairness of deliberations, and a sense of whether each member left the meeting knowing what he/she needs to do next. Completing these individual meeting evaluations helps the CEO to continually refine the board agenda, and respond to board needs.

Executive Sessions

One of the most productive places for candid and forthright board/CEO discussion to take place is in an executive session.

Executive sessions are settings that allow the board to handle confidential matters behind closed doors without staff or "outsiders" present. They typically take place following adjournment of the regular board meeting, but they may also take place before or during the meeting.

Appropriate topics for an executive session may include personnel matters, investigations or updates on alleged improper conduct, CEO performance assessment, legal negotiations and financial discussions with an auditor, or other topics that must remain highly confidential for a limited period of time. Items appropriate for executive sessions will vary if the organization is a public or private hospital, and depending upon state laws and regulations.

In addition, there are times when the board simply needs to have an opportunity to openly and confidentially share opinions among board members on a particular topic. In order to be effective and not misused with a "shadow-agenda," executive sessions should address only pre-determined issues and not delve into discussion and decision-making that could more appropriately be conducted in the regular board meeting. The executive session is not an excuse to avoid difficult topics and conversations, or inappropriately hide board deliberations behind closed doors.

Good Reasons for Executive Sessions. Holding regular executive sessions can go a long way toward building a strong sense of connection and communication between the board and the CEO. The executive session enables both to engage in the kind of dialogue that is oftentimes difficult during regular

Legal Language Trustees Need to Understand	
Disqualified Person	A "disqualified person" in compensation matters, according to the IRS, is any executive who can exercise "substantial influence" over the organization. Examples of persons with substantial influence include persons making substantial contributions to the organization, those who draw compensation based on revenues from activities under the CEO's control, persons with managerial authority, or who serve as key advisors to a person with managerial authority, and trustees actively involved on the board at the time an executive of substantial influence earns an "excess benefit."
Excess Benefit	An "excess benefit" is an economic benefit that exceeds the value of the disqualified person's services. The excess benefit is the difference between the value of what the organization receives, and the value of what's been given to the disqualified person. An excess benefit transaction can occur when the disqualified person's compensation is considered above fair market value, or is deemed unreasonable.
Intermediate Sanctions	"Intermediate sanctions" are financial penalties imposed by the IRS on managers of tax-exempt organizations that engage in excess benefit transactions. You never want to see a letter from the IRS with the words "immediate sanctions" on it.

board meeting when staff members and, in the case of public hospitals, the press and members of the community, may be in attendance.

Rules of Engagement. The following rules are critical to observe in order to ensure successful executive sessions:

- Executive sessions should be short and highly focused;

- They should never be used as a method for operating "under the radar" of the regular board meeting;

- They should not be an ad hoc, anecdotal free-for-all;

- If the CEO is not present, he or she should be provided with a summary of the session immediately after the meeting; and

- Sessions should be held with the CEO's support and approval.

CEO Compensation and Evaluation

One of the most important board responsibilities is hiring, motivating, and retaining the hospital CEO. Maintaining clear performance expectations and ensuring a regular compensation and performance review of the CEO encourages frequent and open communication between the board and CEO, and helps ensure the CEO's performance drives achievement of the hospital's goals.

Throughout the process, it's critical that board members maintain an organization-wide focus, ensuring that the CEO's compensation is aligned with the organization's goals, and that no conflict of interest exists between board members and CEO compensation decisions.

The CEO Compensation and Evaluation Process
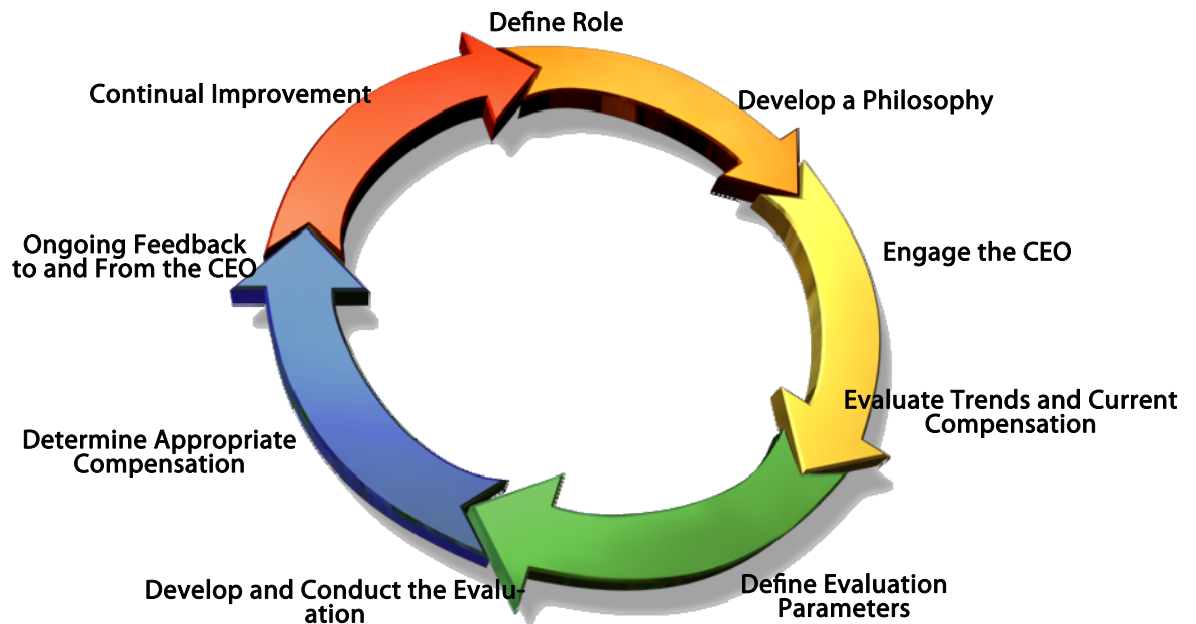
The Board's Role in Compensation Assessment. When determining CEO compensation the board should take into account a variety of factors, including overall organizational performance in meeting board expectations; the challenges and risks addressed by the CEO; a comparison of the CEOs compensation with his or her peers who lead similar sized organizations; the risk or volatility of the position; the CEO's tenure in the organization; and the implications of the loss of the CEO in the event that inadequate compensation causes the CEO to seek employment elsewhere, or become the target of executive recruiters who are constantly on the lookout for high performers to recruit for their clients.

The compensation and performance evaluation is straightforward, but it does include a number of key steps that should be undertaken in a logical and progressive order.

The process begins with a clear definition of the role of the compensation and performance review process in building leadership loyalty and commitment, and ensuring leadership success and continuity. In addition, a compensation committee should be established, and its purpose should be clearly defined in the document that includes the committee's mission, composition, objectives and action plans, responsibilities and time frames, and projected outcomes.

The Compensation Philosophy. Once the board's role has been clearly defined, a compensation philosophy should be developed, which includes the role of CEO compensation in stimulating high-performance, and as a reward for achieving board-approved priorities. The philosophy should outline the organization's position regarding the level CEO compensation should be at relative to the CEO's peer group, and define the organization's philosophy on pay-for-performance. It should be tailored to and support the organization's culture, mission and strategy, and it should explain the values and goals the hospital seeks to reward.

The Compensation Policy. Once the compensation philosophy has been developed, a policy to support the philosophy should be created. Like the philosophy, the compensation policy should be aligned with the hospital's mission and strategic goals. It should define such areas as the purpose of the performance and incentive compensation program; the process for controlling and administering the compensation and performance review; the criteria for the identification of incentive targets and the payment of performance incentives; the timeframe for the evaluation process; and details of the process for payment of incentive compensation earned in the event of the CEO's termination, death or disability.

CEO Engagement. The CEO should be engaged in the process early-on to ensure that he or she agrees with the compensation committee's work plan, and that there is enthusiastic CEO buy-in to the compensation philosophy. The CEO should provide input to the compensation committee to enable it to best understand his or her contribution to organizational success. This is typically done later on in the process, when the CEO reports on the results of his or her personal objectives and success in achieving board-defined performance objectives.

The Compensation Evaluation. It's at this point that the serious work of the compensation committee begins. The committee should evaluate current trends in CEO compensation and seek out information on comparative salary, incentive compensation and benefits for organizations of similar size around the country. At the same time, the committee can begin to define the parameters for the CEO's evaluation and determine the performance criteria to be used. At this point, it is critical to reengage the CEO to ensure that he or she is in agreement that these criteria are appropriate, and that he or she agrees to be held accountable for achieving them.

What Protects Boards and Individual Trustees?

There are some inherent legal risks in CEO compensation assessment that trustees need to understand. There are three key ways for the board to protect itself and individual trustees in deliberations and decisions about executive compensation:

- Executive compensation must be approved by the governing body, or by a compensation committee whose members have no conflicts of interest;

- The governing body or compensation committee should collect and use relevant data to establish fair market compensation levels when approving executive compensation; and

CEO Evaluation Goals
The list below includes typical goals that should be considered in the course of undertaking a successful CEO evaluation process.
1. Expectations should be clearly identified well in advance of the evaluation
2. The evaluation should be a continuous, year-long process culminating in a formal annual performance review, with no surprises for either the board or the CEO
3. The evaluation should provide meaningful feedback to the board on the CEO's success in achieving board-approved objectives
4. The evaluation process should enhance board/CEO working relationships
5. The evaluation should link the attainment of organizational objectives with the CEO's personal performance objectives
6. Data, not subjective assessments, should be the foundation of the evaluation and decisions about compensation
7. Leadership in achieving the mission, values and vision should be a centerpiece of the evaluation
8. Compensation should be driven by specific performance in specific areas, including achievement of quality outcomes

Typical CEO Evaluation Criteria

The CEO should be evaluated using pre-determined criteria and goals specified in the CEO compensation policy established by the board's compensation committee, and agreed to in advance by the CEO. The evaluation may include a "360-degree" approach that seeks feedback on qualitative performance from the board, medical staff leaders, senior management, and the CEO him or herself. Measurement should also utilize performance in achieving defined objectives, including financial success, patient satisfaction, strategic performance, etc.

Quantitative Measures

Potential quantitative measures may include, but not be limited to:

- Financial and operating performance, using a variety of ratios, with comparison to peer groups
- Market share growth
- Physician satisfaction

- Employee satisfaction
- Patient satisfaction
- Achievement of hospital strategies/objectives
- Achievement of specified quality measures

Qualitative Measures

In addition, qualitative measures can help identify how well the CEO performs in several important areas, including:

- Medical staff relations
- Internal operations
- Leadership and strategic development
- Financial development
- Community relations;
- Board relations and development

- Communication
- Problem solving
- Ethics
- The CEO's success in accomplishing specific hospital and personal objectives defined by the board at the beginning of the evaluation period

For example, in the area of medical staff relations, the CEO may be held accountable for developing medical staff cohesiveness and a strong medical staff working relationship with management and the board; inspiring loyalty among the medical staff to further the strategic objectives of the hospital; and communicating effectively and in a timely manner with the medical staff.

In the area of community relations, he or she may be held responsible for such accountabilities as working effectively with community leaders and with other health providers in the region; encouraging public trust and confidence among the community; and continually maintaining a high awareness of community needs and identifying ways to meet those needs.

- The basis for compensation approval must be adequately documented in written or electronic records.

When trustees ensure adherence to these compensation principles, they have what the IRS refers to as "rebuttable presumption." A board has rebuttable presumption on the reasonableness of executive compensation if it approves CEO compensation based on appropriate data that helps determine comparability or fair market value, and documents the basis for its determination at the time it makes its decision.

The Compensation Committee

The board is solely responsible for ensuring that the CEO is appropriately and fairly compensated.   According to Larry

Tyler, president of Tyler and Co., an executive recruitment firm, before the CEO evaluation process can begin a number of questions must be considered. For example, what performance areas should be evaluated? What individuals or groups will have the most amount of insight into the nature of the CEOs performance? What steps should be followed, and what methodologies will be used? Who is responsible for ensuring that the performance evaluation remains on track? And how will the results of the evaluation be used and communicated to the CEO?

Compensation Committee Responsibilities. The compensation committee should ensure that:

- A current written CEO job description exists and has been reviewed and approved by the CEO;

- There is agreement by the board and CEO on the performance measures that will be used to evaluate the CEO's success;

- There is full agreement with the CEO on the basics of his or her compensation, including base pay, annual incentives, benefits, and additional executive benefits, as appropriate;

- The board has full knowledge of the comparability of the CEO's compensation to that paid to CEO's in organizations of similar size and scope; and

- There is a process for regularly reviewing the compensation strategy to ensure its alignment with the organization's mission and goals, market strategy, critical success factors, changes in CEO responsibilities and the dynamics of the health care market.

The compensation committee should utilize benchmarking data that satisfies all IRS requirements, including an examination of compensation levels paid by similar organizations, both taxable and exempt, for comparable positions. It should compare the hospital to organizations similar in size, and utilize compensation surveys compiled by independent firms and/or organizations.

Conducting the CEO Compensation Review

The *Hay Group's Hospital Compensation Report*, the most comprehensive and widely used compensation benchmarking resource in health care, is an excellent resource for data on comparing CEO compensation to defined peer groups. The Hay Group annually compiles hospital compensation trends by gathering compensation data for hospital CEOs and other health care executives in approximately 800 health care organizations throughout the country. In addition, compensation may also be compared to data derived from other reliable hospital CEO salary surveys from state hospital associations. Inflation implications should be considered, and current market trends for base pay and incentive pay compensation structures should be factored into the analysis.

The degree of success of the CEO in achieving board-approved objectives should also be a major factor in determining CEO salary and incentive compensation. Trends in various financial and operating indicator areas, and the organization's financial and operating success over the previous year should be considered by the board of trustees when reviewing the CEO's compensation structure and level. These operating and financial indicators may be compared to other hospitals in the organization's peer group (for example, by revenue, number of beds, geographic location, etc.), using resources such as the Optum's *Almanac of Hospital Financial and Operating Indicators*.

Financial and operating indicators are no longer the only metrics by which to measure successful CEO performance. As organizations face public scrutiny of costs and as they seek to advance and succeed in a value-based health care environment, growing attention is being focused on linking CEO compensation to the organization's value-based performance. In particular, boards are taking steps to link CEO compensation to the organization's quality metrics and physician engagement, alignment and recruitment.

Ensuring Performance and Alignment: The CEO Evaluation

Establishing a CEO compensation process is an important first step, but there's more to be done. The CEO evaluation provides the CEO with specific direction on board expectations, and ensures a consistent focus by the CEO on the board's most urgent and critical priorities.

In essence, the evaluation is a process for ensuring continuous leadership accountability, renewal, focus and success. An effective CEO evaluation will identify and confirm the essential functions and personal attributes necessary to CEO success, and provide a valuable opportunity for well-planned, constructive two-way communication between the board and the CEO. It will identify specific areas requiring increased

Action Agenda
❏ Examine your compensation and performance evaluation process and policies. Do they satisfy the IRS's requirements for rebuttable presumption? Do they inspire CEO commitment and loyalty? Do they energize and reward high performance?
❏ Have a candid conversation with your CEO about your board/CEO relationship. How trustful is it? How can it be improved? What are the barriers to better dialogue and streamlined accountabilities?
❏ Reexamine your respective roles and responsibilities. What are the major functional leadership areas of responsibility? Where is there a clear delineation of authority and responsibility? Are there grey areas? If so, how can they be clarified?

attention by the CEO, and will ensure that the CEO is appropriately rewarded for his or her performance in meeting the board's expectations.

The board's responsibility is to keep the leadership and the organization focused on achieving the mission and vision. The board defines the leadership competencies and personal attributes required by the CEO, the organization's most important executive leader. In order to fulfill its responsibility, trustees must have a clear understanding of CEO responsibilities and accountabilities, the unique challenges the CEO faces, the nature of the highly-competitive marketplace for high-performance CEO talent, and the key motivators that drive the CEO to succeed.

Communicating Results and Driving CEO Performance Improvement

Communication of the results of evaluation and compensation decisions to the CEO in a timely manner is important in building a climate of trust and maintaining a strong relationship between the board and the CEO. The discussion of the CEO's evaluation should be used as a tool to strengthen the relationship between the CEO and the board, enhancing communication and identifying both strengths and potential areas for improvement. When sharing the results, a meeting should be held with the board and CEO to present the findings and provide the CEO with an opportunity to give feedback.

Q: What is the board's responsibility for planning for the future?

Building and maintaining focused, accountable and visionary trustee leadership is one of the principal challenges for hospitals in today's turbulent health care environment. Hospital boards face difficult choices in a time of burdensome governmental regulation, inadequate reimbursement, increasing competition and shifting community needs. Complexity, financial strain and demands for a greater level of governance accountability require motivated, knowledgeable trustees who understand how to think and lead strategically in today's demanding environment.

High-Level Purpose of Strategic Planning

A highly effective strategic plan is not simply a set of strategies, plans, budgets and responsibilities. Instead, it's an ever-evolving process of examination of the market, forces for change, and other current information that helps the board to understand changing dynamics, and continually reshape or fine-tune the hospital's strategic direction.

In essence, strategic planning is an organized, systematic approach for understanding and dealing with the hospital's future possibilities and uncertainties. It takes an "outside in" view of the organization, and what is required to achieve the defined objectives expressed in the mission and vision statements.

In order to be successful, a high-performance strategic plan relies on the viewpoints of a broad range of constituents and stakeholders. The hospital's planners must reach out to people and organizations throughout the community, and engage them in meaningful discussions about their views of the hospital, community health needs, barriers to care, issues of access and more. Typically, this is accomplished through a community health needs assessment, interviews, surveys and focus groups with physicians, employees, business leaders, elected officials, opinion leaders and others whose views are important to understand in shaping strategies for a successful future.

The strategic plan should also help the hospital's leaders determine a meaningful, realistic, challenging and compelling vision of the future. The key for the board is to ensure that the hospital's vision truly means something. Finally, a high-performance strategic planning process ensures a clear understanding of the resources required for strategic success, and the accountabilities of everyone in the organization for performing their part in ensuring strategic success.

Three Important Truths to Understand About Strategic Planning

While it can seem to be an overwhelming and highly detailed process, in the final analysis there are three important truths that hospital boards should understand about strategic planning.

1. *First, board members don't need to know everything there is to know in order to make intelligent decisions and wise choices about the future.* There is an overwhelming amount of information available at any given time that may be relevant to the planning process. Trustees need to have assurance that senior leadership is asking the right questions and utilizing the appropriate tools to ensure an evidence-based, outcomes-focused process.

2. *Second, because of the rapid pace of change in health care, what organizations know today is very different from what they're likely to know tomorrow.* That means that strategic planning processes, structures and systems need to be nimble and flexible, and that the plan must be adaptable to new information and new realities of the future that have not yet been envisioned.

3. *Third, trustees will never know everything they'd like to know to be totally confident in every decision they make.* What they need to have is the assurance that the board's "knowledge bank" has sufficient "capital" to ensure that the decisions they make, and the directions they outline for the future of the hospital can withstand scrutiny.

Steps in the Strategic Planning Process

While the process itself can be very detailed and complex, depending upon the hospital's size and market, there are five key steps in a typical strategic planning process:

1. *Ensure a Strong Foundation.* Step one begins with the three critical components of the hospital's foundation: its mission, values and vision. While the mission and values may change little over time, the hospital's vision is an ever-evolving look into the future. The board of trustees should ensure that these three components are carefully examined:

   - Is the mission as presently stated still a meaningful and memorable description of the core purpose of the hospital?

   - Are the values or principles underlying the mission still relevant?

   - Is the vision, or what the hospital is striving to achieve, still a challenging but realistic stretch?

2. *Understand the Environment.* Step two involves conducting a thorough and comprehensive scan of the environment, both inside the organization, in the community and nationally. The board should ensure that the hospital's strengths, weaknesses, opportunities and threats have been fully explored in a way that results in strategic change. In addition, the board should ensure a robust examination of demographic trends, economic trends and forecasted community needs, and ensure that the vision, goals and strategies developed respond to both external trends and internal issues and opportunities.

3. *Understand Challenges and Opportunities.* Step three is to utilize the findings from steps one and two to define the primary challenges, barriers, and opportunities confronting the hospital, and determine the factors most critical in future success.

4. *Set the Direction.* Step four involves board assurance of a careful analysis of changes to existing strategies, or development of new strategies that respond to environmental change and that capitalize on the most significant opportunities for the hospital as it moves forward.

5. *What's Most Critical?* Finally, step five entails careful prioritization of strategies and objectives to ensure their match with the mission and vision, using rating criteria such as urgency to achieve, feasibility of success, and overall impact on community health and the hospital's competitive position.

Strategic Plan Elements

When the strategic plan is completed the hospital will have assessed its mission, conducted a thorough environmental scan, recalibrated its vision based on emerging trends, issues and opportunities, and will have conducted a thorough analysis of strengths, weaknesses, opportunities and threats.

Following this fundamental work, strategies and measurable objectives to achieve the strategies will be developed.

It's important for board members to know that their primary strategic planning responsibility is contained in these critical areas. Once this work has been accomplished and the board is satisfied with the broad strategic direction of the hospital, the management team can go to work to develop action steps, communicate the plan throughout the organization, and ensure that everything is in place to ensure a successful strategic implementation.

What Does a Good Plan Achieve?

Before the hospital begins the development of an action plan for undertaking its strategic plan, the board should ensure a full understanding of what it seeks to have the plan achieve. Management teams will often, and for good reasons, become consumed with financial and operational issues and challenges. It is the primary responsibility of the board to ensure that the hospital's mission, values and vision remain at the center of the strategic planning process. This focus will help ensure that the strategic plan has timely, responsible and realistic goals that support the mission and vision.

An aggressive strategic plan requires strong and effective leadership to meet the new opportunities and challenges that will develop as the plan is being carried out. The board should ensure that its own governance leadership, as well as executive leadership, is a well-positioned and highly knowledgeable assets in the hospital's strategic success.

Powering Strategic Success: Nine Key Governance Assets and Abilities

The board plays a significant role in ensuring the success of the hospital's strategic plan. However, fulfilling that role isn't easy. It requires a number of governance assets and abilities that must be consistently practiced in order to ensure strong and effective leadership of the strategic planning and strategic change process.

1. The board must have the ability to pioneer new thinking and new responses to emerging community needs. That requires innovative thinkers able to think outside the customary boundaries of strategic planning.

2. The board must have the ability to create and nurture a culture that welcomes and embraces change as a creator of new opportunities. Change is and will be a constant in health care. It needs to be accepted and utilized as a strategic asset, not a success inhibitor.

3. The board must have the ability to deal forcefully with unplanned and unexpected change. In order to do that, the board must carve out adequate time on every board meeting agenda to discuss emerging trends, issues and challenges, and determine their relevance to the strategic plan.

4. The board must realize that there is no straight path to the future. Instead, the dynamic, rapid-change maze hospitals must navigate requires governing boards to be able to think creatively through strategic responses to a wide range of scenarios. Accomplishing that requires a governance environment and infrastructure capable of fully capitalizing on board members' knowledge, insights and experiences. This leadership capital is essential to the hospital's strategic success.

5. Strategic governance leaders also have the ability to define the community benefit and value created as a result of successful execution of the plan. The ability to define, measure and report benefit and value is becoming increasingly important in today's hyper-scrutinized environment.

6. A focus on vision and outcomes, vs. programs and actions, is vital to strategic planning success. The board should be most concerned with the "what," rather than the "how" of strategic planning. That requires a consistent focus at the very highest level, leaving the details of plan implementation to those who are accountable for it.

7. New information and knowledge is not useful unless it's put to work. The board must have the ability to make rapid, timely and well-informed decisions resulting from their commitment to continuous knowledge development.

8. Strategic winners are those who develop the ability to anticipate market needs and opportunities ahead of their competitors. This governance asset is a powerful companion to management's day-to-day focus on strategic implementation.

9. The ability to lead with purpose and consistency through unplanned and unexpected change gives senior leaders and employees confidence in the organization's ability to adapt its strategic thinking and strategic responses when necessary.

A good plan also has a logical, clear strategic fit of plans and resources. The board should ensure that when a commitment to undertake strategies and achieve objectives is made, adequate resources exist to ensure their success. This requires a careful process of prioritization.

One of the key factors in the success of any strategic planning effort is how well its focus will be embraced and supported by the broad community – physicians, patients, consumers, businesses and payers. To accomplish this, boards of trustees need to be active "community connectors." They need to be strong advocates, educators and promoters of the hospital in the community, and build awareness, understanding and loyalty to the hospital as the community's most important and most needed health care asset.

Finally, a good strategic plan is measurable. The board needs to know continually and precisely how well the hospital is progressing in achieving its stated strategies and objectives. The way to accomplish that is through a robust set of "key performance indicators" or "vital signs" that tell the board if potential "strategic gaps" are developing.

Key Board Responsibilities and Opportunities

Governance leaders play a unique and very important role in the hospital's strategic planning process, and in its ongoing strategic success. The role of the board is to be a leader, a motivator and a catalyst for strategic success. The board does not need to be involved in the details of strategic plan development and implementation.

It's the strategic thinking role that is absolutely unique to the board in the strategic planning process. Simply stated, the board should govern and lead the strategic plan, not create or manage it. But that simple statement too often gets lost in misunderstanding, miscommunication, misapplication and missed opportunities.

The board is the driver and keeper of the organization's mission, values, vision, goals and strategies, but it should not dictate the plans for delivering on those expectations. When it does, it ceases to play a governing role, and instead plays a management role, blurring the lines between these two critical elements. The board bears ultimate responsibility for the design of the strategic planning process and for the organization's success or failure. To fulfill this responsibility the board must assume a strong and focused leadership role; it cannot afford to stand back reactively waiting to see what developments will unfold in the marketplace.

The board must be able to engage in new thinking and help executive management develop new directions to successfully compete in an increasingly challenging marketplace. Board leadership must be fast, fluid and flexible, and power an expectation of innovative ideas, new thinking and new directions to successfully compete in today's turbulent environment.

Effective board-level planning emphasizes a continual strategic dialogue into which are continually fed new information, new ideas and new perspectives, and out of which emerges a constant stream of strategic development opportunities.

Why Strategic Plans Fail

One reason plans may fail is because the board does not make strategic planning a high enough priority and does not hold executive management appropriately accountable for plan outcomes.

Achievement of the hospital's mission and vision is the number one job of the board. And the best way to ensure that the mission and vision are achieved is to have a strong, vibrant and outcomes-focused strategic plan. Furthermore, the best way to ensure that the plan is meaningful and measurable is to have in place a reward system for the CEO and other senior leaders that are tied to the achievement of specific objectives.

Another reason plans may fail is because the board of trustees is unwilling or unable to devote the time and resources necessary to develop and carry out the plan successfully. Thirdly, plans may fail for one simple but false reason, and that reason is a belief that health care is changing too rapidly, and the environment is so uncertain that long-range planning is simply an exercise in futility.

Nothing could be further from the truth. The rapid-change and uncertain environment creates even more of a need for strategic thinking and strategic planning. However, that planning cannot take place in a traditional "straight line" manner. Instead, it must rely on an ability to think and plan in "black, white and gray." Boards and executive teams need to be able to think through scenarios for the future, define the potential changes that may take place in a variety of circumstances, and define strategic responses in advance.

Governing the Right Way for Strategic Success

How does the board play the most positive role possible in the strategic change process? What can the board of trustees do to help ensure a successful hospital future? And how can the board drive strategic discipline and strategic thinking throughout the organization, and govern the right way for strategic success?

Think of it as a three dimensional role: Hospital boards must first establish direction. The board must ensure that the hospital has a meaningful, unique, market-specific and compelling mission and vision, statements of purpose and long-term focus that inspire employees, physicians, trustees, volunteers and others.

Second, the board must ensure that the entire hospital family, from top to bottom, sees their role and value in achieving the hospital's strategic initiatives. Every single person plays a role, and each person should hold him or herself accountable for understanding that role and playing their part in organizational success. That culture of commitment is created and inspired by the board.

Third, and very importantly, the board plays a unique role in motivating and inspiring hospital leadership to excel as strategic change leaders, individuals who can coalesce their colleagues in a strategic movement unified by purpose, committed to excellence and rewarded for performance.

Driving SWOT Deep Into the Organization

Conducting a SWOT analysis, or analysis of strengths, weaknesses, opportunities and threats, is one of the core features of most hospital strategic plans. The problem with most SWOT analyses is that they are very general in nature, and oftentimes add little to the strategic planning effort.

For example, typical strengths identified in a hospital strategic plan includes such things as high quality, dedicated employees, strong financial position, committed physicians, etc. and while each of these may be true, they would also be true for virtually every other hospital in America.

The Strategic Assessment

The following are some examples of the types of questions that typically emerge at the board level when a strategic assessment is properly used:

1. What are the most important forces driving the hospital's future success?

2. How does the hospital's value-based performance affect its revenue and brand image? Is the hospital being financially rewarded or penalized based on its quality metrics? How does the hospital's quality performance compare to competitors?

3. How well aligned is the hospital's with its medical staff?

4. How can the hospital improve its image and enhance consumer preferences?

5. How can the hospital best capture market share from its competitors? Will the hospital's competitors be different in the future? How?

6. What hospital services have the most potential for growth, both existing services and services that could be created?

7. What are the primary factors driving patient outmigration, and what can be done to retain more business for the hospital?

8. What health care needs were identified by the community health care needs assessment? What should is the hospital's role and responsibility be in addressing the community's most serious health risks?

9. How attractive will the primary and secondary service areas be to aggressive competitors in the future?

10. How do the service area population mix and economic character affect future hospital development potential?

11. What should be the hospital's financial growth strategy, both short and long term?

12. How should the hospital balance expense reductions with the need to invest in future service development needs and opportunities?

13. How can the hospital continue to fund capital needs and growth strategies in the face of declining margins?

14. How can the hospital ensure an adequate supply of RNs, technicians and other employees required to meet emerging needs?

These are the types of critical questions that need to be explored in the strategic planning process. They're the questions that typically result from a close examination of the data and information contained in a well-executed strategic assessment. And they are the kinds of questions that hospital leadership needs and expects to be raised by the board of trustees.

There is a way to conduct a SWOT analysis that results in dozens if not hundreds of individual strengths, weaknesses, opportunities and threats that can be effectively utilized in the strategic planning process. It's simple, straightforward, and involves everyone in the organization.

Each hospital service line, program and/or department should develop its own individualized strategic analysis. Service and program leaders should work with their employees through focus groups, surveys and other interactive methods to engage everyone in the process of strategic thinking about the area they know best - their own program or service.

Management may provide each program or service line with a template to be used to guide their analysis process. The template should result in an analysis that includes statistics on utilization and personnel; assessment of the strategic significance of the program or service to the hospital's future; a summary of the market for the program and service; an assessment of major trends and factors likely to influence program or service success in the future; and strengths and ways to maximize them, weaknesses and ways to minimize them, opportunities and ways to capitalize upon them, and threats and ways to eliminate them.

In addition, the strategic assessment should identify primary and secondary competitors, assess long-term financial potential, evaluate quality performance and identify the factors that are most critical to the future success of the program or service. The result of all of this is a grassroots analysis of organizational position, needs and opportunities, a sense of engagement across the organization in strategic direction, and a long list of potential strategic initiatives for prioritization and implementation.

Vital Signs: Requirements for Evidence-Based Governance Decision Making

One of the primary challenges for hospital boards is to know whether the strategies and objectives adopted and implemented are achieving the desired outcomes. Being able to engage in a continuous analysis and dialogue about strategic progress and performance requires a set of key performance indicators that tell the board where current strategic gaps exist, and where potential strategic gaps may be on the horizon.

With the input of the CEO and management team, the board should track performance and progress using a set of metrics, a

periodic review process, and an incentive system to reward management for meeting organizational objectives.

Well-designed vital signs have several specific attributes: they are few in number; strategically significant; quantifiable and "trendable," time-specific; and consistently reported and used to determine and close strategic gaps.

An accountable, mission and vision-focused board will review strategic performance and progress at least quarterly, and most will review progress indicators on a monthly basis.

Developing and Using Vital Signs. Developing and using a set of hospital-specific vital signs is a straightforward process.

1. The board and management team must first determine what should be measured.

2. Then data that indicates the degree of success in achieving an objective should be determined. For example, in the area of financial performance the hospital may seek to reduce its average days in accounts receivable from 85 days to 55 days over a 24 month period.

3. Once the metric has been set, performance should be regularly reported in a way that shows actual performance compared to projections, and/or comparison with external benchmarks, such as the performance or best practices of other similar organizations.

4. If management reports a significant gap between projected performance and actual performance, it should also be charged with recommending specific actions to be taken to close the performance gap.

5. Then, on a continuing basis, the board should re-examine progress and performance resulting from the changes made to close the gaps.

6. In many instances vital signs become outdated based on new information or organizational changes. Rather than continue to rely on outdated or outmoded strategic progress indicators, the board should periodically update both its indicators and its performance expectations.

There are a variety of areas in which strategic measures may be developed to gauge the hospital's success in achieving its strategic objectives. The most common and easiest to develop are financial indicators. Equally important, however, are indicators in areas such as quality and patient safety, organizational efficiency, workplace culture, productivity and mission, among others.

Governance Planning Pitfalls: 8 Dangers to Avoid

As board members work to examine their strategic planning process and find new ways to engage the board in more meaningful involvement, it's important to recognize potential governance planning pitfalls that are important to avoid, including:

1. Assuming that the past is a reliable predictor of the future

2. The inability to craft a compelling, dynamic and meaningful vision embraced by all

3. Attempting to manage plan details instead of engaging in critical strategic dialogue

4. Taking narrow, board-centric approaches that do not involve a broad range of participants

5. The failure to see strategic planning as a continual process of real time responsiveness to change, rather than an end point

6. The failure to define precise targets, measure progress, and continually work to close strategic gaps

7. The inability to drive the strategic planning process, outcomes and responsibilities deeply into the organization

8. The inability to continuously turn new information into strategic knowledge, and transform it into strategic action

Each hospital's strategic measures will be different. The key to success is to ensure that the measures chosen are relevant to understanding the hospital's progress in attaining its individual strategies. Performance indicators need to be examined and discussed in the same way a balance sheet or income statement is discussed. No one indicator by itself can tell a complete story. In fact, a single indicator may be misleading if not examined in relationship to others. Taken together, key performance indictors reveal much about what's happening in an organization. This is where board insight and perspective becomes pivotal to strategic success.

Prioritizing Strategies

All strategies are not created equal. Some strategies are absolutely urgent, critical and vital to achieve within a certain time frame, while others, while important, may not be nearly as urgent or critical to organizational success.

An easy way to prioritize strategies is to give them a "weight" using different rating dimensions. For example, strategies can be prioritized based on their "do-ability," or how feasible a strategy is given current and anticipated resources. Strategies could also each be given a rating based on their impact in fulfilling the community health mission, the urgency of undertaking the strategy, or the value of the strategy in ensuring the hospital's long-term strategic success.

Charting a course for the hospital's future is one of the most important responsibilities of the board. However, there's a big difference between mapping a course, or being a navigator, and driving the bus.

To successfully lead their organizations toward the future, boards of trustees must clearly understand and successfully carry out their unique and vital role in the strategic development and implementation process.

Action Agenda
Below are some ideas for actions the board can take, moving forward, as an accountable, responsible and responsive strategy-focused board:

1. Review the current strategic plan, and evaluate its purpose and value

2. Lead the initiation of a deep, wide-ranging and comprehensive examination of organizational fitness for future success

3. Identify the most critical challenges and forces shaping the hospital's future, and develop a compelling and responsive vision

4. Examine the governance substance and style, and adopt new leadership processes and practices to ensure future strategic planning success

Reviewing Your Strategic Plan: Ten-Point Success Checklist

At each board meeting, a few minutes should be spent discussing the following 10 questions about the strategic plan and strategic planning process, and give the strategic planning efforts a grade.

1. Does the plan and build on the hospital's strengths?
2. Does the plan correct or minimize the hospital's weaknesses?
3. Does the plan contain a realistic appraisal of the hospital's markets, customers and competition?
4. Can the plan be understood by everyone who has a need to relate to it?
5. Does the plan appropriately balance risk and return?
6. Is the timing of the plan realistic?
7. Does the hospital have ready access to the resources required to achieve the plan?
8. Is the organizational structure compatible with the objectives of the plan?
9. Does the plan support the image the hospital wants to convey, both internally and externally?
10. Does the hospital have the leadership capacity to sustain the plan over time?

Q: How can the board be visionary in an era of uncertainty and transformation?

Time and again in recent years, hospital trustees have questioned how they can be expected to determine a strategic future when so much in health care is changing, and the future is seemingly unknown and unpredictable. But this is precisely the time when the board must be at its visionary best. Forward thinking visionary boards anticipate potential futures. They prepare for and embrace the changes ahead.

In the book *Governance as Leadership: Reforming the Work of Nonprofit Boards*, the authors define three types of governance: fiduciary governance, strategic governance and generative governance. Fiduciary governance should be a boardroom basic, the cornerstone of the board's responsibilities. The practice of fiduciary governance includes stewardship of the organization's assets, responsibility for the organization's finances, ensuring the highest and best use of resources, monitoring and ensuring legal and regulatory compliance and providing operational oversight.

Strategic governance responsibilities encompass setting a vision and identifying initiatives and strategies for achieving that vision, as well as fulfilling the organization's mission. Strategic governance responsibilities include allocating the resources required to pursue strategic initiatives and monitoring progress to ensure goals are achieved.

While strategic governance might seem to be closely aligned with being a visionary board, it is actually generative governance skills that must be a priority for trustees in today's environment, which is characterized by fast-paced change with a hazy view of tomorrow. Boards that practice generative governance make time to question assumptions, they explore areas which lie outside the proverbial "box" and they envision new and innovative ways of accomplishing goals, achieving visions and fulfilling missions.

anticipate emerging trends. They begin to envision potential futures by asking themselves "What if…?" For example, "What if our patient volume continues to decline as preventive and wellness efforts succeed in improving our community's health, as our initiatives succeed in reducing readmissions, and as care continues to shift to outpatient settings?" "What if health care is no longer hospital-centric?" "What if retail pharmacies become a preferred source of diabetic care?" "What if we formed a partnership with…?" "What if we look at this differently?"

Boards move another step closer to becoming visionaries when they also ask: "What could that mean to us? What implications does it have for our hospital?" and "What could or should we do to be prepared?" These are questions that begin to generate deeper understanding of new paradigms and their implications for the hospitals and health systems that boards are responsible for leading. They are the questions that prompt challenges to the assumptions and status quo that may hold organizations back.

By considering a variety of potential scenarios and possible responses, visionary boards are able to carefully consider what possible actions they must take to capitalize on the forces for change. They are better prepared to act quickly, confidently and on their own timetable instead of being reacting to situations that may be forced upon them.

"What If" and "So What"?

Visionary trustees consistently ask themselves a series of questions, including "What do we know today that we didn't know yesterday?" By staying well-informed with a continuing flow of new information and evidence, visionary boards can

Challenges to the Board's Visionary Potential

While there are many potential challenges that prevent trustees from maximizing their visionary potential, below are a few of the most common causes that derail boards.

Failing to Stay Well-Informed. Without credible and current information and data, trustees cannot hope to recognize or anticipate the forces, trends and changes happening in the environment around them. They must develop a high level of understanding in the areas most critical to organizational success and performance. Passing knowledge is not enough. Well-informed boards search out opinions, ideas and perspectives that may be different from their own. They listen to a variety of voices outside the organization, engaging the viewpoints of people with unique experiences and perspectives. In doing so, visionary boards expand their knowledge base and open new lines of thinking.

Poor Agenda Planning and Meeting Management. Confronted with multiple challenges and competing priorities, effective boards must focus their time and attention on the issues most critical to achieving the organization's mission and vision. Board chairs must ensure meeting agendas are structured to allow the board to focus on bigger strategic issues in board meetings. The board chair must manage meetings to engage trustees at a higher level of thinking and planning, enabling and facilitating the inquiry, dialogue, and debate needed to be visionary.

Focus on the Wrong Issues. Boards must continually adjust their attention to deal with the issues of the future, not the issues of the past. Time should be concentrated on understanding trends and priorities, and their implications for the organization, rather than dealing with operational details. The board's focus should be on generative thinking and visionary-focused dialogue about the challenges, issues and opportunities ahead.

Disengaged Trustees. Board service has never been more challenging. Trustees must know and understand more, and take on greater responsibility than they have in the past. Board members must have the time, availability and discipline to act on their commitment to the board and the responsibilities of trusteeship. They should possess the personal attributes and qualities that ensure the caliber of engagement and contribution required for effective, visionary governance.

Failing to Engage in Deep, Decisive Dialogue. Visionary board members ensure their governance conversations are always vibrant, vital, and focused on purpose and outcomes. Dialogue should be the board's "social operating mechanism." Through synergistic discussions, innovative solutions are generated by grappling and grasping with new concepts, ideas and solutions. Without constructive challenges to conventional wisdom and thought, the best solutions may

10 Leadership Transformations for Visionary Governance

1. Develop new levels of expertise in the issues driving health care
2. Envision multiple futures
3. Focus more on the emergent and less on the urgent
4. Be catalysts for change, challenge assumptions, generate new thinking
5. Focus on strategic issues
6. Listen to outside views and perspectives
7. Engage in deep, decisive dialogues
8. Ensure high-quality trustee engagement, commitment and contribution
9. Understand the community's health concerns
10. Maintain a constant focus on mission and value

never surface. Visionary boards regularly confront issues by challenging assumptions and exploring alternatives to traditional thinking.

Holding onto the Status Quo. Holding onto the status quo will not push organizations to excel in the future. Improvement and advancement are the keys to future viability in a complex, competitive health care world that will not be the same as it is today. Trustees must lead organizations that can capitalize on new opportunities. Innovation and change must be encouraged and rewarded in all areas and levels of the organization. This requires trustees' leadership of thought, ideas, creativity, accountability and purpose.

Lack of a Common Purpose. As organizations grow through mergers, joint ventures, partnerships, and collaborations across the continuum of care, all stakeholders must share a common purpose or mission. Nothing is more motivating than a clear picture of a bright and successful future. Accomplishing this demands that the board develop an exciting, shared mission that will stimulate enthusiastic followership.

Attributes of Visionary Trustees

Visionary trustees possess the personal attributes and qualities that ensure the caliber of engagement and contribution required for generative governance. Developing the expertise needed requires motivation, commitment, and time. High-caliber trustees voluntarily seek to be well-informed and knowledgeable, and demonstrate intelligence and quick

understanding. Visionary trustees are big-picture thinkers open to new ideas. They think and speak strategically in discussions about complex scenarios and situations. Visionary trustees analyze trends to determine possible implications to the hospital or health system. They display creative and resourceful thinking, considering situations from various angles and perspectives. Visionary trustees use "reasonable inquiry" to pursue new solutions and opportunities, asking thoughtful and insightful questions. Visionary trustees are willing to challenge the status quo and take calculated risks in the interest of moving their organizations forward and fulfilling their missions. These individuals look into the future and imagine what might be achieved.

Visionary boards do not happen by chance. They build on the sound foundation of their organizations' missions, a good understanding of their communities' health care concerns and the bigger perspective of how health care is evolving. By asking penetrating questions and engaging in vibrant conversations that explore new possibilities, the board's visionary focus can stimulate creative thinking, dialogues and debates that help trustees identify and evaluate new and different strategies, overcome challenges and barriers, and encourage calculated risk-taking that leads to visionary futures.

Generative Governance: Where Real Leadership Power Lies

According to the authors of *Governance as Leadership: Reforming the Work of Nonprofit Boards*, generative governance is where real leadership power lies. It's where the board has a clear sense of problems and opportunities facing the organization. Meaningful goal setting and direction setting originates from generative thinking, which requires leaders that not only contribute generative insights to their hospitals, but also engage others in generative thinking. It occurs when boards question assumptions, probe feasibility, identify obstacles and opportunities, and determine alternate ways of framing issues.

Generative governance requires a new type of agenda that features ambiguous or problematic situations rather than reports and routine motions, with a goal to frame decisions and choices, not simply make them. Trustees promote robust dialogue around generative ideas and concepts, which stimulates a "culture of inquiry," creating more substantive and intellectually attractive agendas that create more interesting and productive work, and a more influential role for board members.

Chiat, Richard P., Ryan P. William and Barbara E. Taylor. Governance as Leadership: Reforming the Work of Nonprofit Boards. BoardSource. October 22, 2004.

Q: How does the board hold itself accountable for continuous leadership improvement?

Extraordinary changes and transformation in the health care delivery system are occurring. These forces hold significant opportunity for hospitals. They also hold substantial implications and remarkable challenges for hospital management and governance. The most critical challenge confronting many boards is determining a strategic plan for a leaner, more efficient organization without sacrificing high-quality care, offering more and better programs and services, and achieving it all with fewer resources.

Recognizing new and different opportunities, mapping out plans, monitoring performance and ensuring achievement in today's quick-pace world of change are key responsibilities of the board. New rules and regulations are going into effect, driving all members of the health care delivery system to act and react. Trustees must be nimble, astute, and highly-competent in carrying out their responsibilities and fulfilling the hospital's mission. How the board must perform today and tomorrow is different than how the board needed to perform yesterday. Just as there are new standards by which hospital performance is being measured and reimbursed, there are new criteria the board should evaluate when gauging its performance. Some criteria are driven by the IRS' Form 990, the Patient Protection and Affordable Care Act (ACA), and the Joint Commission. Other standards like trust and value are driven by the demands of patients and communities the hospital serves. High caliber boards will ensure their annual governance practices and performance assessment is updated with the criteria needed to prepare them to lead into the future.

Mission-Driven Leadership
Media attention often calls into question the mission of hospitals. Many are asking if hospitals are driven by their mission motives, or by profit motives. How well the hospital achieves its vision, adheres to its values and fulfills its mission is one of the strongest rebuttals trustees can offer in the face of questions. As the hospital's leaders, trustees are accountable for ensuring the hospital's mission, values and vision are successfully communicated and carried out.

To assess how well the board is leading, trustees should ask themselves if the mission, values and vision are being taken into account in their decision making at all board meetings. To ensure a well-aligned organization capable of delivering high quality care, the board must work in close collaboration with senior management and medical staff leadership in developing the vision, values and mission of the hospital, and then infuse them throughout the organization. Together, these three groups should be vested in annually reviewing the hospital's performance in relation to its mission, vision and goals.

Ensuring Continuous Board Improvement
The American Hospital Association has coined the phrase "redefining the H" as hospitals consider what it means to be a hospital in today's transforming health care environment. In order to be successful in this endeavor, hospital trustees must also redefine their boards, including the board's roles, responsibilities, and composition. Governance practices and performance assessments are an important starting point boards can take to ensure their boards are well-poised to carry their organizations into the new health care world.

A governance practices and performance assessment is an organized evaluation of board members' satisfaction with all aspects of board performance in fulfilling the board's governance responsibilities. Governance assessments generally use a combination of quantitative and qualitative measurements of board, committee and individual performance.

Conducting a "Best Practice" Governance Practices and Performance Assessment

Successful assessments enable boards to identify "governance gaps," or areas in which the board has the greatest potential for improvement. The assessment process identifies these gaps, and facilitates the development and implementation of initiatives and strategies to improve leadership performance.

Through an effective, well-developed governance practices and performance assessment process growth opportunities can be realized, education can be pinpointed to unique governance needs, recruitment of new trustees can be undertaken with increased confidence, and long-range planning can be conducted within a consensus-based framework with everybody on the same page.

	Goals of a Governance Assessment
1	Set measurable objectives for improving hospital performance
2	Gather information to assess board effectiveness in improving hospital performance
3	Use pre-established, objective process criteria to assess board effectiveness in improving hospital performance
4	Draw conclusions based on findings, and develop and implement improvement in governance activities
5	Focus on sustained improvement in leadership areas defined as needing attention

Using the Governance Practices and Performance Assessment to Improve Governance

A successful governance assessment engages the board in a wide-ranging evaluation of its overall leadership performance. At the same time, it provides trustees with an opportunity to rate their personal performance as vital contributing members of the board of trustees. An excellent assessment process will achieve several key outcomes:

- Define the board's most critical governance success factors;

- Secure anonymous, broad-based and insightful trustee input on the critical fundamentals of successful governing leadership;

- Create an opportunity to address major issues and ideas in a non-threatening, collaborative manner;

- Clearly demonstrate where the board is both in and out of alignment on leadership fundamentals and issues;

- Objectively assess the degree of common trustee understanding, expectations and direction for the board;

- Assess the deficiencies that may impact the board's ability to fulfill its fiduciary responsibilities;

- Identify opportunities for meaningful leadership improvement; and

- Help administration better understand and respond to the board's leadership education and development needs.

Many hospital boards conduct an assessment prior to their annual retreat, at which they have ample time to discuss the

assessment results and explore ways to improve leadership performance.

Some boards have the internal resources and knowledge to successfully design and conduct the assessment, compile and analyze the results and present the findings in a way that facilitates discussion and governance action planning. Others rely on outside consultants with experience using tested and proven tools, techniques and processes.

Conducting the Governance Assessment

The governance assessment may be conducted using a printed survey, an online survey, individual interviews, a facilitated, full board discussion, or some combination of these methods. In addition, a board may choose to utilize electronic keypads to conduct a "real-time" assessment at a board meeting or retreat, with results instantly available for evaluation and discussion.

The assessment should include specific, precise and well-articulated criteria that relate to the hospital's unique board and leadership challenges. These criteria should be developed by a board development committee, or a special governance assessment task force, and should be reviewed and endorsed by the full board as leadership accountabilities they embrace.

Areas addressed in many assessments include: assessment of overall board performance in several areas of leadership accountability; assessment of committee performance; identification of issues and priorities facing the board; assessment of individual trustee performance, including a peer evaluation; and assessment of the board chair.

A meaningful rating scale must be developed that ensures clear and concise input that results in an effective scoring of the board's performance. A good scale to use is one that rates board performance on a scale of level 5 – level 1, including a

Conducting a "Best Practice" Governance Practices and Performance Assessment

clear definition of what each rating level rating represents. Below is an example of a "Level 5 – Level 1" rating scale:

- *Level 5:* I strongly agree with this statement. We always practice this as a part of our governance. Our performance in this area is outstanding.

- *Level 4:* I generally agree with this statement. We usually practice this as a part of our governance, but not always. We perform well in this area.

- *Level 3:* I somewhat agree with this statement. We often practice this in our governance, but we are not consistent. We perform fairly well in this area.

- *Level 2:* I somewhat disagree with this statement. We inconsistently practice this as a part of our governance. We do not perform well in this area.

- *Level 1:* I disagree with this statement. We never practice this as a part of our governance. We perform very poorly in this area.

- *N/S:* Not sure. I do not have enough information to make a determination about our performance in this area.

Assessment of overall board performance should be divided into several leadership responsibility areas, such as:

- Mission, values and vision;

- Strategic direction;

- Leadership structure and governance processes;

- Quality and patient safety;

- Community relationships;

Questions to Consider About Your Governance Assessment Process
❑ Do you conduct a governance assessment annually?
❑ Does your full board participate in the assessment process?
❑ Is your assessment anonymous, allowing trustees to freely and candidly express their opinions and ideas for governance change?
❑ Does the full board review the results of the assessment, discuss their interpretation of the findings, and determine potential areas for necessary board improvement?
❑ Do you use the assessment results to develop actionable and measurable plans for governance improvement?
❑ Do you communicate the results of the assessment and the board's governance improvement plan to hospital employees? To the local community?

- Relationship with the CEO;

- Relationships with the Medical Staff;

- Financial leadership; and

- Community benefit and health.

Rating Committee Performance. The committee performance evaluation asks trustees to rate criteria specific to the charter and goals of each committee. The committee evaluation may also ask trustees to provide additional ideas for ways each committee can improve its leadership performance.

Below are some examples of areas to be rated for various committees. These are limited examples, and are not intended to be all-inclusive:

Finance Committee

- Reviews and refines the annual operating and capital development budget prepared by management

- Monitors the implementation of major initiatives that impact strategic and financial objectives, making appropriate recommendations to the board on an as-needed basis

- Reviews monthly financial statements

- Recommends hospital investment policies and monitors the hospital's investments

Quality Committee

- Oversees the development, implementation and reporting of a hospital-wide program that measures quality, risk management and clinical resource utilization

- Reviews results of regulatory and accrediting body review of the hospital's performance

- Reviews quality and patient safety indicators

- Periodically reviews trend reports that reflect the overall performance of the hospital in providing quality care in a customer-focused, cost-effective manner

Compensation Committee

- Evaluates the CEO's performance at least once a year in light of the established performance goals and objectives, using the evaluation to set the CEO's annual compensation, including salary, bonus, incentive and equity compensation

- Ensures that the CEO's performance evaluation is based on pre-determined and clearly communicated performance criteria

- Recommends the CEO's annual compensation package

- Ensures that the CEO's compensation package is tied to performance and is comparable to CEO salaries of health care organizations similar in size and scope

Audit Committee

- Assists the board of directors in fulfilling its oversight responsibilities with respect to the independent auditors' qualifications and independence

- Is financially literate and possess a general understanding of basic finance and accounting practices

- Has at least one member that is determined to be an "audit committee financial expert," possessing accounting or related financial management expertise

Major Governance Issues and Priorities. When done correctly and consistently, a governance assessment process enables the board to identify critical "governance gaps," and achieve and maintain the level of governing excellence required for success in today's challenging health care environment.

In addition to rating the board's performance in the important areas outlined earlier, the assessment should also provide trustees with an opportunity to answer several open-ended questions, such as:

- What is your single highest priority for the board in the next year?

- What are the governance strengths that must be maximized in order to ensure leadership success in the next year?

- What are the governance weaknesses that must be overcome in order to ensure the hospital's success in the next year?

- What do you see as the most significant health care trends that the hospital's leadership must be able to understand and deal with in the next year? In the next five years?

- What challenges or issues are most critical to be addressed if the board is to be most successful in leading strategic change in the next year?

Individual and Peer Performance Assessment

An individual performance assessment is a critical piece of a quality governance assessment process. Trustees may have one view of the overall board's performance, and have an entirely different view of their own individual performance, and that of their colleagues. A personal, introspective look at individual leadership enables trustees to focus on the essentials of good leadership and their personal impressions of their individual performance.

A good way to evaluate personal governing performance is through a peer assessment. This enables trustees to personally evaluate their performance, and the performance of each of their board colleagues, using a short list of relevant criteria.

Trustees should rate themselves and their colleagues in two broad areas: 1) governing attributes, the factors that define their performance in fulfilling their governance duties; and 2) personal competencies and attributes, the factors that describe the personal strengths and abilities required for effective trusteeship.

In addition, each trustee should answer one simple question after rating each individual board member: "What suggestions do you have for ways this trustee colleague can improve his or her governing performance?"

The process provides trustees with unique insights into their leadership attributes and needs from the informed perspective of their trustee colleagues.

Compiling and Analyzing Governance Assessment Results

There are a variety of ways to compile and analyze the results of your governance assessment, from simply tallying responses using Microsoft Excel to using customized governance assessment software or external consultants. Although every organization may approach the process differently, it is critical that the results are reported in an easy-to-understand format that sparks meaningful dialogue about the findings.

The five steps below outline one potential process for analyzing assessment results:

- Compile the results using software, such as Microsoft Excel, that allows the creation of graphs using a variety of combinations or sorting.

- Develop bar graphs that display the ratings for each of the assessment areas, ordered from highest to lowest scores, and that depict the number of trustees assigning each

rating to the criteria which reveals the degree of consensus among board members.

- Develop a written report or PowerPoint presentation that includes summary graphs of the criteria in all of the rating areas, as well as key themes from trustees' open-ended comments.

- Present and discuss the results at a special board meeting or board retreat, allowing ample time for trustees to discuss their interpretation of the findings as well as develop "governance gain" action plans to address low-performing areas.

- If a peer evaluation is conducted, each trustee should receive a report that includes his or her personal performance rating and their colleagues' ratings of their performance, using the same criteria. Each trustee's unique report should be then reviewed in a one-on-one meeting of the individual trustee and the board chair.

The full board assessment report should include a summary of trustee performance ratings, in graph form, to enable quick analysis of the degree of consensus on important leadership criteria. It should also include analysis of the ratings, highlights for board discussion, a summary and analysis of verbatim ideas and answers to questions, and recommendations for improving board performance in each rating area.

Putting Your Assessment Results to Work

Conducting the governance assessment is just the first step in improving governance leadership performance. The key to success of the full process is not simply the measurement of trustee viewpoints, but is instead the action that is taken as a result of a careful examination of trustee viewpoints.

The assessment results should be a catalyst to engage trustees in a wide-ranging discussion of findings that highlight performance gaps and areas where trustees lack consensus about the board's performance.

A full review of trustees' viewpoints should stimulate the board to discuss their opinions and ideas for improving board success, and result in the development of a governance improvement action plan with clearly defined responsibilities, time frames and projected outcomes. Boards should then monitor their progress to ensure that projected outcomes are achieved, and revise the governance improvement action plan when necessary.

Communication with Employees and the Community

The practice of using governance assessment results to not only achieve a higher level of board and organizational performance, but also strengthen employee and community trust, is often an overlooked advantage. The most important element of the assessment process is what happens after the assessment is complete.

In addition to using the results of assessment to develop specific governance improvement goals and action plans, the board should communicate its process and general results to hospital employees and the community at-large. This communication will help employees, the medical staff and others to understand the challenges the hospital faces and recognize the board's efforts in addressing those challenges. Support from employees and the local public is vital to hospital success in the face of increasing public scrutiny from lawmakers, regulators, community groups and the media.

Communicating with key stakeholders will deepen understanding of the board's commitment to the hospital and the community, raise awareness of the depth and range of challenges the board faces, and demonstrate the high standards the board holds itself accountable for.

The results should be shared with hospital employees first; boards will build trust with employees by ensuring that they hear about the assessment first, before it is reported in the local media. The employee memo should include:

- An overview of the process, why it was conducted and how often it is conducted;

- High-level results;

- Board improvement opportunities identified; and

- Specific actions the board intends to take to create governance gain.

Boards should also tell employees that a news release is expected to be published in the local newspaper promoting the hospital's emphasis on transparency and willingness to share its strengths, opportunities for improvement and challenges with the community. Following distribution of the employee memo, the news release should be provided to local media, and should include information similar to that in the employee update.

Using Your Governance Practices and Performance Assessment to Build Governance Gain

After reviewing the results of your governance assessment, developing a "Governance Gain Plan" will assist the board to create actionable, measurable next steps for improving leadership. The plan should include specific ideas for governance improvement in each area the board believes needs the most attention. Specific items to include for each governance improvement include:

- *Initiative Description.* A detailed description of the governance improvement initiative, effort, program or action to be taken that will result in governance gain.
- *Priority.* Prioritize the initiative on a scale of 1, 2 or 3, from highest to lowest priority
- *Projected Outcomes.* Specific goals and outcomes that will be achieved as a result of the completion of the governance improvement initiative.
- *Primary Responsibility.* The individual, group or committee primarily responsible for ensuring the governance improvement initiative is completed.
- *Resources Required.* The estimated cost of implementing the initiative.
- *Start Date.* The assigned date for work on the governance improvement initiative to begin.
- *End Date.* The target date for completion of work on the governance improvement initiative.

Governance Gain Examples

Each governance gain plan is unique to the board's assessment results. For example, if corrective action is needed in the area of the board's structure and processes, governance gain initiatives may include some of the ideas below:

Education Initiatives

– Provide trustees with the background information and intelligence resources required for active participation in board dialogue

– Conduct a regular community health care environmental assessment; ensure trustee understanding of the changes taking place in the health care environment, and their implications on the hospital, its physicians, and local health care consumers

– Develop an education plan that ensures trustee understanding of the issues essential to effective governance; conduct education and orientation at every board meeting, and annually at the board retreat

Structural Initiatives

– Examine board composition, and match present skills against current and emerging trends, challenges and issues; ensure that skills are/will be in place to successfully deal with the future

– Clearly define board, medical staff leadership and management strategic planning roles and responsibilities

– Involve physicians in meaningful ways as key participants in governance decision making, including trusteeship, committee appointments, strategic task force involvement, etc.

– Develop comprehensive and usable governance policies and procedures

– Develop a process for governance "renewal" to ensure that committees, policies, procedures and overall board structure and functions create a high-performance organization

Efficiency Initiatives

– Ensure that trustees receive agendas at least one week in advance of board, committee and task force meetings; provide background materials that ensure trustee understanding of critical governance-related issues

– Examine the board committee structure to ensure responsiveness to evolving challenges and opportunities. Consider establishing "strategic issues teams" to replace some traditional standing committees

– Evaluate the quality and quantity of information used by the board to make policy and strategic decisions; ensure that information is relevant, timely, understandable and actionable, and that it facilitates high-quality board decision making

– Examine the content of board meetings to ensure that the most significant and meaningful issues are being effectively addressed, that trustee time is respected and used efficiently, and that trustee involvement and participation are enhanced

– Examine the prior six board agendas; assess the ratio of time spent discussing issues and opportunities vs. time spent on approval of minutes, committee reports, and other more procedural issues; make discussion of strategic issues the centerpiece of every board meeting

Q: What's the board's role in building trust and connections with its community?

Hospital trustees face a broad array of complex challenges in their continual quest to meet the critical health care needs of their communities. Too often, trustees become so consumed with the organizational issues and challenges that they lose sight of the need to consistently and forcefully connect in meaningful ways with their communities.

With growing scrutiny of the "community benefit" provided by hospitals, hospital boards have a unique opportunity to ensure that their organizations consistently engage in meaningful ways with a broad range of community stakeholders. Although a lack of trust in America's hospitals in some quarters may be primarily attributed to wrongdoing by a few hospitals, the problem is compounded by a lack of effective action and community engagement.

Hospital boards of trustees must not ignore this growing community trust challenge. Most Americans don't understand how hospitals are organized and managed, while even fewer still understand and appreciate the many challenging forces that are impacting local hospitals today. Instead, they tend to rely on personal experiences, and the opinions and beliefs of the media, friends and associates to shape their viewpoints about their local health care system. Trustees should actively engage their organizations in meaningful community partnerships, lead the design of community health improvement initiatives, and engage in community dialogues that promote the hospital's efforts and demonstrate the hospital's genuine interest in the health care needs and challenges of the community.

The Business Case for Community Health Initiatives

It's simple: strengthening community relationships and implementing initiatives to improve the community's health is the right thing to do for hospitals' patients, families and communities. In addition to helping hospitals fulfill their community-focused missions and visions, community health initiatives provide several significant business-strengthening benefits, including:

- Credibility and leverage in representation and advocacy;

- The potential to increase market share;

- Development of allies to address common challenges;

- Creation of new partnership opportunities;

- Foundation fundraising;

- Strengthened support and public trust for the hospital and its efforts;

- Increased awareness of hospital challenges and understanding of the hospital's commitment to addressing community needs;

- Strengthened employee morale and sense of purpose; and

- Preservation of not-for-profit hospitals' tax-exempt status as the community benefit provided by hospitals and health systems becomes clear and measurable.

The Need for Trustee Leadership and Involvement

Hospital trustees are trusted leaders in their communities. Trustees also have a unique and powerful role as key communicators of the benefit provided by their hospital. Because they are volunteers, they are viewed as unbiased impartial protectors and stewards of the hospital's cherished mission, values and vision.

Becoming a Community-Centered Board

A board emphasis on the importance of improving community health sets the stage for hospital leaders, employees and the medical staff to develop strategies for community health improvement. To effectively lead their organization in building and strengthening community health, boards must:

1. **Define the "community" (or communities)** the hospital serves, creating a focus for the community health improvement initiatives, and enabling measurement of the impact and success of the hospital's efforts.

2. **Develop partnerships** with other health care providers and community organizations that can bring diverse resources to the table.

3. **Develop a shared community health mission**, values, vision and plan, including specific goals and measurable outcomes to track success.

4. **Create a "culture of community commitment"** throughout the organization, with the hospital's leaders setting the tone for the medical staff and hospital employees.

5. **Conduct routine assessments** of the community's health status, using the first assessment as a baseline by which to track progress and the success of community health initiatives.

6. **Develop community health status indicators** and routinely report them widely to all key stakeholders, highlighting both areas of success as well as areas in need of improvement.

Rules for Building Sustainable Community Partnerships	
Rule 1	It's not an event or a one-time fix, but a continuous commitment to community
Rule 2	Lasting partnerships cannot be created overnight, and must be sustained over time
Rule 3	Don't reinvent the wheel; learn from and use the success of others
Rule 4	Cultivate broad-based buy-in and commitment from all stakeholders
Rule 5	Communicate, communicate, and then communicate some more

7. **Consider creating a board committee** to oversee the community health partnership and ensure the partnership is "staying on track" and making progress toward achieving its goals.

8. **Hold the CEO accountable** for achieving community health improvement objectives by developing specific, measurable outcomes that are mutually agreed upon with the CEO.

9. **Continuously integrate existing initiatives** for community health assessment with new ones.

10. **Build and sustain the concept of board responsibility** for community assessment, involvement and improvement, including an emphasis on community health at board meetings and in the board's regular board self-assessment process.

Testing Community Centeredness

The following statements include key components of a community-centered hospital or health system. How would you respond to the following statements?

- We have clearly defined our community.
- Our mission describes our commitment to the community, and is used to evaluate key decisions facing the hospital.
- We promote and support specific initiatives whose sole purpose is improving community health.
- We assess various stakeholders' needs and interests when developing goals and strategies.
- We regularly discuss community health improvement challenges and barriers.
- We meet regularly with community partners to assess and discuss our progress in meeting community needs.
- We have formal working relationships with organizations that share our community health improvement mission and vision, and that leverage our services and resources for maximum benefit.
- We regularly assess the value and impact of our joint community health improvement efforts.
- We communicate our efforts and results widely in our community in the form of a community benefit report.
- CEO performance objectives include a focus on improving community health.

Community Centeredness: Questions to Consider

- What is the state of public trust in your hospital?

- Do people in your community see your hospital as being community-centered?

- Can you describe your community partnerships and their value and results?

- What does community accountability mean to you? How do you define and measure it?

- What are you doing to ensure that the entire organization embraces community accountability?

- What strategies do you use to engage the community in the hospital's long-range planning?

- What information about hospital performance do you report to your community?

- What approaches do you use to advocate in your community and to legislators?

- What is the individual community and political advocacy role of every trustee?

Using Community Connections to Build Community Health and Strengthen Public Trust

Hospitals and health systems impact their community in many dimensions, giving hospital leaders and trustees a unique opportunity to connect with and influence a variety of stakeholders. Potential stakeholders hospitals should consider partnering with include patients and families; advocacy groups; churches; schools; health policy makers; physicians; hospital employees; the media; insurers; lenders; and the general public.

Ensuring Collaborative Community Governance

Collaborating in meaningful ways with key community influencers and stakeholders is no easy task. Every partnership will be different, as each organization has its own structure, strategies to addressing local challenges, and individual agendas and goals. In addition, partnerships often lack a formal structure and may not have a formal authority for making final decisions.

Hospital leaders can be the catalyst for developing successful community-based partnerships by ensuring a focus on shared goals and objectives, and creating a mutually agreed upon process for the group's meetings and decision-making approaches. When establishing community-based partnerships, boards should consider the following principles:

- Engage a wide spectrum of the community as partners for improving community health;

- Identify and invest in existing community assets rather than creating new assets;

- Be willing to let go of control;

- Be transparent, open and inclusive; and

- Be accountable through ongoing measurement, reporting and action plans for improvement.

Identifying, Evaluating and Including Partners. Although partnership potential varies greatly from community-to-community, the guidelines for determining the most appropriate stakeholders remains the same. When developing partnerships, hospital leaders should consider whether the prospective partner:

- Can commit to the partnership's vision and goals;

- Brings something unique and valuable to the table;

- Is willing to commit meaningful resources;

- Fits existing "zones of collaboration" or creates new ones; and

- Is truly interested in advancing community health.

The Result of Collaborative Community Governance. Successful community partnerships are formed with a shared vision, coordinated, sustainable solutions to improve community health. The shared efforts and resources translate to a better use of limited resources, thus ensuring that the right care, service, test or treatment is provided in the right place and the right time. Effective partnerships also result in improved understanding and trust between the hospital and the community as a whole, and an expanded pool of powerful advocates for local and regional health needs. In addition, collaboration to improve the community's health sends a powerful message to the community about the hospital's commitment to providing community benefit and improving the overall health of local citizens, resulting in increased local support for the hospital.

Avenues for Building Community Centeredness

In addition to building and sustaining partnerships, there are a variety of avenues by which hospital trustees and leaders can gain a greater understanding of the community's health care needs and challenges, increase awareness of existing

programs, seek feedback and ideas for new initiatives, and build trust and promote the hospital's image. These include:

- Community surveys;

- Focus groups with key stakeholders;

- Task forces with hospital leaders, employees and key stakeholders;

- Conducting a community needs assessment;

- Advertising and promotion of the hospital's services and community benefit initiatives;

- Presentations throughout the community;

- Interviews with patients, key stakeholders, and the community at-large; and

- Healthy community initiatives.

The "bottom line" value of being a community-centered organization is that the community will better understand the challenges the hospital is facing, the hospital's efforts to address the challenges, and the barriers to success. The hospital must connect with stakeholders and key constituents in ways that can be leveraged to more successfully advance the hospital's agenda. The benefits that result from the hospital's community benefit initiatives must be defined, reported and discussed throughout the community to build a sense of the hospital's health care and economic value.

Pricing, quality and governance transparency are important to the business community, governments, payers and consumers. Hospitals should provide information on pricing, quality, compensation and governance practices to enrich the

community's awareness, confidence and trust. This will not only build greater community support for the hospital's efforts, but will also help patients and the community as a whole trust that the hospital, its staff and physicians are committed to the hospital's mission and vision of community care, not to simply create economic gain.

Making Community Centeredness Happen at Your Organization

Hospital boards can take steps now to become a community-centered board. Key action steps include:

- Ensuring that the board has a clear, consensus-driven understanding of community health issues and needs;

- Conducting an annual or semi-annual community health needs assessment;

- Establishing a process for eliciting community input and viewpoints;

- Ensuring that board policies support community engagement and involvement programs;

- Monitoring and evaluating the hospital's progress in meeting its community service goals;

- Ensuring that board composition represents a broad spectrum of community perspectives;

- Staying continuously aware of the extent of the community's health care needs; and

- Engaging in community-centered thinking and actions at every board meeting.

AHA Study: Re-Establishing Community Bonds
A study by the American Hospital Association and American College of Healthcare Executives identified seven key strategies that leading hospitals use to maintain their focus on community health. Strategies include:
1. **Envision a healthy community:** set goals that incorporate community health as part of your strategic initiatives.
2. **Finance a healthy community:** Compensate management based on achieving pre-established community health criteria.
3. **Educate about a healthy community:** Establish a curriculum to teach community health initiatives to your hospital's staff, physicians and board members.
4. **Personnel decisions for a healthy community:** Establish a senior management position for community health.
5. **Market for community health:** Promote community health with and through partners.
6. **Structures to support community health:** Create a committee of the board to promote quality and community health.
7. **Processes that enhance community health:** Develop an ongoing board improvement process.

Source: Dolan, Thomas. *Rekindling the Flame. Hospitals & Health Networks. October 2001.*

Q: How does the board ensure strong collaboration and partnerships with the medical staff?

The hospital/medical staff relationship should be a trusting partnership, where both the medical staff and hospital work closely together to provide quality care for patients. But hospitals and medical staffs often have differing perspectives and unique cultures, which can lead to a disconnect between the two. There are actions that board members can take to improve alignment to build a high functioning, strong hospital and medical staff relationship.

As the relationship between hospitals and physicians evolves, it is more important than ever for hospital boards to have a strong, trustful relationship with the medical staff. While the financial relationship between hospitals and physicians is differs between organizations, there are many challenges related to hospital/medical staff relationships that arise in hospitals of all types and sizes.

First, hospitals and physicians simply have different financial needs and financial pressures. These pressures can result in split interests, and a sense of disconnection. It's important for board members to understand how those financial pressures differ, as well as where they converge.

Second, hospitals and physicians don't always share the same mission, values and vision. The hospital's mission and vision is typically much broader and more community health improvement centered, while physicians' mission is more narrowly focused on individual patients and practice development. This is an area that is growing in alignment as hospitals and physicians increasingly collaborate together, but there is much room for improvement.

Finally, like everything that happens in the hospital/medical staff relationship, board inattention to the importance of building a culture of collaboration, cooperation and the pursuit of opportunities with mutual self-interest can contribute to the development of problems that may remain below the administrative and governance radar screen.

The hospital/medical staff relationship should be a trusting partnership, where both the medical staff and the hospital's executives and governing board work closely together to provide consistently high quality, safe care for patients. Unfortunately, there is too often a "division" between hospitals and their medical staff, a sense of "us" vs. "them" in many areas critical to the hospital's success in achieving its mission and vision.

What Alignment Creates

Alignment between the hospital and the medical staff creates a number of positive outcomes that are vital to success in meeting the needs of patients and the community. Once effective alignment occurs, it creates strong and meaningful participation, collaboration and mutual benefits for both the hospital and its medical staff. It encourages a sense of empowered and interdependent interaction at multiple levels through which both the hospital and the medical staff can build teamwork and align their understanding and solutions to common challenges.

In addition, it creates the capacity to form an agreement around a common commitment and a common strategic direction for achieving common objectives. And finally, alignment creates an atmosphere for the potential development of meaningful, value-driven economic integration that meets the needs of both the hospital and its physicians.

There's Much at Stake

There's much at stake in the enhancement and success of the hospital/physician relationship. In order for the hospital to be successful in achieving its mission and vision, it must be successful in ensuring that it's able to offer the most appropriate and needed services with high quality and safety.

Patient loyalty is a critical component in sustainable service success. That loyalty is driven by the patient's sense that the hospital and its physicians are working together in a coordinated way to ensure that their health care needs are met.

Patient loyalty and service success drive the hospital and its physicians' market reputation as collaborative health care leaders committed to a common purpose, and united in their drive for quality, safety and patient satisfaction.

And clearly, the community will benefit significantly more when hospitals and their medical staffs understand the community's most critical health care needs and perceptions, and put their collective shoulders behind unified solutions designed to deliver the highest level of community benefit possible.

All of this - success and service delivery, building and sustaining patient and community loyalty, building an unassailable market reputation, and delivering a level of benefit the community wants and deserves - result in the greatest opportunity to build sustainable financial strength that will fuel the growth and relationships of the future.

Health Care Transformation Makes Hospital/ Medical Staff Alignment an Imperative

One of the most frequent criticisms of the nation's health system has been its fragmented, fee-for-service structure. Critics have long argued that this structure encourages providing a greater volume of services over focusing on services that provide superior quality and outcomes and/or reduce costs.

A 2008 Commmonwealth Fund study conducted by Harris Interactive asked patients about their care experiences, views of the U.S. health care system, and ways to improve patient care. The most important things patients said they wanted to see change include:[24]

- Better coordinated care, with one place or doctor responsible for their care;

- Easy access to medical records for both patients and providers; and

- Information about the quality and cost of care.

Accountable care organizations (ACOs), patient-centered medical homes (PCMHs), value-based purchasing (VBP), and bundled payments are being recognized as delivery systems and reimbursement models that may be able to give patients what they want. In response, the number of mergers, acquisitions and other partnerships among hospitals, health systems and physicians have increased significantly in the past couple of years.

But success requires close hospital and medical staff alignment. Alignment between the hospital and its medical staff ensures strong collaboration, and encourages empowered, interdependent and trustful interaction between the two groups. Nurturing a trust-based hospital/medical staff relationship will help to ensure the hospital's ability to respond most effectively to reform issues and challenges.

True Physician Integration. Whether hospital leaders are considering an ACO or simply preparing for payment incentives that are based on patient outcomes, strong hospital/ physician relationships are essential. Health care transformation encourages more than hospitals and physicians cooperating to care for patients. It requires hospitals and physicians to provide integrated care - care that is coordinated, uses seamless technology, and involves providers across the spectrum working together to care for each patient as an entire "episode of care."

This is a necessary shift in thinking for many health care leaders. Hospital trustees and leaders should be preparing for that shift now, working jointly with their medical staff and other providers in the community to develop shared solutions and forge partnerships that will provide better care and prepare all health care providers for a successful future.

Preparing the Hospital for Increased Care Coordination. Strong hospital/medical staff alignment will be critical to success in the more integrated world envisioned under health care transformation. Trustees should consider the following questions:

- How well aligned is the hospital and its medical staff?

- Are physicians meaningfully involved in hospital decisions that impact patient care and physician practices?

A Common Foundation and Understanding

Trust and alignment between the board, the hospital and the medical staff requires a foundation of collaboration, communication, common objectives and mutual dependence. Do the hospital and its medical staff have:

- A shared foundation of trust?

- Physicians involved in leadership?

- Clearly defined economic benefit for all parties?

- A shared commitment to meeting community needs?

- How vibrant are physicians' voices in the hospital's strategic thinking and planning processes?

- Does the hospital work closely with the medical staff and other providers in the community to develop shared solutions and forge new partnerships that will be mutually beneficial in this new era of coordinated care?

The Goal: A Tight and Trusting Relationship

Without a strong, robust, trustful relationship based on mutual needs and expectations, the medical staff and hospital will not be fully aligned, and the quality, efficiency and effectiveness of care may be affected. Both must see the arrangement as a partnership with equal give-and-take, and listen openly to the other's ideas and needs. With a strong, vibrant relationship, quality care is provided to patients, preserving services and improving patient loyalty and market share. This helps hospitals build financial strength and improves workforce morale.

A Hospital Where Physicians Would Send Their Family. The ultimate achievement is creating a hospital that physicians are loyal to, a hospital where they would send their own families for care without hesitation. How is this done? According to a survey by Press Ganey Associates Inc., the best ways to promote physician loyalty are to improve ease of practice, improve quality of care and stay adaptable.

- *Improve Ease of Practice.* What will make a staff physician loyal? Making their job easier. How can you do that? Make sure they have the tools they need— the services, the equipment and the personnel they need to effectively do their job.

- *Improve Quality of Care.* Physicians are genuinely concerned with quality of care. When they see high quality of care, they are more likely to recommend the hospital to their patients. It is important that physicians see the leadership's commitment to quality of care. This leads to physician loyalty to the leadership, and to the hospital itself.

- *Stay Adaptable.* When physicians perceive that the facility's leaders are adaptable to the health care environment, they become more loyal.

A Shared Mission: It's All About Quality

Both hospitals and physicians place a high importance on quality of care. Unfortunately, when the two are misaligned,

Hospitalists Increasing Dramatically

According to an American Hospital Association survey, extrapolated with data from the Society of Hospital Medicine's own survey through 2014, hospitalists are growing dramatically. Hospitalists, or physicians focused on the sole purpose of inpatient care, are playing an increasing role in quality through readmission prevention, infection control, electronic health record use, improve patient experience scores, and more. Study findings include:[25]

- The number of U.S. hospitalists has increased from 100 in 1996, to 11,000 in 2003, to 44,000 in 2014.

- The percentage of hospitals using hospitalists grew from 29% in 2003, to 50% in 2007, to 72% in 2014.

- Hospitalist pay has increased 12.2% from 2010 to 2014.

- Hospitalists are not just employed by hospitals anymore— they are also employed by skilled nursing facilities, rehab units, long-term care, and more. About 2 in 5 work for medical groups or private clinics.

quality may suffer—an unacceptable trend in today's environment.

When physicians and hospital leaders work together an environment of higher quality of care is created. Increased efficiency results, imaging and testing services are used more appropriately, and therapies are prescribed more carefully. Positive outcomes also may include a reduction in medication errors, better use of services, (such as outpatient services instead of inpatient), use of disease management programs and improvements in end-of-life care.

A quality project undertaken by the Centers for Medicare and Medicaid Services (CMS) demonstrates the potential quality of care improvement when the hospital and medical staff are aligned. Between 1991 and 1996, a CMS demonstration project tested the effectiveness of gainsharing. Gainsharing is a payment arrangement aligning physician incentives with that of the hospital. Four hospitals agreed to accept a global rate covering Medicare Parts A and B for patients having a coronary artery bypass graft (CABG). Two of the hospitals chose to implement a gainsharing program.

These hospitals found cost reductions in intensive care, laboratory, routine nursing and pharmacy services costs. Not only were costs reduced, but operating room procedures, intensive care unit stays, and post-ICU stays were all reduced and patients had better outcomes overall.[7] Participating hospitals determined that "aligning surgeons' goals with

hospital incentives to reduce costs was absolutely critical in changing practice patterns and improving department efficiency."[8]

When medical staffs and hospitals are aligned, medical errors are reduced, patients have better outcomes, efficiency is improved and overall quality of care improves. Increased cooperation between the hospitals and physicians leads to better patient care and improved satisfaction. This common mission should drive alignment initiatives.

Causes of Misalignment

The differences in the drivers and mindsets of physicians, administrators and trustees are often significant. But the facts of professional training, experience, needs and expectations must be taken into account as alignment strategies are developed.

Think for a moment about the environment in which physicians do their jobs, and the environment in which administrators and board members carry out their responsibilities.

Differences in Perspective. Physicians are trained to react quickly and provide evidence-based diagnoses and treatments. In many cases they're expected to have an immediate response and make rapid decisions under her intense time and emotional pressure. In addition, they work autonomously and independently as advocates for individual patients in their care. They identify primarily with others in their profession, and by nature think, plan and act independently.

Now think about administrators and boards of trustees. Their perspectives and mindsets are almost opposite. They're long-term planners and thinkers who engage in broad group discussions about organizational issues that may not be decided for weeks, months or years. They're individuals who delegate much of their work to others and collaborate with broad range of constituents and stakeholders. And rather than focusing on individual patients, they have a fiduciary responsibility to meet the needs of the broad community in both clinical and non-clinical ways. Rather than relying on their independence, they instead value an ethic of interdependence on one another for consensus-based thinking and decision-making.

Besides the differences in the drivers and mindsets of physicians, administrators and trustees, several factors can disrupt the hospital/physician relationship, including a lack of consistent and meaningful physician involvement in hospital

decision making; governance and leadership in attention to the current and emerging challenges that physicians face in building their practices; taking a dangerous "generic" view of the medical staff as a cohesive and like-minded group, rather than recognizing and understanding the real challenges, issues and needs of individual physicians and practices; and finding themselves in a situation where the hospital and its physicians compete in the service arena rather than collaborate in ways that add strength and value to their respective missions and visions.

"Physicians are not different creatures. Physicians do have a very different kind of pressure on them, though. It's hard for most of us to really imagine the decisions and judgments that physicians have to make every single day. I'm not sure we realize how difficult physicians' jobs are or how personally driven they are to do their jobs right."

-Richard deFilippi, a Cambridge Health Alliance trustee, Massachusetts Hospital Association board member and past chair of the American Hospital Association board of trustees

Noblis studied the root causes of hospital/physician misalignment. Formerly known as Mitretek Healthcare, Noblis is a nonprofit science, technology and strategy organization that helps clients solve complex systems, process and infrastructure problems.

Noblis' electronic survey targeted 3,000 Society for Healthcare Strategy and Market Development members, and was completed by 362 individuals. In addition, more than 60 phone interviews were completed. One member, Richard deFilippi, a Cambridge Health Alliance trustee, Massachusetts Hospital Association board member and past chair of the American Hospital Association board of trustees, characterized the differences between physicians and hospital executives this way: "Physicians are not different creatures. Physicians do have a very different kind of pressure on them, though. It's hard for most of us to really imagine the decisions and judgments that physicians have to make every single day. I'm not sure we realize how difficult physicians' jobs are or how personally driven they are to do their jobs right."

Similarly, physicians and executives have different expectations in relation to time. According to Dr. Joseph Bujak, Vice President of Medical Affairs for Kootenai Medical Center in Idaho and a leading health care consultant, perceptions of time

can create a division between physicians and hospital leaders. The definition of "now" is different to a physician than it is to an executive. For example, a member of the medical staff may tell an administrator that he needs new surgical equipment "now" and the administrator may agree to purchase the equipment, but it may not be purchased until the next budget cycle, which is "now" to the executive. These varying expectations can create frustration for physicians and lead to anger or distrust.

Poor Communication. Communication problems can also contribute to misalignment and are often due to cultural divisions and false assumptions between physicians and executives. Dr. Bujak states that physicians have an "expert" culture while hospitals have a "collective or affiliative" culture. In the latter, process is more important and respecting emotions is essential. On the other hand, accomplishing goals and exerting power motivate the physicians working in the expert culture.[10]

Dr. Bujak also lists two specific false assumptions that impact communication, negatively affecting hospital/medical staff relationships:

- *False: The medical staff is organized and structured.* Bujak argues that physicians long for autonomy, but are asked to work as a collective group, making decisions for the organization as a whole. This can cause the group to be reactive and not proactive. It hinders leadership, because when acting collectively, "physicians function as a town hall democracy in which one person gets one vote and majority rules."

- *False: All physicians are alike.* Another false assumption is that all physicians are alike. Bujak believes that there is not enough dialog between the hospital leaders, board members, and physicians, and this creates a hostile environment where money and control becomes the focus.

  Building an organizational culture and dispelling false assumptions will improve communication between hospital leaders and physicians creating a stronger, robust alignment.

Lack of Trust. A lack of trust can directly affect alignment between hospitals and physicians. When physicians become unhappy or disgruntled with their experience with a hospital, they may become competitors.

Although both hospital executives and physicians believe in treating patients with quality care, each may have its own vision as to how to execute that goal.

A lack of trust will only continue to negatively affect relationships between hospital leaders and the medical staff. In order to create a meaningful partnership for patient care, both physicians and hospital leaders must move beyond competition to build better relationships and improve alignment.

Lack of Hospital Appreciation of Physicians' Challenges. The changing health care environment continues to strain physicians as they experience a loss of autonomy, high malpractice costs, increased administrative responsibilities, competition, regulatory requirements, and tighter reimbursement. Many board members and executives do not fully understand the difficult economic pressures faced by physicians, or are not aware or educated about these issues. This lack of understanding and support has the potential to alienate physician participation.

The board needs to be willing to listen to and work with physicians in order to provide a positive outcome. It is also important to identify key objectives that affect both the board and physicians, strengthening the working relationship between the two through open communication. Effort must be made to recognize physicians' goals and work to align these with hospital practices in order to encourage the two parties to work together.

But despite differences in mindset and direction, and despite the factors that can disrupt the hospital/physician relationship, one critical, common bond that binds both hospitals and physicians together is the joint commitment to service, quality, patient safety and patient loyalty.

This is the centerpiece of creating meaningful hospital/medical staff alignment. Because while hospitals and physicians may disagree, or find themselves at odds on many things and in many areas, the commitment to providing the right care in the right way at the right time, in the safest manner and with the highest level of quality will always be at the heart of what hospitals and physicians are all about.

Bridging the Gap: Strategies for Success

Dr. Bujak suggests getting rid of the "generic image of physicians." He explains that boards "see doctors as this generic entity and are constantly asking questions conveying this bias. 'Tell me, what do the doctors think?'…What 'he said' suddenly becomes the gospel. The medical staff is not a singular entity, it is pluralistic. Boards…must stop dealing with THE medical staff and start dealing with physicians in subsets."

Building Constructive Hospital/Physician Relationships and Alignment

The question is, how do you do that?

The three strategies described below will help encourage a successful, steadfast relationship between hospitals and their medical staff. They include: 1) involving physicians; 2) understanding physician needs; and 3) creating mutually beneficial collaborative business relationships.

Involve Physicians. One key strategy for success is to involve physicians in hospital leadership. Physician leadership encourages loyalty to the hospital, and physicians have experience and knowledge that is beneficial to leadership.

What does the ideal physician leader look like? According to a roundtable discussion of health care experts, a number of important characteristics describe the ideal physician leader.

The experts discussed the importance of key personality characteristics. Good communication, people skills, honesty and the ability to be straightforward are all vital to gain respect as a leader. For those physician leaders who do not have formal business training, developing business skills through experience and further education can be important to supplement a clinical career. Keep these in mind as you make decisions about physician leaders. Encourage physician leaders, as they can improve physician loyalty and improve relations between the medical staff and the hospital.

Understand the Needs of Physicians. To maintain physician loyalty to the hospital, it is important to understand their needs, demonstrate to physicians the hospital's understanding of the difficulties they face in practicing medicine, and show them what action is being taken to minimize or remove these obstacles. To ensure understanding, it is a good idea to conduct an annual medical staff satisfaction survey. This survey will clarify physicians' opinions about a broad range of issues relating to their practice needs, and their relationship with the hospital.

Create Mutually Beneficial Collaborative Business Relationships. In today's health care environment there are two choices for hospitals and physicians: either compete or collaborate. As Dr. Charles Peck stated in a story in *The Physician Executive*, "Physicians and hospitals collectively suffer from 'mural dyslexia,' characterized by an inability to read the handwriting on the wall. The handwriting is indeed clear."

"Hospitals must collaborate with doctors because the most expensive piece of medical technology is the physician's pen. In turn doctors must collaborate with someone, and the hospital remains the natural partner." Creating mutually beneficial collaborative business relationships can lead to a robust, successful alignment and increase financial success.

Joint ventures are growing in popularity because they benefit both hospitals and physicians. Collaborative business relationships provide both defensive and offensive solutions, as hospitals want to continue to protect their existing market share and grow. It also allows them to have better control of the market while improving patient satisfaction and efficiency.

Steps to Build Alignment

Consider the five essentials below to help build a strong, sustainable relationship with the medical staff. When these five elements are embedded in the relationship, physician and hospital allies will be created.

1. *Trust.* Trust is an essential part of any successful relationship and is critical for building successful, lasting relationships. Without trust, doubt, uncertainty and reservations will ruin any potential for alignment. According to an article in the *Journal of Healthcare Management*, "no matter how innovative, equity-oriented, or financially beneficial the physician-health system relationship may be, they will fail in the absence of mutual trust and feelings of shared destiny that are engendered by the environment in which the relationships are forged."

    Physicians and hospital executives must trust one another. Barriers to trust include miscommunication, different backgrounds, and other issues discussed earlier. Renew trust and create an alignment between the hospital and medical staff by understanding the needs of both entities and using a board-driven alignment strategy.

    Specific ideas for establishing trust include:

    -   Make a clear commitment to support physicians in the turbulent economic and operational challenges they face;

    -   Answer commitments with concrete actions to make the hospital a more productive, efficient environment for physicians;

    -   Include physicians in various stages of planning and budgeting to give them more responsibility for the hospital;

    -   Respond to physician input about quality and the general practice of medicine at the hospital; and

    -   Keep the board up-to-date on increasing restrictions and economic challenges that physicians face. Allow opportunities for the medical staff to share these issues with board members directly.

2. *Communication.* When good communication is lacking, misunderstanding occurs. Steps for improving communication include:

- Make the CEO regularly available to physicians through dedicated time listening to and communicating with members of the medical staff;

- Create systems that alert physicians of critical issues. Allow the medical staff an opportunity to provide input with the board about these issues before decisions are made;

- Create means for regular communication with the entire medical staff; and

- Provide physicians with a forum to provide input into important decisions before they are made.

3. *Voice.* Allow physicians to share their expectations, experiences and ideas in order to encourage a relationship built on trust and communication. Provide physicians with a voice by:

- Giving physicians adequate representation on the board of directors and on relevant board and hospital committees and subcommittees;

- Including medical staff leaders at meetings where critical issues are discussed; and

- Creating a formal program for training physician leaders.

4. *Relationships.* Building positive relationships between physicians and executives is critical. Tips and strategies to improve relationships include:

- Conduct an assessment of the current relationship and identify strengths and weaknesses that need to be addressed;

- Provide assistance to help physician groups develop organizational maturity;

- Improve communication between the hospital, the board and physicians. Include physicians on the board, and in joint planning activities, leadership retreats and social events;

- Address conflict at the earliest possible stage;

- Monitor the relationship and look for opportunities to constantly improve it;

- Host informal social gatherings to promote relationship growth between administrators, board members and medical staff; and

- Create opportunities for community events where executives, physicians and board members can see first-hand the impact of their joint initiatives.

5. *Connections.* Creating mutually beneficial collaborative businesses will establish a link between physicians and executives. Although creating joint ventures may not be an option for every hospital, there are many other ways to build alliances between the hospital and physicians and create opportunities for success for both.

The Role of the Board: Creating a Culture of Collaboration

Think about the initiatives that hospital boards are pursuing to improve relationships and alignment between the hospital and physicians. What governance leadership is the board providing to ensure constructive relationships? In establishing goals, what is your future vision for hospital/physician relationships?

Create Partners for Progress. As trustees you must work to create partnerships between the medical staff and the hospital. The Center for Healthcare Governance suggests that the board do three things to facilitate a business partnership between hospitals and physicians.

- First, move beyond operational relationships into more physician-based partnerships for system-wide services, governance, accountability and incentives, and continuity of care and care improvement through technology.

- Second, create an environment that encourages physicians to work on business development, quality of care, customer service, simplifying internal systems, staying abreast of business trends and balancing risks and rewards.

- Finally, build an entrepreneurial infrastructure based on collaboration that develops funds for investment, establishes a business strategy, develops new business opportunities, and publishes results. For some organizations creating a business partnership between the hospital and physicians is the best way to align the two and improve relations.

Promote Collaboration. Board members need to be supportive and open-minded about new business ventures and the potential for improving the current business model.

Creating Opportunities for Collaboration
❏   Ask what makes a physician's life more convenient
❏   Invest significant time in building relationships
❏   Engage physicians intellectually
❏   Challenge physicians to advance the institution

There may be many risks involved and trustees should determine if the benefits outweigh the risks. In order to maximize benefits and decrease risks, create hospital collaboration policies and principles. Boards need to advise and consent to the mission, vision and goals, and create an environment of collaboration. All of these should emphasize partnership and acceptance of nontraditional health care models.

The Center for Healthcare Governance encourages collaboration that is supported by the board. "Hospital governing boards will need to take the lead in moving their organizations beyond only seeking excellent relationships with physicians to creating an environment of ongoing market-based collaboration. While proven models and emerging opportunities for these types of collaborations exist, the impetus for them needs to start with the board."[19]

Understanding Needs, Aligning Focus, Building Bridges: A Board-Driven Process

One of the ways to build trust, open up lines of communication, provide physicians with a real voice and build personal relationships is to involve physicians in very meaningful ways in understanding community needs and designing collaborative strategies for meeting those needs.

Accomplishing that requires a board driven process that engages physicians in assessing service area needs, gauging medical staff needs and opportunities, and collaborating on mutual opportunities for community service and community health improvement.

Here's a nine step process for accomplishing these important objectives:

1. *The Market You Serve:* Work with the medical staff to assess your service area. That includes gathering historical market information, developing a demographic profile, with projections for the future, gathering and assimilating local-area market and economic data, assembling readily available information on community health status and risks, and analyzing the payer mix, and potential changes to that mix based on projected market trends.

2. *Medical Staff Resources Today and Tomorrow:* Work with the medical staff to develop a medical staff profile that defines medical staff resources today, and development needs for tomorrow. This part of the process would include an assessment of physicians by specialty, age, clinic affiliation, and other relevant factors; admission trends and volumes, by specialty; and an analysis of turnover and recruitment trends, with an eye toward determining medical staff development needs the future.

3. *The View from the Physician Front Lines:* Secure viewpoints from the physician front lines. You can do this by conducting a medical staff survey of physician viewpoints about the hospital, equipment and support needs and major issues and challenges facing physicians. In addition to a broad medical staff survey, some physician leaders should be interviewed personally to gain their insights about emerging opportunities, areas of physician need and requirements for future medical staff development.

    The medical staff needs assessment can be conducted as an online survey or printed survey (or both), whichever best meets your medical staff's needs. Questions on the survey should be precise and focused, and the survey should be constructed to determine areas of agreement and disagreement in a variety of areas. It should also include several open-ended questions where physicians are invited to express their verbatim views in a variety of important areas.

    Areas you may want to assess in your medical staff needs survey included viewpoints about hospital performance and support, ways to build increased hospital competitiveness, influencers of individual practice success, views about significant community health issues that need to be addressed, patient care issues, hospital strategic development challenges, information about referral patterns and the rationale for those patterns, ideas for service expansion of service improvement, and views about hospital recruitment needs and objectives.

4. *Expanding the View: Additional Perspectives:* Other personal interviews should also be conducted as part of the strategic assessment, including interviews with the hospital's administrative staff and trustees. These interviews should be used to compare and contrast non-physician leadership ideas and viewpoints with those of

Nine Practical Steps to Understanding Physician Challenges and Building Alignment
The following nine steps describe a plan to gain understanding of the challenges and needs of physicians and the community and how to create a plan to improve alignment between medical staff and the hospital.
1   Develop a service area analysis. Research the payer mix, economic data and gather historical market and community health information in order to paint a picture of the needs of the community.
2   Profile the medical staff, examining hospital admissions and turnover and recruitment trends, listing physicians, by specialty type, age and clinic affiliation. This step will reveal how to create the right balance within the medical staff.
3   Survey and interview the medical staff to determine how to keep current staff loyal and motivated to provide great care for patients.
4   Interview trustees and hospital administrative staff to understand their view of medical staff needs for the hospital.
5   Examine trends in discharges and market share trends by major diagnostic code and zip code to understand market trends like outmigration.
6   Survey the community, examining viewpoints about physicians and the hospital, health risks and barriers to care in order to understand the needs of residents in the area.
7   Identify "gaps" in the medical staff, like emerging staff shortages, while involving physicians in planning to create a common mission and vision.
8   Create a medical staff/community needs summary report, summarizing the needs of the community and medical staff and incorporating the mission and vision of the hospital, projecting the staff needs and opportunities, and recognizing the factors needed for success will facilitate collaboration on opportunities.
9   Present results to the board, medical staff, management and others so they can understand and learn what is needed to improve alignment and build the best hospital to serve the community.

the medical staff to determine areas of concurrence and areas of divergence.

5. *Where Do They Go, and Why?* Develop an analysis of patient outmigration trends. Outmigration should be determined by measuring discharges from various hospitals of residents of zip codes in the primary and secondary service areas. It should define the hospital's market share by major diagnostic category, or by DRG.

6. *What Are the Needs? Making the Community Connection:* Conduct an assessment of perceptions about community health needs. This involves surveying residents' viewpoints about physicians and the hospital, community satisfaction with available health resources, an assessment of health risks, barriers to access to care, and perceptions about unmet health care needs. It should result in a projection of both current and future needs that will provide clear insights into service expansion opportunities and medical staff development needs.

7. *Identify the Evidence-Based Medical Staff Gaps:* At this point in the process you'll have the evidence you need to define any gaps between medical staff needs and medical staff supply. Your physicians will have been intimately involved in the strategic assessment process, and should

be fully engaged in helping to design solutions and recommendations to fill the emerging gaps.

At this point you'll also begin to engage physicians in identifying ideas for joint hospital/physician planning to meet emerging needs, and you'll begin to come to a consensus around a common mission and vision for moving forward.

8. *Collaborate on Opportunities:* Once all this work has been completed you'll be in a position to develop a report that will summarize your process and findings to-date. The report would likely include the mission and vision, and relevant elements from the hospital's strategic plan that relate to process findings. In addition, it would include a projection of future medical staff development needs and opportunities, critical factors in ensuring alignment success moving forward, and joint recommendations to the board of trustees from medical staff leaders, administrative team members, trustees and others who worked together in the process.

9. *Come to a Consensus:* And finally, with a properly prepared and well-executed process will come a consensus that will be evident in the report that is presented to the board of trustees, the medical staff, the

management team and others whose understanding and buy in to the process is critical.

Action Agenda
Real, effective alignment will not occur without strong leadership from the board. Here are some ideas for putting the power of governance to work:

- Have a focused discussion about the state of alignment at your hospital - your risks, needs and opportunities;

- Ask what initiatives are being pursued right now to improve hospital/physician relationships and alignment;

- Assess the scope and value of the specific government's leadership your board is providing to ensure constructive hospital/physician relationships;

- Conduct a thorough, evidence-based, physician-centered community needs assessment; and

- Make hospital/medical staff alignment a strategic board priority, and back it with the appropriate resources.

Conclusion
In the final analysis, trust between the hospital and the medical staff will be built on a foundation of collaboration, communication, common objectives and mutual dependence. Nurturing a trust-based hospital/medical staff relationship will help to ensure the hospital's ability to respond effectively to future issues and challenges.

Sources and Additional Information

1. Rice, J. Developing a partnering culture: the role of board and management in improving medical staff relations. *Healthcare Executive.* May/June, 2002.
2. Berenson et al. Hospital-physician relations: cooperation, competition, or separation? *Health Affairs.* December, 5, 2006.
3. Orlikoff, J. and Totten, M. The hospital-physician relationship: redefining the rules of engagement. *Trustee Workbook.* February 2005.
4. Are you looking for a fresh start with your MDs? *Hospitals and Health Networks.* May, 2005.
5. Mitretek Healthcare. Strengthening hospital-physician relationships presentation. *Trustee Conference.* January, 12, 2007.
6. Schoen et al. *Public views on shaping the future of the US health care system.* August, 2006.
7. Wilensky et al. Gain sharing: a good concept getting a bad name? *Health Affairs.* December, 5, 2006.
8. OIG. Fact sheet: federal anti-kickback law and regulatory safe harbors. November, 1999.
9. Jeffries, C. "Herding Cats: Leadership is Possible."
10. Bujak, Joseph. How to improve hospital-physician relations. *Frontiers of Health Services Management.* 20:2.
11. Schein, EH. *Organizational culture and leadership.* San Francisco: Jossey-Bass, 1992.
12. The Governance Institute.
13. Fabrizio, N. What can MDs bring to your board? *Trustee.* January, 1999.
14. HealthLeaders panel of experts. Physician leadership: more than clinical excellence. *HealthLeaders Roundtable.* October 2002.
15. Thrall. Money matters, but MDs want much more. *Hospitals and Health Networks.* February, 2007.
16. Peck. The Enterprise Circle. *The Physician Executive.* January/February 2001.
17. Boards and docs: a critical relationship. *Trustee.* February 2007.
18. Lifton and Bryant. Establishing principles for hospital-physician joint ventures. *Trustee.* February, 2006.
19. Developing a Partnership Culture. *Healthcare Executive.* May/June 2002.
20. Healthcare Financial Management Association. Baylor finds success with joint venture specialty hospital. *HFMA wants you to know newsletter.* February, 8, 2006.
21. Baylor Healthcare website. http://www.baylorhealth.com/aboutus/press/2007/012607b.htm. Accessed 6/13/07.
22. Healthcare Financial Management Association. Report 4: joint ventures with physicians and other partners. *Financing the future II white paper.* 2006.
23. Center for Healthcare Governance. Exploring hospital-physician business relationships: what trustees need to know. *Monograph Series.* 2005.
24. Public Views on U.S. Health System Organization: A Call for New Directions. Data Brief. The Commonwealth Fund. August 2008.
25. Clark, Cheryl. Hospitals' Numbers Quadrupled in Last Decade. *HealthLeaders Media.* September 4, 2014.

Q: How should the board gauge the hospitals' financial performance?

The board is responsible for the financial success of the hospital. In order to fulfill this fiduciary responsibility, trustees must have a solid grasp of the indicators of the hospital's financial health, and be knowledgeable about key financial interrelationships.

For the lay person, or the person with limited knowledge of financial statements and financial statement analysis, the issue of corporate governance and oversight as they relate to financial statement analysis can be an intimidating task. In order to effectively serve as a board member, trustees must begin by understanding their responsibility as a board member, and then learn the financial basics necessary to fulfill their role.

The Board's Role in Financial Oversight

The board is responsible for the financial success of the hospital, and fulfills a fiduciary responsibility that is defined as: a duty of organizational loyalty; a duty of care through application of business judgment; and a duty of obedience in abiding by laws, regulations and standards of hospital operations. Given past fiascos such as the Enron, WorldCom and HealthSouth governance failures, which led to charges against board members entrusted to protect the corporation's assets, the accountability of hospital board members is greater than ever.

Applying firm and consistent ethical practices to decision-making responsibilities is a necessary hallmark of the hospital board. An abiding interest in utilizing a "moral compass," well-established ethical principles to be used when deciding about board actions that concern ethical/moral dilemmas of services provided to the community served, provides the necessary balance to board decisions.

Boards have a broad responsibility to protect the limited resources of the hospital to ensure optimum services and benefit to the community. The board must ensure the cost-effective utilization of resources and the establishment of both long-range and short-range financial plans. The board should

regularly review meaningful and understandable financial reports, ensure that adequate capital is available for the hospital's investment strategies, and actively participate in and encourage regular philanthropic efforts.

One of the most critical functions of the governing board is protecting the hospital's financial status. The board should establish financial goals in a variety of key areas including growth, debt capacity, return on equity and other areas that define financial success. The board approves the annual operating and capital budgets, receives and approves a variety of budget reports throughout the year, primarily through a finance committee, and oversees the hospital's investment policies and goals.

In addition, boards of trustees are typically involved in assessing the impact of the hospital's pricing strategies and discount policies, and become involved in discussing and

Key Financial Questions for Boards to Consider

When reviewing the hospital's finances, the board should know answers to questions such as:

- What is your organization's payer mix? How is it changing?
- How has/will health care reform and the subsequent payment incentives impact the organization's financial viability?
- What are the organization's major investments, and are they financially sound?
- What are the major drivers behind changes in the organization's key financial metrics over the past 3 years?
- What are the organization's financial projections for the future, and what assumptions were used?
- Does the board have a sufficient financial understanding to review and analyze financial statements, trends and projections and identify warning signs and the potential need for a change in the organization's course?

Actions Boards of Trustees Can Take: Financial Focus and Leadership

- Ensure that annual operating and capital budgets are developed and approved, and that rolling 3-5 year financial forecasts are produced
- Identify, review and approve targets for debt, liquidity, ROI, profitability, and other important measures of financial and operational performance needed by the board to monitor organizational performance and make timely, informed decisions
- Ensure that key financial ratios are monitored at least quarterly, and that financial and operational implications and corrective measures are developed by management, when appropriate
- Develop a reporting style that is easy to understand, highlights major trends, and stimulates creative discussion
- Exercise broad authority to protect the limited resources both of the institution and the community
- Ensure the cost-effectiveness utilization of resources
- Lead the development of long-range and short-range financial plans, performance evaluation against the plans, and regular financial reports to the board
- Review the types and scope of services being offered
- Ensure that adequate capital is available for the organization's investment strategies
- Actively encourage philanthropic support
- Approve the budget and provide for day-to-day cash needs
- Determine fiscal policy relating to insurance coverage, discount policies and third-party reimbursement
- Determine policy on the provision of needed community services

approving contractual arrangements and other determinants of financial performance. Boards also determine policy on uncompensated care, provision of needed community services that may not be financially viable, and development of diversified revenue streams.

Over the years, Medicare and Medicaid payments have not kept pace with inflation and hospitals have increasingly experienced financial difficulties. One of the primary objectives of the ACA is to shift the nation's health care delivery system from one that is paid based on volume (the number of services received/fee-for-service) to a payment system based on value (payment for high quality, cost-effective care). Enactment of new payment systems under the ACA may drive further reductions in revenue if hospitals fail to prevent readmissions, have a high incidence of hospital-acquired conditions, or fail to achieve or improve value-based quality scores.

Furthermore, boards are responsible for ensuring that the hospital consistently complies with all applicable laws and regulations. With the federal government's emphasis on detecting and punishing health care fraud, trustees must ensure that an ethical business climate always exists in the hospital, and in particular that financial procedures and processes are conducted in an ethical manner.

Compliance

A strong and effective compliance plan is a comprehensive strategy that ensures that the hospital consistently complies with all state and federal laws governing its activities and the delivery of health care. It also ensures that the hospital consistently complies with the applicable laws relating to its business practices.

A key board responsibility is determining the hospital's financial goals and monitoring its operations to ensure the attainment of those goals. The annual budget is the primary vehicle for the board and administration to establish financial objectives. Board members must clearly understand the assumptions upon which the budget is based. Budget assumptions should be reasonable and clearly understood, and should tie directly to service development and to the hospitals mission, vision and strategies.

The governing board also has a responsibility to engage external auditors to perform an annual audit of the hospital's financial records. This audit helps the board determine if the financial position and operations are accurately and fairly presented, and are in accordance with generally accepted accounting principles. The board should use the audited financial statements to determine whether the hospital is reaching its established financial and operational targets; it should be a tool in helping to determine progress and assess whether goals and strategies require modification.

The board's financial planning direction and decisions should flow out of the hospital's long-range strategic planning initiatives. Studies of the financial feasibility of new programs or

capital acquisitions should be regularly performed and reported to the board. The board should then use financial performance against budget and compared to peer groups as a tool for gauging organizational progress and effectiveness.

Financial Basics

As a general overview, there are three basic statements that board members should review. These statements, the Balance Sheet, Statement of Operations and the Statement of Cash Flows, should be reviewed together, rather than on a stand-alone basis, since they are all interrelated. Problems that might be masked by looking at one or two statements become easier to identify when examining all three together.

The Balance Sheet

The balance sheet lists the assets, liabilities, and equity of the hospital. It also classifies those assets which are expected to be turned into cash within one year (identified as "current assets"), and those debts which are going to be due for payment to the lender within one year (identified as "current liabilities").

The Statement of Operations

The statement of operations (or "income statement") identifies the sources and amounts of revenue after they have been adjusted for contractual allowances, as well as the operational and non-operational expenses of the organization. It provides the reader with the "bottom line" of the organization, from both an operating and non-operating basis.

The Statement of Cash Flows

The statement of cash flows is without a doubt the statement that provides the most confusion in financial statement analysis. This is unfortunate, since it can in certain circumstances be the most important statement reviewed. The statement of cash flows identifies the sources and uses of cash. It attempts to explain to the reader where the cash is coming from, and what it is being used for.

What is your organization's cash balance? What is that cash being used for? Is there a declining balance? Are large payments due to be paid on debt which will reduce the amount of cash further, and which will strain the organization? How can you find the answers to these questions?

These questions can be answered by looking at the statement of cash flows and the balance sheet. The balance sheet lists the cash balance as the first item. On comparative statements (statements with balance information from prior periods listed for comparative purposes next to the current information) you can see if the cash has increased or decreased since that time.

Source: Best Financial Practices for Trustees, James S. Vaughan, Principal, Catherine J. Robins, VP, Cain Brothers. Trustee Magazine. March 2001.

But the most important question to ask is what is causing the cash balance to go up or down. This can be answered by reviewing the statement of cash flows. This statement tells the reader where the cash is coming from and where it is going. For instance:

- If the source of the increase or decrease in cash is from the operations of the organization, than there will be an increase or decrease in the line "Net increase (decrease) in cash from operating activities"

- If the source of the increase or decrease is from purchases or sales of fixed assets or from purchases or sales of investments of the organization, there will be an increase

or decrease in the line "Net increase (decrease) in cash from investing activities"

- If the source of the increase or decrease in cash is from incurring debt or repayment of debt, or from equity related activities, then there will be an increase or decrease in the line "Net increase (decrease) in cash from financing activities"

The question to ask is "why is our cash balance increasing or decreasing?" Just because a hospital has more or less cash than it had in the prior month is not necessarily a cause for alarm. The reasons are many and varied, good and bad. Did you refinance or incur new debt? Did you make a large debt payment? Is operations using cash, or providing cash to the organization? Did you purchase fixed assets or property?

Another question to ask related to cash is "what is our cash balance anticipated to be in the future?" Do we have any large debt payments or other obligations that we are going to be required to pay in the near future? This can be answered by looking at the balance sheet and seeing if the current liabilities are large, or if they have increased over the prior comparative balances.

Accounts Receivable and Revenue

Most of the revenue derived from patients is received based upon contractual arrangements with payers.   The hospital records revenue for the services at a standard amount, called the Gross Revenue amount, and then adjusts this amount down through a Contractual Allowance or Adjustment to record the actual amount which it will receive. The corresponding accounts receivable for the balance due is based upon the adjusted or Net Revenue amount.

Investments

Investments by the organization are a critical area to monitor. When the organization invests in an affiliated or unaffiliated entity, such as a medical office building or a partnership with a medical imaging organization, the income and losses of those investments need to be recorded by the investing organization.

Those persons responsible for oversight of the organization need to be aware of the results of operations of these investments and management's level of responsibility in the investment. Is your organization responsible for debt of the investee organization if the investment becomes insolvent? Ask management for details of all material investments. Ask if the organization is liable for losses. Ask if all losses are being recorded properly.

Liabilities

Management is required to record a liability when they become aware of the liability and when the amount of the liability can be determined. Management is given some leeway in estimating the amount of liability to record, based upon their judgment of the likelihood of occurrence of the event or the degree to which changes in the amount due could change over time.

Increases in accounts payable on the balance sheet should be understood by those responsible for oversight. An understanding of why there have been increases is necessary for proper governance. Is management holding back payment to increase cash balances? Has the aging of accounts payable increased and are large repayments going to be required in the near future?

Current and Long Term Debt

Current and long term debt is a very important area to understand and monitor. Increases in debt without increases in investments or fixed assets could signal borrowings being used for operational purposes. Understanding the dates that the debt facilities are due to be paid off is critical for cash management. Shortfalls in cash balances should be forecasted by management and discussed. Are bond repayments anticipated in the cash flow model of the organization? Could existing debt be refinanced to obtain better interest rates and repayment terms? A review of the statement of cash flows will reveal how much cash is being paid out for principal repayment, as well as the amount of new debt which has been incurred by the organization during the period.

Understanding Financial and Operating Ratios

Deconstructing your hospital's financial statements into a number of financial and operating ratios enables trustees to better analyze financial performance. In addition, it enables the board to benchmark the hospital's performance compared with a variety of peer groups (other hospitals with similar revenues, geographic locale, highest performance, etc.). A good starting point in using the ratios is to graph a 3-5 five year historical trend line for each. Below is a list of ratios, what they measure, and the implications of each.[2]

Profitability Ratios

Total Margin. Total margin is the excess of revenues over expenses divided by total revenues, net of allowances and uncollectables. It reflects profits from both operations and non

-operations. Hospitals in the high-performance group realize significant improvements in their total margins. Improving total margins are a reflection of success in cost management efforts. **Implications**: *An up trend is considered positive.*

Free Operating Cash Flow to Revenue. Free operating cash flow to revenue is cash flow from operations less capital expenditures, divided by revenue. Free operating cash flow to revenue is a measure of profit often used in valuations because it better reflects the available cash return. A value less than zero most likely indicates an operating loss. The primary strategy for correcting a low free operating cash flow situation is tight cost management. **Implications:** *An up trend is considered positive.*

Free Operating Cash Flow to Assets. Free operating cash flow to assets is defined as cash flow from operations less capital expenditures, divided by assets. A value less than zero most likely indicates an operating loss. The primary strategy for correcting a low free operating cash flow situation is tight cost management. **Implications:** *An up trend is considered positive. A free operating cash to asset less than zero most likely indicates an operating loss.*

Return on Equity. Return on equity is the amount of net income earned per dollar of net assets or equity. High values for return on equity indicate a hospital's ability to add new investment in plant, property and equipment without adding excessive levels of new debt. Return on equity values are significantly lower in smaller hospitals. **Implications:** *An up trend is considered positive.*

Liquidity Ratios

Current Ratio. Current Ratio is the number of dollars held in current assets per dollar of current liabilities. It is the most widely-used measure of liquidity. More profitable hospitals are likely to have higher current ratio values. **Implications:** *An up trend in this area is positive.*

Days in Patient Accounts Receivable. Days in patient accounts receivable is the average time that receivables are outstanding, or the average collection period. Higher collection periods lead to greater AR short-term financing requirements. High-Performance hospitals maintain lower days in AR, which leads to better overall asset efficiency and return on total assets. Reductions in days in patient AR translates into higher values of cash and investments. **Implications:** *A down trend in this area is positive. Reductions in accounts receivable reflect improved hospital management*

in the receivables area. High performance hospitals routinely and aggressively focus on collecting cash as quickly as possible.

Average Payment Period. Average payment period is a measure of the average time that elapses before current liabilities are paid. High values may indicate potential liquidity problems. **Implications:** *A down trend is considered positive.*

Days Cash on Hand. Days cash on hand, all sources measures the number of days of average cash expenses that the hospital maintains in cash and marketable securities. It is a measure of total liquidity, both short-term and long-term. **Implications**: *An up trend is considered positive. High-performance hospitals have higher days cash on hand, from all sources than low-performance hospitals. Low-performance hospitals may face major liquidity problems. High-Performance hospitals maintain needed, but not excessive, cash positions.*

Capital Structure Ratios

Equity Financing Ratio. Equity financing ratio measures the percentage of total assets financed with equity. High values imply that the hospital has used little debt financing in its asset acquisition, and has relatively low financial leverage. **Implications:** *An up trend is considered positive.*

Long Term Debt to Capitalization. Long-term debt to capitalization is the proportion of long-term debt divided by long-term debt plus net assets or equity. Higher values imply a greater reliance on debt financing, and may imply a reduced ability to carry additional debt. High-Performance hospitals rely less on debt and more on equity. Higher bond ratings are usually associated with lower long-term debt-to-capitalization values. **Implications:** *A down trend is considered positive.*

Cash Flow to Total Debt. Cash flow to total debt is the percentage of cash flow to total liabilities, current and long-term. It is an important indicator of future financial problems. High-performance hospitals show an increasing trend in cash flow to total debt. **Implications:** *An up trend is considered positive. Low performance hospitals have a dangerous declining trend in Cash Flow to Total Debt.*

Debt Service Coverage. Debt Service Coverage measures total debt service coverage (interest plus principal) from the hospital's cash flow. Higher values for debt service coverage indicate better debt repayment ability. **Implications:** *An up trend is considered positive.*

Cushion Ratio. The cushion ratio measures the relationship between total debt service, both interest and principal, and

total cash reserves, both current and non-current. A high value means that the hospital is less likely to default on debt service payments because it has the cash reserves to meet its expected obligations. *Implications: High-performance hospitals have higher cushion ratios than low-performance hospitals.*

Asset Efficiency Ratios

Total Asset Turnover. Total asset turnover provides an index of the number of operating revenue dollars generated per dollar of asset investment. Higher values for this ratio imply greater generation of revenue from the existing investment in assets. *Implications: High-performance hospitals have lower total asset turnover ratios than low-performance hospitals.*

Fixed Asset Turnover. Fixed asset turnover measures the number of operating revenue dollars generated per dollar of fixed asset investment. High values imply good generation of revenues from the existing fixed asset base and are a positive indicator of operating efficiency. Rural hospitals have higher fixed asset turnover values than urban hospitals due to older plants in the rural sector and less investment in capital-related assets. *Implications: An up trend is considered positive. Fixed asset turnover is a good measure of hospital utilization.*

Current Asset Turnover. Current asset turnover measures the number of revenue dollars generated per dollar of investment in current assets. Higher values imply a greater efficiency in the employment of current assets than do lower values. Higher investments in cash and accounts receivable will reduce current asset turnover. High-performance hospitals have lower investments in patient accounts receivable, and therefore more cash. *Implications: Increasing values are desirable.*

Other Financial Ratios

Average Age of Plant. Average age of plant provides a measure of the average age in years of the hospital's fixed assets. Lower values indicate a newer fixed asset base and, thus, less need for near-term replacement. Average age of plant may also be indirectly associated with the quality of care provided. *Implications: Higher values for Average age of plant are negatively correlated with most measures of debt financing. High-performance hospitals have significantly newer plants than low-performance hospitals.*

Depreciation Rate. Depreciation rate provides a measure of the rate at which the organization is depreciating its physical assets. Increases in this rate often imply that newer assets are being added to the organization's depreciable asset base.

Larger hospitals have a higher Depreciation rate than smaller hospitals. This is an indication that greater capital expenditures have taken place in larger hospitals and also that they have newer physical facilities. Rural hospitals have lower depreciation rates than urban hospitals. Less capital is being expended in the rural hospital sector. *Implications: Hospitals that curtail capital expenditures will see the average age of their physical facilities rise and their depreciation rates fall. Depreciation rates for high-performance hospitals have been stable over the past five years, while they have decreased for low-performance hospitals.*

Capital Expenditure Growth Rate. The Capital expenditure growth rate is defined as the percentage of the organization's total gross property, plant and equipment that was added in a given year. This percentage will vary greatly over time as capital expenditures fluctuate. Higher values for this indicator imply an active capital expenditure program of additions and replacements. Rural hospitals have lower capital expenditure growth rate values than urban hospitals due to less intense use of newer technology. *Implications: Financial inability to fund capital expenditures in low-performance hospitals. Further declines will result in even older physical facilities and the absence of state-of-the-art technology. This may further compound the problems of low-performance hospitals by driving away needed customers, especially physicians.*

Price Indicators

Gross Price Per Discharge. Gross price per discharge measures the average charge per unadjusted discharge. Gross price per discharge (adjusted for case mix & wage index) adjusts for differences in case mix complexity and differences in prices that may be a result of cost of living differences among regions. Rural hospitals have gross price per discharge values that are lower than those of urban hospitals on both an adjusted and unadjusted basis. However, when hospitals are categorized by size, rural hospitals and urban hospitals have similar prices. *Implications: High-performance hospitals have historically had higher gross prices than low-performance hospitals. High-performance hospitals maintain higher net prices than low-performance hospitals.*

Gross Price Per Visit. Gross price per visit measures the average amount of charges per unadjusted visit. Contractual allowances, bad debts and other discounts are not subtracted in this price measure. It reflects what a patient might pay if there were no discounts or allowances granted. *Implications: High-performance hospitals make more money from outpatient operations than low-performance hospitals. High-*

performance hospitals appear to generate their profit through higher prices and lower costs. This may reflect differences in complexity. It may also reflect greater ability to charge higher prices in these areas.

Medicare Payment Percentage. Medicare payment percentage provides a relative measure of the hospital's reliance on Medicare patients. Rural hospitals have consistently reported higher values for Medicare Payment Percentage than urban hospitals. Some of this difference may be related to size, as larger hospitals are more likely to have a greater range of services than smaller hospitals. *Implications: Medicare is a desirable payer for many hospitals, especially those with high percentages of managed care patients.*

Contractual Allowance Percentage. Contractual allowance percentage defines the percentage of gross patient revenue that is discounted to third-party payers. Increasing values for this indicator put tremendous pressure on hospital prices in those limited areas in which fuller recovery of rate is possible. Significant negative pressure on hospital profitability has been increasing contractual allowance percentages. Much of the increase in contractual allowance percentage results from inadequate increases in Medicare and Medicaid payments, and to increasingly larger discounts granted to managed care payers. *Implications: High-performance hospitals have similar gross prices on a case mix-adjusted basis, but they have higher net prices. Lower write-offs in high-performance hospitals are either a reflection of a better payer mix, especially private insurance, with lower discounting, or better coding of cases. High-performance hospitals may do a better job of optimizing the DRG codes assigned to Medicare patients than low-performance hospitals. Coding can have a pervasive impact upon payment.*

Volume Indicators

Average Daily Census. Average daily census provides a measure of inpatient volume. Average daily census is a function of both discharges and length of stay. Increases in average daily census should ideally come from increases in discharges rather than from increases in length of stay. Urban hospitals have much higher values for average daily census than rural hospitals due to larger number of beds and greater lengths of stays. *Implications: Average daily census is expected to decline as the focus of care continues to shift to outpatient facilities.*

Occupancy Percentage. Occupancy percentage provides a measure of facility utilization based on licensed beds. The use

of beds to measure capacity does not reflect the substantial amount of hospital capacity that is not involved with inpatient care. *Implications: Occupancy is higher in high-performance hospitals. It is not a filled bed which generates revenue, but rather a new admission. High-performance hospitals have much higher discharges per bed than low-performance hospitals.*

Occupancy for Staffed Beds. Occupancy for staffed beds provides a measure of facility utilization based on staffed beds.

Implications: High-performance hospitals have lower values for occupancy for staffed beds than low-performance hospitals. This may indicate that low-performance hospitals have plants that are less utilized, but they are more willing to designate beds as not staffed.

Length of Stay Indicators

Length of Stay. Length of stay measures the average time an inpatient spends in the hospital. In today's environment of fixed payment per case, a reduction in length of stay is usually desirable. The reduction in length of stay is a reflection of cooperative relationships between hospitals and physicians. *Implications: High-performance hospitals have been able to achieve slightly lower values for length of stay than low-performance hospitals.*

Efficiency Indicators

FTEs Per Adjusted Occupied Bed. FTEs per adjusted occupied bed is a traditional measure of inpatient productivity. As Length of Stay declines, the amount of service per day increases because a significant amount of hospital service is front-loaded.

Implications: Controlling FTEs per occupied bed is an important element of total labor productivity. Control over total case cost is the primary objective. High-performance hospitals have reported lower values for FTEs per adjusted occupied bed than low-performance hospitals.

Total Revenue Per FTE. Total revenue per FTE is defined as total revenue, (or net patient revenue plus other operating and on-operating revenue), divided by the number of FTEs. Total revenue per FTE is a useful measure of productivity in an increasingly diversified industry. *Implications: High-performance hospitals have higher values for total revenue per FTE than low-performance hospitals, and the gap appears to be widening. The ultimate measure of productivity is value created per FTE.*

Focus on the Financial Future

Trustees must pay close attention to the financial impacts and implications that the forces and trends of transformation may have on their hospitals and health systems. Moody's Investment Services, Standard & Poor's Financial Services LLC and Fitch Ratings are the "Big Three" ratings agencies. They closely monitor the financial performance of hospitals, frequently issuing financial analyses and projections for the health care field. Ratings agencies and others have projected a financially difficult time for hospitals as the nation's health care system advances through transformation. Hospital boards should be vigilant to the concerns cited by financial experts, engaging in the oversight, discussions and actions necessary to ensure the hospital's or health system's financial stability and sustainability.

Some of the critical concerns cited for not-for-profit hospitals in 2014 include:

- The annual growth rate of expenses is outpacing the growth rate for revenue

- Payer mixes are shifting from commercial payers towards government payers

- Reimbursement cuts in Medicare and Medicaid programs

- Commercial payers are tightening rate increases

- High-deductible plans are increasing, shifting greater percentages of costs to patients and thereby increasing bad debt incurred by hospitals

- Shifts in care delivery from hospitals to outpatient or ambulatory settings

- Declining patient volumes and increased competition for patients

- Increased demand for capital investment in IT and other infrastructure needs

- Declines in operating margins and cash flow

Sources and Additional Information

1. James S. Vaughan, Principal, Catherine J. Robins, VP, Cain Brothers. Best Financial Practices for Trustees. *Trustee Magazine.* March 2001.

2. Almanac of Hospital Financial and Operating Indicators. Optum. 2013.

3. Moody's Investors Service. Moody's: Preliminary Medians for Not-For-Profit Hospitals Show Expenses Growing Faster Than Revenues. April23, 2014. www.moodys.com.

4. Outlook Negative for Not-for-Profit Hospitals. Healthcare Financial Management Association (HFMA). January 2, 2014. www.hfma.org.

Q: What does it mean to be an effective advocate for your hospital?

Trustees often become so consumed with organizational issues and challenges that they lose sight of the need to consistently and forcefully connect in meaningful ways with their communities. With growing scrutiny of the health care field in general, and of the "community benefit" provided by hospitals specifically, hospital boards have a unique opportunity to ensure that their organizations consistently engage in meaningful ways with a broad range of community stakeholders.

Hospitals contribute in many significant ways to their communities, both clinically and non-clinically. As a trustee, do you know all the ways your hospital contributes to the community? Does the board support those activities, seek out additional opportunities to impact the community, and understand and communicate the results and impact the hospital has?

For some boards, the first step may be as simple as identifying or re-defining the hospital's commitment to the community. Next, the board needs to understand what is already being done, what can be done and what more should be done. Finally, and very importantly, the hospital should communicate to key stakeholders and the general public what it is doing to benefit the community. Trustees have an opportunity and an obligation to impact the negative-to-positive ratio of stories and statistics about health care heard by federal and state legislators, the media, and individuals in their own communities.

The Business Case for Community Health Initiatives

It's simple: strengthening community relationships and implementing initiatives to improve the community's health is the right thing to do for hospitals' patients, families and communities. In addition to helping hospitals fulfill their community-focused missions and visions, community health initiatives provide several significant business-strengthening benefits, including:

- Credibility and leverage in representation and advocacy;

- The potential to increase market share;

- Development of allies to address common challenges;

- Creation of new partnership opportunities;

- Foundation fundraising;

- Strengthened support and public trust for the hospital and its efforts;

- Increased awareness of hospital challenges and understanding of the hospital's commitment to addressing community needs;

- Strengthened employee morale and sense of purpose; and

- Preservation of not-for-profit hospitals' tax-exempt status as the community benefit provided by hospitals and health systems becomes clear and measurable.

A big part of what's right about health care in America today is that many hospitals are making significant community contributions already. The problem is their stories aren't being sufficiently told; so the local community, the media and lawmakers don't know about the valuable community health initiatives already underway. If your organization is already sharing stories of its community contributions, look for opportunities to strengthen community health initiatives to both build community relationships and take advantage of the business benefits. If community health initiatives and

community benefit activities are not high on the board's radar screen, they should be.

The Need for Trustee Leadership and Involvement

Hospital trustees are trusted leaders in their communities. They also have a unique and powerful role as key communicators of the benefit provided by their hospital. Because they are volunteers, they are seen as unbiased, impartial protectors and stewards of the hospital's cherished mission, values and vision. This role is commonly referred to as "advocacy," and is a key part of trustees' responsibilities.

Despite its critical importance, the advocacy component of trustees' jobs isn't always prominently discussed. Advocacy is an opportunity to bring valuable information to elected officials that they otherwise would not have. Legislators have to make decisions about a broad range of issues, many of which they aren't intimately familiar with. Trustees can provide legislators and their staffs with the perspective and facts they need to make educated decisions about issues that have a significant impact on local health care and the local economy. When trustees form long-term relationships with elected officials, the legislators look to them for valuable insight and information on issues for which they may have limited knowledge or first-hand experience.[1,2]

Trustees' Advocacy Carries a Powerful Message

Trustees provide a fresh perspective to supplement the efforts of hospital CEOs, hospital associations and other membership organizations that conduct advocacy efforts on behalf of the hospital. Trustees' voluntary commitment to the hospital and to the community makes their message powerful, and carries great weight because it doesn't have the real or perceived "bias" associated with the potential personal benefits that may be derived from hospital CEOs or lobbyists.

Experts agree that in many cases trustees are the most effective advocates for their hospital, largely because of their volunteer status. Dan Sisto, former president of the Healthcare Association of New York State (HANYS), says that "trustees have more influence with legislators because they are voluntary board members and community leaders…Politicians pay attention to trustees because a trustee's livelihood does not depend on a hospital's financials."[1] That opinion was echoed by Joe DaSilva, previous Senior Vice President for Advocacy and Education for the Texas Hospital Association in a *Trustee*

Magazine article, where he explained that "the trustees are the most important component of the grassroots effort because they don't have any personal gains other than the gains that may be passed on to the community by their success…They have stature within the community that garners respect, they bring business acumen to the discussion, and they have friendships with elected officials."[3] In another *Trustee Magazine* article Barbara Lorsbach, Senior Vice President, Member Relations for the American Hospital Association, reiterated the importance of trustee advocacy when she explained that "trustees are personally willing to commit their time and energy, and that says a lot about how important the hospital is."[4]

The board is ultimately responsible for ensuring that the hospital has the resources it needs to carry out its mission, and effective advocacy plays a critical role. At CHRISTUS Santa Rosa Health Care in San Antonio, TX, two staff members work solely on advocacy issues. While not all organizations are large enough to warrant this level of staff dedication, CHRISTUS Santa Rosa's investment in staffing and funding for advocacy activities demonstrates how important the board believes advocacy is. At CHRISTUS Santa Rosa, the advocacy staff provides information to the board so they are well-prepared for advocacy opportunities, such as representing the organization in civic and government settings. And as members of the community, trustees attend civic meetings and other functions along with the hospital staff, which helps them to have a better understanding of community issues and opinions and also provides opportunities for them to communicate the benefit that the hospital provides.[5]

While not all hospitals will take the same approach as CHRISTUS Santa Rosa, every hospital should look for ways to maximize trustees' credibility in ways that the hospital staff cannot do alone. Opportunities include:

- *Communicate the Impact of Potential Decisions.* Trustees can help communicate the impact of budget cuts and other potential legislation on their hospitals and communities in personal ways, such as the impact on patient care on an individual, personalized level, or the impact on the hospital's workforce or the local economy.

- *Talk about Community Benefit, Don't Just Ask for More Reimbursement.* As investigations and lawsuits have demonstrated, some lawmakers are becoming increasingly skeptical about hospitals' true "financial needs" and whether they are deserving of their tax-exempt status. Lawmakers are increasingly interested in the amount of

charity care hospitals provide, the community benefits they offer, and the ways in which they handle patient billing and collections. According to Joe DaSilva, "We have lost some opportunities by focusing so much on 'Just give us more money.'" Trustees need to communicate a deeper message about what's right about health care and opportunities to do even more, rather than simply focusing on needing more money.

- *Look for Opportunities to Tell Stories.* People tend to take for granted the great work that hospitals do, and they need to be reminded. Lawmakers, key stakeholders, and the general public need to hear stories about what their local hospitals are doing to save patient lives, improve individuals' quality of life, contribute to new research and development, and make a difference in the health of their communities. Without hospitals taking the initiative to ensure these stories are heard, the public may only hear the more negative stories about hospitals and health care that tend to dominate the news and personal conversations.

- *Be Engaged.* Boards need to be engaged and knowledgeable about their hospital's community benefit activities and charity care so they can effectively communicate it with legislators and key stakeholders. The more trustees are engaged, the more they will be able to communicate their hospital's story on a personal level, sharing individual stories and talking from personal experience.[3]

Trustee Advocacy Provides Stability

Successful advocacy is highly dependent on relationships. It involves building ongoing relationships that include regular interactions and communications, not just seeking out a lawmaker or community representative when the hospital wants something. When forming deep and long-term relationships in the community, an experienced trustee with a personal interest in the community is the best voice to form lasting partnerships that can benefit the hospital.

As trustees work to form long-term relationships, they should look for opportunities with politicians at every level - city, county, state and federal. In many cases, forming relationships with a lawmaker's legislative staff can be just as important as forming relationships with lawmakers directly, since most rely on their staffs to provide them with research, information and perspective on issues.

One way to form relationships with state and federal legislators is to take advantage of opportunities that already exist. When possible, seek out legislators or their staff members at social gatherings or civic meetings to begin forming relationships. Host legislator visits to your hospital and take them into the community to see the community benefit work you're doing outside the hospital.

Many state hospital associations often hold advocacy days and offer support for trustees who want to visit their state capitals to meet with legislators and key decision-makers. In addition, the American Hospital Association organizes trips to Capitol Hill during their annual meeting every spring.[2]

Grassroots Advocacy: Using Community Connections to Build Community Health and Strengthen Public Trust

Successful advocacy is about more than establishing relationships with legislators. One of the most important roles of the board is to maintain strong and vibrant community relationships that build community understanding and loyalty to the hospital. Trustees play a vital role in securing strong public perceptions of the hospital and raising its profile as a premier community financial, health care and social services asset.

As a part of hospitals' grassroots advocacy efforts, every community has a broad range of key constituencies or stakeholders who should be communicated with and influenced by the hospital. The hospital board is the ideal conduit between the hospital and these community groups, including:

- Community spokespersons or health advocates;

- Purchasers of health care;

- Insurers and other payers;

- Patients and families;

- Legislative and regulatory bodies;

- The news media;

- Civic groups, agencies and organizations;

- Religious leaders;

- Business owners; and

- Educational institutions.

Key Trustee Roles in Legislative and Community Advocacy

- *Advocate:* Taking the hospital's message to legislators through lobbying or delivering testimony at hearings, representing the community's interests in board decision-making.

- *Educator:* Speaking on issues facing the hospital at schools or civic groups; appearing on local television or radio shows to discuss health care, and highlighting what the organization is doing to contribute to the community's health well-being.

- *Conduit:* Participating in public forums to discuss issues facing the hospital, share what the hospital is doing in the community, and learn about community opinions or health care needs.

- *Ambassador:* Representing the hospital at important community social gatherings.

- *Host:* Presiding over visits of legislators, senior citizens, or key business leaders to the hospital to help them learn about available services and to hear about their interests or needs.

This type of grassroots networking is an opportunity to leverage already existing relationships. For example, trustees can educate the community through one-on-one conversations and presentations before local organizations such as Kiwanis and Rotary clubs. These relationships should include two-way communication – trustees have an opportunity to share what the hospital is doing well and the challenges it faces, but they should also seek out community members' opinions and perspectives and take that information back to the board and hospital leadership.[1]

Getting Started: Strengthening Trustees' Advocacy Role

Successful hospital advocacy in today's environment requires trustees' commitment and involvement to share the "hospital's story" and strengthen their relationships with community members, opinion leaders and elected officials. Some specific steps trustees can take include:[1,6]

- If you haven't already, talk with the CEO and find out how the organization is engaging the community and what role trustees can play;

- Talk about the hospital and health care in general with family, friends and colleagues, noting the many contributions the organization makes to the health, economy and quality of life in the community;

- Ask to do a short presentation about the hospital that involves active listening at a meeting of one of the clubs or organizations to which you belong;

- Make sure that trustees "talk up" the hospital and solicit opinions about what is happening in health care at the local level, at meetings, parties, and other events they attend; and

- Review the American Hospital Association's Community Connections toolkit entitled "Telling the Hospital Story: Going Beyond Schedule H," which includes tips and questions for a communications strategy to bolster the hospital's public messages, a sample community benefit report and presentation, and a community benefit report worksheet to guide trustees' thinking and help summarize the ways in which the hospital helps the community.

Five Steps to Bolster Your Advocacy Effectiveness

Whether the board already has a trustee advocacy approach in place or is starting from scratch, the following five recommendations from CHRISTUS Santa Rosa Health Care suggest ways the board can either begin or strengthen its advocacy effectiveness.

1. *Discover existing relationships.* Find out where relationships exist between the hospital, members of Congress and state/local government officials.

2. *Find interested participants.* Identify individuals who are willing to become public policy advocates.

3. *Participate in advocacy initiatives.* Trustees typically write letters, make phone calls and visit lawmakers to present policy facts and information about the hospital.

4. *Contact legislators.* Develop relationships with legislators before the hospital needs them, in order to be ready to contact them on advocacy issues. Use relationship-building time as an opportunity to tell the hospital's "story" without asking for anything in return.

5. *Develop an advocacy profile.* Evaluate existing relationships with senators and representatives and develop methods for building and strengthening these relationships.

Source: Beeler, Don A. Be an Advocate for Your Community. Trustee Magazine. November 2008.

Avenues for Building Community Centeredness

In addition to building and sustaining partnerships, there are a variety of avenues by which hospital trustees and leaders can gain a greater understanding of the community's health care needs and challenges, increase awareness of existing programs, seek feedback and ideas for new initiatives, and build trust and promote the hospital's image. These include:

- Community surveys;

- Focus groups with key stakeholders;

- Task forces with hospital leaders, employees and key stakeholders;

- Conducting a community needs assessment;

- Presentations to community groups; and

- Interviews with patients, key stakeholders, and the people in the community at-large.

The "bottom line" value of being a community-centered organization is that the community will better understand the good work the hospital is doing, challenges the hospital is facing, the hospital's efforts to address the challenges, and the

Rules for Building Sustainable Community Partnerships

- *Rule 1:* It's not an event or a one-time fix, but a continuous commitment to community

- *Rule 2:* Lasting partnerships cannot be created overnight, and must be sustained over time

- *Rule 3:* Don't reinvent the wheel; learn from and use the success of others

- *Rule 4:* Cultivate broad-based buy-in and commitment from all stakeholders

- *Rule 5:* Communicate, communicate, and then communicate some more

barriers to success. The hospital must connect with stakeholders and key constituents in ways that can be leveraged to more successfully advance the hospital's agenda. The benefits that result from the hospital's community benefit initiatives must be defined, reported and discussed throughout the community to build a sense of the hospital's health care and economic value.

Sources and Additional Information

1. Health Care Trustees: Essential Partners in Advocacy. *Trustee Leader.* Healthcare Trustees of New York State. May 18, 2006.

2. Greene, Jan. A Natural Fit. *Trustee Magazine.* January 2008.

3. Sandrick, Karen. The New Political Advocacy. *Trustee Magazine.* December 2009.

4. Larson, Laurie. Telling the Story. *Trustee Magazine.* December 2009.

5. Beeler, Don A. Be an Advocate for Your Community. *Trustee Magazine.* November 2008.

6. Telling the Hospital Story: Going Beyond Schedule H. American Hospital Association. March 2009. www.caringforcommunities.org.

Q: How does the board ensure successful leadership for tomorrow?

High performance governance in today's environment is critical. Every board member must clearly understand and be capable of carrying out his or her responsibilities at the highest level of governance performance. Recruiting new trustees to serve on your board is every bit as important as CEO recruitment. How well boards plan and execute this vital process defines the hospital or health system's leadership success for years to come.

The importance of governance succession planning is growing as health care organizations and their governing boards face increased pressure for high performance, transparency and accountability in a field undergoing significant change. The board should be composed of individuals who display a diversity of opinions and independent thought and actions. Trustees should have demonstrated achievement in their career field and possess the intelligence, education, and experience to make significant contributions to governance. They should also possess the personal attributes that will contribute to sound working relationships with other board members and the executive staff. Instead of a board composition that is simply representational, boards of trustees should seek to develop a composition that also reflects the overarching experience and expertise needed to successfully govern in today's era of transformation.

Boards of trustees should be asking themselves: "When current trustees' terms end, who will replace them? Where will we find highly qualified board members who are "experts" in the areas of governance in which we need the most help, who are free of potential conflicts of interest, and who are able to meet the required time and energy commitment?"

Governance succession planning is the key to not only filling an empty seat on the board, but to strengthening board and organizational performance. By regularly assessing the board's leadership strengths and weaknesses, and using the hospital's strategic plan to define critical future leadership requirements, a board can identify governance "gaps" that can be closed through targeted trustee recruitment.

A trustee succession plan should be developed to recruit trustees that meet the specific governance needs. These "gaps" will be different for each board and organization; while one board may need increased diversity another may seek greater clinical expertise or an improved balance between visionary, "big picture" thinkers and more practical, shorter-term thinkers.

Increased Trustee Demands

Boards of health care organizations govern highly complex organizations. The nature of hospitals requires trustees to engage in ongoing education, time-consuming individual preparation for board and committee meetings, and attendance at trustee conferences and other educational and governance development events.

According to the Governance Institute, La Jolla, CA, board members spend an average of 20 hours per year on health care education. In addition, the average board member spends between 120 – 200 hours annually preparing for and

Key Factors to Consider When Recruiting

- Recruit trustees with the skills that will best complement the hospital's future strategic needs.

- Select trustees who have the passion and time to be committed to the organization's mission.

- Seek candidates who have experience working with both corporate and not-for-profit boards.

- Ensure a commitment to the organization, experience as a trustee, and a willingness to learn about health care issues and trends.[4]

Breaking Barriers to Board Diversity

- **The just-like-me syndrome.** Too often nonprofit boards look for candidates similar to themselves in their career positions or education. The result is either outright failure, if no willing or suitable candidates can be found in the narrow segments that are searched, or a superficial increase in diversity that neglects diversity of ideas and experiences.

- **Ineffective nominating procedures.** Board members are typically drawn exclusively from the local community, and recruitment can be hampered by the limited scope of contacts and life experiences of the existing board members, who often act as the primary board recruiters. To achieve a broader perspective, boards should consider expanding recruitment of trustees to qualified individuals outside of the area.

- **Inflexible board membership requirements.** Overly strict criteria for board membership can be counterproductive. Eliminate requirements for recruiting individuals that represent specific constituencies or occupations (unless, for example, you seek a financial "expert" for your audit committee). Look instead for the very best thinkers and leaders. [16]

participating in board and committee meetings and conducting other board activities. [2] An average of 150 hours alone is the equivalent of nearly 20 additional work days in one year. Many hospitals are challenged to find trustees who not only meet specific board leadership requirements, but who are also willing to commit a significant amount of time to fulfill their growing responsibilities and accountabilities.

Recruiting the Right Trustees

Properly identifying, assessing and successfully recruiting a new trustee involves several steps. Boards should begin by conducting a comprehensive governance self-assessment to determine where they may have potential leadership "gaps," either now or in the future. After identifying specific characteristics and skills sets desired, the board should seek out and talk with a variety of candidates who may meet their board service requirements. Once a new trustee is selected, orientation and ongoing education is critical to ensuring trustee success in providing strong and effective leadership to the hospital on behalf of the community.

Identifying Leadership Gaps. In order to gauge leadership strengths and weaknesses, boards of trustees should conduct an annual board self-assessment. A comprehensive, meaningful self-assessment includes ratings of leadership performance in a broad range of areas. Each area should include several positively worded statements about the board's

performance; trustees should rate the board's performance in each statement, and each broad area should be followed with one simple question: "How can the board improve its performance in this area"? The assessment should also include a section in which trustees evaluate their personal performance in several areas of leadership effectiveness. Broad areas of board performance to be evaluated may include:

- Observing fiduciary duties and adhering to organizational ethics;

- Ensuring attainment of the mission, vision and values;

- Defining a purposeful strategic direction;

- Ensuring quality and patient safety;

- Providing sound financial leadership;

- Building strong relationships with the CEO;

- Building and sustaining community relationships;

- Building strong relationships with the medical staff;

- Ensuring improvements in community health;

- Ensuring a sound leadership structure and governance processes;

- Commitment to governance education and knowledge; and

- Demonstration of leadership excellence.

Once board strengths and weaknesses, leadership challenges and future leadership needs have been identified, the board can then develop a list of specific skills, attributes and characteristics that are important for new trustees to possess. The specifications should complement existing board members' skills and competencies, and assist the organization in furthering its ability to provide high-powered, thoughtful, diligent leadership. In essence, instead of simply accepting any person who expresses an interest in serving on the board, or persuading a reluctant potential trustee to serve, the board should recruit trustees with the skills and personal characteristics that complement existing board members' resources and which results in a more well-rounded, competency-based board.

Governance Accountability for Cultural Competency. As a part of the board's accountability for mission fulfillment and leadership, trustees are being called upon to address their community's health care disparities and strengthen hospitals' and health systems' cultural competencies. A diverse board

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membership that reflects the community's diversity offers the board the benefit of first-hand insights, understanding and information that can contribute to the board's ability to appropriately recognize and take actions to address the health care needs, disparities and inequities of the entire community.

Essential Skills, Experience and Knowledge. Boards of trustees can successfully recruit new trustees that meet their governance needs by selecting individuals with the right skills, experience and knowledge. Critical characteristics most often sought by hospital boards include:

- *Motivated, committed and passionate in serving the hospital and community.* Board members must be willing to commit to the time required to serve on the

board and be active in fulfilling the hospital's mission and vision.

- *Ethical, respected and held in high esteem by the community.* Health care organizations will increasingly need to partner with both other health care providers as well as organizations that have an interest and stake in the community's health (such as police or fire departments, local business groups, religious organizations, public health agencies and others). Board members must be actively involved in gaining and sustaining the trust of the community and forming strong community partnerships to ensure the hospital's success.

Key Steps in the Trustee Recruitment Process
The following steps are recommended for recruitment of trustees to serve on community hospital boards. The philosophy and process may be similar for governmental hospitals whose trustees are appointed, however the process is only a recommendation to the officials who will make the appointment.
1. Secure board agreement on a long-term succession plan and process: Purpose, participants and objectives
2. Appoint a board development committee to oversee the recruitment process
3. Develop appropriate background material on the hospital and board of trustees: Bylaws, board member biographies, information about the hospital, its market and its challenges, information on trustees and officers liability insurance, conflict of interest statement, board self-assessment process, board orientation process, etc.
4. Develop a trustee candidate overview and application (includes board job description, trustee qualifications, and candidate application), and a letter to be sent to prospective trustees indicating the hospital's interest in discussing potential trusteeship opportunities
5. Develop a summary of candidate qualifications and a candidate profile, and a candidate assessment form to use as a tool in evaluating potential trustees. The assessment should be based on the criteria included in the candidate profile and job description. Consider assigning a "weight" to each criteria that reflects the relative importance of the criterion (e.g. 5 = greatest weight, 1 = least weight), and include specific questions to ask candidates to determine motivation and willingness to serve, ability to devote time required, knowledge of issues, conflict of interest, etc.
6. Secure board approval of the board development committee's recruitment process and recruitment materials
7. Identify potential field of candidates
8. Make preliminary contact (letters and/or telephone calls), assess initial candidate interest and willingness to serve, if chosen
9. Review candidates and arrange interviews with members of the board development committee
10. Evaluate candidates using the candidate assessment tool, and prepare a brief written summary of each candidate (occupation, length of residency, community involvement, answers to questions, etc.)
11. Determine top-rated candidates, and present to the board development committee
12. Board development committee makes recommendation to full board
13. Nomination of candidate(s)
14. Send follow-up letters to candidates not selected, and determine other ways for candidates not selected to be involved, such as serving on the foundation board, on task forces, etc. Assess interest in filling future vacancies

Planning Today for Tomorrow's Trustee Leaders

Anytown Community Hospital Trustee Candidate Profile

A one-page candidate profile should be developed to clearly describe the responsibilities, success factors and skills and assets the hospital seeks in a new trustee. The profile should begin with a one-two paragraph overview of the hospital, followed by specifics about the trustee role.

Major Responsibilities. Anytown Community Hospital (ACH) trustees are responsible for overseeing the progress and success of ACH. The board of trustees must ensure that the organization achieves its mission, vision and values. The board also leads the hospital's strategic direction, development of ACH's strategic plan, evaluation of the plan's implementation, and oversight of plan progress and achievement, taking corrective action when necessary. Anytown Community Hospital's board of trustees is responsible for hiring the CEO, conducting CEO performance evaluations and determining the CEO's compensation. The board of trustees assumes ultimate responsibility for the quality of care and patient safety provided by the hospital, and is accountable for the financial soundness and success of ACH.

Success Factors. The successful trustee will have strong interpersonal skills, and will be comfortable with interacting with other board members, the CEO, medical staff leaders and the hospital's executive team. The trustee must be willing to commit the time necessary for successful board service, and have a willingness and a desire to learn and understand the complexities of the health care environment and the challenges of meeting Anytown Community Hospital's patient and community needs. The ability to constructively challenge the status quo, understand and evaluate financial information and collaborate with a broad range of diverse stakeholder groups is key to the success of the trustee. The trustee should understand and follow the fiduciary requirements to the organization and not serve any individual constituency or group.

Personal Skills and Assets. The successful trustee will build positive relationships with other board members, the hospital's executive team, medical staff leaders and the organization's other key stakeholders. Adaptability, flexibility, organization, initiative, leadership and analytical skills are key qualities which will enable the trustee to be successful as an Anytown Community Hospital trustee. Other important personal assets include sound, independent judgments and decisions; the ability to analyze complex issues and develop effective solutions; and the ability to create a vision for the future, given the many uncertainties prevalent in today's health care environment. The trustee should have a basic general understanding of the health care field, be committed to preparing for active insightful involvement in board and committee meetings, and be able to read, understand, and apply industry information and financial acumen to strategic decisions. Strong communication skills are essential. The trustee should be deeply committed to the hospital and the community it serves, and have no unresolvable conflicts of interest with Anytown Community Hospital's operations or key stakeholders. When conflicts of interest do arise, the trustee must be willing to abstain from discussions and votes surrounding the issue.

- *Strategic, innovative and visionary thinker.* Boards of trustees must understand that there is no single future that can be planned for and successfully executed. Board members will need to be flexible, dynamic governance decision-makers who are not surprised as the future unfolds. They must continually challenge the status quo, and encourage innovation, risk taking and new ways of embracing the opportunities of the future. They must push for change, value creativity and innovation, and leverage change for strategic advantage.

- *Advocate.* Trustees are the voice of the community. They can and must use their clout and credibility to be strong and powerful influencers of lawmakers, regulators, community groups and others who influence or make decisions that affect the future of their organizations. Trustees need to be continually aware of political issues and legislative processes, and able to establish relationships with their state and national legislators and their health policy staffs. Advocacy success requires individuals with deep health care knowledge and literacy.

- *High intellect and willingness to learn.* Board members must develop a high level of understanding in the areas most critical to organizational success and performance. Decisions must be guided by the organization's mission, vision, values and strategic initiatives, and be based on facts that focus on priorities vital to the organization's success. Board members must be highly attuned and adaptable to change, requiring them to be proactive thinkers. They must also commit to and engage in continual governance education.

- *Collaborative, artful listener, and willing to engage and ask hard questions.* Miscommunication and misjudgment often are a result of inadequate listening, not from a lack of words. Strong and effective governance communication will require board members who are willing to listen attentively without rushing to judgment, and absorb information before offering a definitive

response. Board members must also be able to engage in critical conversations to ensure that decisions are made by grappling and grasping with concepts, ideas and practical solutions, leading to more informed and rational conclusions. They should also be willing to regularly confront issues by challenging assumptions and exploring alternatives to traditional thinking.

- *Ability to grasp implications of financial statements.* One of the principal jobs of the board of trustees is to oversee the financial performance and progress of the hospital. The board must have individuals with professional experience and expertise in accounting and/or finance. A successful trustee with skills in this area brings professional expertise to financial discussions and decisions.

- *Ability to understand and value perspectives of the medical staff and patients.* Boards of trustees are responsible for ensuring the quality of care and patient safety provided by their organization. Trustees must take strong, organized action to establish and ensure an organizational culture that continually strives to improve quality and patient safety at every turn. While community board members are not expected to be physicians, a successful board should be willing to make a commitment to developing a good understanding of medical issues that affect the organization's success.

- *Prior board experience.* Individuals with experience on other boards bring unique governance and business perspectives that broaden and enrich the organization's governance functions. Their experience will provide community contacts and new ideas for ways to lead most effectively.

Finding Qualified Board Members. Once specific desired skills and characteristics have been identified, the board must recruit individuals that meet these specifications. Several approaches may be undertaken to find candidates, including:[3,5]

- Maintaining a list of potential board candidates, often developed by the Nominating Committee or the Board Development Committee, including the specific skills they can bring to the organization;

- Assessing the leadership potential of individuals who already volunteer for the hospital in other capacities, such as serving on the hospital's foundation, or participating in ad hoc committees and task forces;

- Seeking out individuals who have a record of successful governing service on other boards, and who have the potential to bring credibility, expertise and community connections to board work;

- Asking the CEO and former board members to suggest replacements for outgoing members;

- Contacting successful former board members who were highly regarded for their leadership skills, and ask if they would be willing to serve again. These individuals are often a deep well of information and perspective; and

- Considering expanding the "network" of potential candidates, perhaps looking outside the immediate community for qualified trustees.

Throughout the recruitment process, stick to the board's pre-defined specifications for new trustees. Trustees must know and understand more, and take on greater responsibility than they have in the past, underscoring the critical work of the board and weighty nature of board responsibilities. Candidates must have the time, availability and discipline to act on their commitment to the board and the responsibilities of trusteeship. When interviewing potential trustees, do not "sugarcoat" the job; be honest about board members' roles and responsibilities and the time commitment required. The last thing a board needs is to select a new trustee who did not understand the commitment and who is then unable to fulfill his or her duties.

Next Steps. Once a potential trustee (or trustees) has been identified, several additional steps should be taken before extending an offer to serve on the board:[5]

- Double-check for potential conflicts-of-interest that cannot be resolved;

- Invite the prospective board member to meet with the board chair and the CEO for a detailed overview of the organization as well as relevant organizational materials, a board member job description, etc.;

- Provide the candidate with the names and contact information for board members he or she may contact with questions; and

- Invite the prospective new member to observe a board meeting, and follow up with the candidate after the meeting to discuss his or her continuing interest.

What About the Next Generation of Leaders?

The keys to a successful and sustainable organization are rooted in a mission-driven focus, a sense of vitality and the ability to look ahead and plan for continued success into the future. Who better to contribute energy, new perspectives and a vested interest in the future than the next generation of leaders? Yet nearly 60 percent of not-for-profit board members are over the age of 50; add in board members over age 40 and the percentage jumps to 86 percent.[7] If your board is missing the diversity of age, you may also be missing the commitment, passion for service, and fresh thinking of your community's next generation of leaders. In addition to the benefits younger leaders can offer to your board, you may also be missing an opportunity to offer your community a valuable leadership development experience for these future leaders.

Four generations are now represented in the work force, but not necessarily around the board table. If nearly sixty percent of not-for-profit board members are over age 50, and 86 percent are over age 40, there's a good chance that generations X and Y (those born between 1965 and 2000) are probably not represented on your hospital's board. And it's not because they aren't interested. Talented and educated young leaders are committed to not-for-profit work because of "its promise of meaningful work leading to social change." In a national study in which two-thirds of respondents were under the age of 40, nearly half the respondents indicated that their ideal next job would be in the nonprofit sector.[8] Instead, the skepticism of current board members often keeps the next generation from serving as trustees.[9]

Why Gen X and Y Are Missing from the Board Room. The Heckscher Foundation for Children released a board development grant request for proposals "to address the need for younger (next generation) board members for its grantees and other non-profits serving New York youth." In their release, the Foundation observed that boards are reluctant to bring on next generation leaders because:[10]

- Next generation leaders lack financial resources, professional status and the connections the board would like from its members;

- Next generation leaders require significant training; and

- Attracting and retaining next generation trustees is difficult when most board members are older.

Echoing the same reasons listed above, board members from other organizations often report an admitted bias to C-suite executives from the Baby Boomer generation when seeking to fill vacancies on their boards.[9] Yet the next generation is

Is Your Board Age Diverse?

With only 14 percent of not-for-profit board members under the age of forty, hospitals may be missing young leaders' passion for service, their energy and ambition, and their fresh ideas and perspectives of the future. If the board is not engaging these young leaders as trustees, hospitals are also missing the chance to contribute to the growth and experience of the next generation of leaders. If there are lingering doubts about the next generation's leadership ability, experience and resources, consider *Fortune's* list of "40 Under 40 2013."[13] The nation's top businesses are benefiting from the leadership of these young C-suite executives. And so is health care, as demonstrated by *Modern Healthcare's* annual "Up & Comers"[14] recognition of health care management executives under age 40. Businesses both inside and outside of health care are recognizing the contribution of young executives and leaders to their success, but boards continue to lag in this area. With an eye on the future, consider these questions:

- How many generations are represented on the board? Are there three or even four generations?

- Are any of the current trustees from Generations X or Y?

- Does the board have a trustee succession plan? Does it include actions for building a pipeline of young trustee talent?

- What's keeping the board from seeking out and including younger members of the community as trustees? Are these barriers valid? What can the board do to overcome them and invest in the next generation of leaders?

committed to contributing value to their community by giving their time, money, skills and abilities. Despite skepticism and reluctance, ensuring a vital board now and into the future requires making a place for the next generation at the board table today, and acknowledging that young leaders are also donors, volunteers and active members of the hospital's community with a desire to contribute.

The Importance of Including Young Leadership. Based on interviews with 50 not-for-profit executives, BoardSource reported four primary benefits derived from engaging Generations X and Y on not-for-profit boards.[9] The first is the passion that individuals from Generations X and Y have for the mission of not-for-profit organizations. Second, younger board members want to connect their passion with results. In his book Y-Size Your Business, Jason Dorsey also addresses the driving need

Defining the Generations	
World War II	Born 1922—1945
Baby Boomers	Born 1946—1964
Generation X	Born 1965—1980
Generation Y	Born 1981– 2000

Generation Y individuals have for understanding objectives and achieving tangible outcomes.[11] Third, Gen X and Y want to contribute in meaningful ways. They are willing to invest their time, energy and knowledge of technology, the Web and social media to raise the organization's visibility and build new channels and networks of community support. Finally, younger trustees will have new ideas, perspectives and approaches to offer. Not afraid to ask questions, their new ways of thinking should be embraced as an opportunity to add vibrancy and depth to board deliberations.

The health care landscape is one of rapid change and evolution. Hospital boards need a diverse mix of trustees who can bring together new ideas, concepts and thinking that will help to propel their organizations forward.

Traits for Success. Securing and retaining trustees of any age should begin with an investment in succession planning rather than trustee recruitment or appointment. By assessing the board's leadership strengths, weaknesses and using the hospital's strategic plan to define critical leadership requirements, the board can identify the skills, knowledge and expertise it needs from new trustees. Beyond that, young trustee candidates should demonstrate a readiness to be active board participants and have the maturity and sense of accountability for the responsibilities they will assume as a trustee. They should possess enough confidence to speak up and engage collaboratively and constructively with other trustees in board discussions. The ability to analyze issues, formulate an opinion and clearly articulate a position without defensiveness are characteristics that all trustees, young and old, should possess.

Finding the Next Generation of Leaders. The most common means used by boards to recruit new board members is to simply ask for recommendations from current board members.[7] The result is a gravitation to the familiar, recruiting friends and acquaintances that mirror one's self instead of drawing in younger individuals with leadership talent. But investing now in the effort it may take to recruit young talent to the board will define the hospital's leadership succession and success for years to come.

Hospital boards can start by looking at organizations that employ and/or interact with the talent pool of young leaders. Ask the administrators of agencies and organizations that serve younger populations to recommend responsible, confident and talented young individuals. Organizations to approach might include the Chamber of Commerce, local alumni associations, youth advisory councils, Rotary, AmeriCorps, faith-based organizations and young professionals associations.[12, 9]

Bringing Young Leaders on Board. Investing in governance succession planning is a critical component to creating a pipeline of well-prepared young leaders. Consider sponsoring or co-sponsoring a board training program for your community to ensure that not only the hospital's board, but also the community's other not-for-profit organizations have a growing pool of trained board candidates ready for service. Share with participants the benefits of board service, educate them about the responsibilities of board members and highlight the need for their leadership skills. Nurture and evaluate the "board readiness" of emerging young leaders by inviting them to serve on task forces or committees, and continue building their board readiness with a strong orientation program. Many new trustees, not just the young, arrive on the board with little or no prior board or health care expertise. A strong orientation program and warm welcome is critical to their successful service on the board.

Take orientation to the next level by linking experienced board members as mentors with new trustees. As a mentor, an experienced board member has the opportunity to offer a new trustee support, background information and insights, recap critical issues and identify subtle nuances. Mentors that successfully engage new trustees can also help prevent potential feelings of isolation that new and particularly younger board members might experience.

Ensuring Inter-Generational Success. Generational differences, perspectives and experience all have the potential to create challenges for effective board operations. The first step to avoiding or preventing problems is to ensure that diversifying the age of board members is a sincere and not token effort. Early identification of opportunities for new trustees' engagement and participation in the work of the board is important. An attentive board chair can create opportunities for young trustees to voice their opinions without putting them "on the spot" by asking all board members to express their thoughts and viewpoints on key issues in "round robin" discussions.

No one, young or tenured, should discount the value of fresh perspectives and new ideas that younger trustees can offer. For their part, younger trustees must also give credence to the concerns and experience of more seasoned trustees. All trustees will need to recognize, respect and account for the fact that each age cohort may have a different communication style and varying comfort levels with the use of technology. As with any endeavor, positive communication, attentive listening and mutual respect among trustees are foundational to success.

Sources and Additional Information

1. Hembrock Daum, J. and Neff, T. "Cornerstone of the Board: The New Steps of Director Search." Spencer Stuart. www.spencerstuart.com. October 2004.

2. Kazemek, E. and Peregrine M. "Health Care Boards: Who Will Serve?" *Trustee Magazine.* September 2003.

3. Blecher, M. "Wanted: A Few Good Trustees." *Trustee Magazine.* March 2002.

4. Earle, P. and Schlosser, J. "The Next Trustee—What Skills Does Your Board Need?" *Trustee Magazine.* April 2005.

5. McNamara, C. "Guidelines for Recruiting New Board Members." *Corporate Board Member Magazine.* www.boardmember.com. January 2001.

6. Walker, Larry. "Nurturing a Precious Commodity." *Trustee Magazine.* July/August 2003.

7. BoardSource Nonprofit Governance Index 2010.

8. Cornelius, Marla; Corvington, Patrick; Ruesga, Albert. Ready to Lead? Next Generation Leaders Speak Out. A National Study Produced in Partnership by CompassPoint Nonprofit Services, The Annie E. Casey Foundation, the Meyer Foundation and Idealist.org. 2008.

9. Terry, Alexis S. Next Generation and Governance, Report on Findings. *BoardSource.* 2009.

10. The Heckscher Foundation Board Development Grant Program Request for Proposals. Accessed May 15, 2012. www.heckscherfoundation.org.

11. Dorsey, Jason Ryan. Y-Size Your Business: How Gen Y Employees Can Save You Money and Grow Your Business. Hoboken, New Jersey: Wiley, 2010.

12. Leadership Lessons: Mining the Next Generation of Board Leaders. *Board Member.* November/December 2009.

13. 40 Under 40 2013. *Fortune.* 2013. www.fortune.com.

14. Up & Comers. *Modern Healthcare.* Accessed July 15, 2014. www.modernhealthcare.com.

15. Whitehome, Samantha. Make Room for Gen Y. *Associations Now.* ASAE, The Center for Association Leadership. Accessed May 15, 2012. www.asaecenter.org.

16. McCrory, K. "Breaking Barriers to Board Diversity." *Association Management.* January 2005.

Q: How does the board ensure continuous growth in its critical leadership knowledge?

Health care is moving at the fastest pace in history. What trustees needed to know five years ago is no longer sufficient in today's world, where governance "knowledge capital" is one of a hospital's most valuable assets.

It's possible in hospital boardrooms today to just "get by" on what you know. However, trustees who are committed to contributing value to their organizations must prepare themselves by continuously improving their knowledge in order to deliver penetrating, insightful leadership that their communities want and deserve.

Governing boards need to be able to make sense out of very complex issues and possibilities. That "sense-making" requires a strong grounding, awareness and understanding.

Education vs. Knowledge and Intelligence

Governance education is a continual process, not an end result. Education is the vehicle for improved governance knowledge. The end result and benefit of governance education is greater knowledge, understanding and heightened leadership intelligence that ensures trustees are fully-prepared to engage around critical issues, and make evidence-based vs. "gut"-based decisions. Well-planned and well-focused governance education builds the "knowledge capital" the board needs to ensure that the right decisions will be made, using meaningful information and data.

Working with Individual Trustees to Assess and Meet Education Needs

Trustee knowledge-building must take place continuously, and through a variety of venues. Sources of information include state hospital association conferences; reading and absorbing information and ideas in trade journals including *Trustee* and *Hospitals & Health Networks*; through reports and studies available online, such as HealthLeaders, the Kaiser Daily Health Policy Report, *Health Affairs*, and online versions of national newspapers; and through targeted education at every board meeting. The key to success is to develop trustee knowledge that enables governance leaders to put the bigger issues and challenges into a local market framework, identify local market implications, and lead with confidence.

A well-planned and financially well-supported effort will result in better decisions based on better knowledge and insights; an improved capacity to be a well-informed advocate for the hospital and its community; increased capacity to engage in challenging and productive governance dialogue; and an ability to think beyond "conventional wisdom."

In order to be successful in evaluating trustee education needs and ensure a successful education process, several factors are critical, including: board dedication to and investment in knowledge building; trustee participation; clearly stated education expectations; trustee involvement; and education that is individualized and customized to trustees' unique needs.

> **Governance education is a continual process, not an end result.**

The board must invest in knowledge building, both financially and intellectually.
The governance education process should be undertaken with a firm and defined purpose. That is, the board should define for exploration several months in advance the issues and topics that are most critical for board members to understand in order to make critical decisions. These topics should be drawn from the forces and factors that are driving hospital success in achieving the mission, vision and strategic objectives. Knowledge-building venues and available resources for delivering the education (meetings, publications, trustees themselves, consultants, etc.) should then be determined. A basic strategy should be set, with objectives and outcomes; success should be evaluated periodically; and

new opportunities should be incorporated into the educational development effort as changes occur in the market. Education should not be a one-time event, but should instead be an institutionalized commitment to ensuring that the governing board has the knowledge resources necessary to make strategic decisions and be a highly-effective leadership body.

Participation should be mandatory as a condition of trusteeship, not a "suggestion." Hospitals owe it to their patients, physicians and communities to ensure that governance decisions are made and directions are set as a result of vigorous scrutiny and informed intelligence. This means that every board member, not just some, must have a common level of understanding of critical issues and developments, and their implications for the hospital.

> **Governance education should be viewed by trustees not as a requirement, but as an opportunity to best serve the hospital and the community.**

Requirements for governance participation should be expressly discussed in trustee recruitment. Governance education requirements should not be a surprise to new trustees after they begin serving on the board. Instead, trustees should be fully informed in advance about education requirements, which should be presented as an avenue to best serve the hospital and the community. Prospective trustees should embrace the importance of health care education in their development as a valuable leadership asset.

Education planning should be directed, where possible, by trustees themselves. Trustees may be asked to research certain topics or issues, and present the findings, implications and possibilities to the entire board, in essence making trustees the knowledge-builders for the benefit of the entire board. This level of involvement not only brings credibility to the importance of education, but also results in deeper trustee understanding of the most critical topics.

Education should be individualized and customized. Every trustee is in a different "place" in terms of his or her level of awareness and knowledge of the issues discussed and the decisions made at board meetings. Nonetheless, every trustee has the same fiduciary obligation, and the same responsibility to be well-informed. Efforts should be made to understand the knowledge needs of each trustee, and plans should be developed for providing each individual with the information

he/she needs to be active, engaged, and productive participants in the governance process.

Designing an Effective Governance Education Process

The critical question remains: How to go about doing it? That's where commitment, collaboration and consensus come into play.

Below is an outline of how a board of trustees may design a process that will ensure optimum development of leadership knowledge and effectiveness:

Step One. Define the board issues about which every board member needs to have a common understanding in order to be a high-performance trustee. Subjects may include, but are not limited to:

- Health care payment issues;

- Health care regulation;

- Workforce issues and challenges;

- Quality and patient safety;

- Transparency in health care;

- Delivering and communicating community benefit;

- Factors impacting patient access to care;

- Hospital/physician alignment; and

- The board's role in CEO compensation and evaluation.

The hospital's current strategic plan should serve as a basis for determining the most critical board education topics and current health care trends impacting board, and ultimately, hospital success.

Step Two. Assess each individual trustee's awareness and understanding of the issues and situations likely to come before the board in the coming months. This may be done though a board self-assessment, a simple survey, or in causal one-on-one conversations, typically between individual trustees and the board chair and/or CEO. The individualized knowledge assessment is not a "test," and should not be intimidating. Instead, it is a conversation to help determine the areas where pinpointed education should be focused to most quickly get trustees "up to speed" on the issues and decisions for which they are fully responsible.

Step Three. Assign an experienced board colleague to work closely as a "mentor" with newer trustees to help them understand issues, questions, nuances, etc.

Step Four. Develop a 12-month or longer "curriculum" of topics that are essential to effective governance, and determine the most appropriate resources to assess or deliver the information. Ensure that trustees are actively involved in the selection of topics, and that the methodology for presenting the information is conducive to trustee learning styles. Delivery methods may include in-person presentations, facilitated discussions, online presentations, reading materials, and more.

Step Five. Leverage the improved trustee knowledge not only for board discussion and decision-making, but also through coordinated outreach, including legislative advocacy and connections with the local community through trustee involvement in community activities, and formal and informal community discussions and presentations about the organization and the challenges it faces.

Step Six. Continuously refine and improve the process. Conducting a regular board self-assessment process is one method to measure year-over-year improvements in board understanding and education effectiveness, and determine potential "knowledge gaps" that still exist.

Building expectations for growth and development of the board's knowledge capital will result in better dialogue, better decisions, and knowledge-based leadership that will drive future governance performance and organizational success.

Q: How does the board keep conflict out of the boardroom?

It's a simple fact that conflicts of interest erupt in hospital boardrooms from time-to-time. It is the board's fiduciary duty to ensure that all governance deliberations and decisions are carried out without conflict of interest, always with the best interests of the hospital at the forefront.

Hospital board members often are involved with many other organizations in the community, resulting in a wide range of business and personal relationships. Ethical codes and policies developed by a hospital and its board members serve as a foundation to ensure a conflict-free environment. Hospital leaders who create and adhere to a strong conflict of interest policy will be successful in ensuring open and honest deliberation.

For example, questions may arise when board members serve in various roles with other organizations. There might be interpersonal and financial relationships that call into question whether the individual will be able to make decisions free from the influence of their other roles.

Questions should arise when the personal interests of a board member appear to be at odds with the interest of the hospital.

What is a Conflict of Interest?

A conflict of interest exists when a board member, senior leader, or management employee has a personal or business interest that may be in conflict with the interests of the hospital. A "red flag" should be raised anytime the personal or professional concerns of a board member affects his or her ability to put the welfare of the organization before personal benefit.

Board members are often affiliated with many business, social, charitable and religious organizations in the community. There may be times when trustees feel pulled in conflicting directions, and where they must decide between loyalty and fiduciary service to the hospital, or to another community organization, friend, or family member where there is a close and potentially conflicting connection.

The key for boards is to establish a process for preventing and addressing the inevitable conflicts that arise, and ensuring that conflict of interest policies and procedures are consistently adhered to.

Conflicts Are Not Always Cut and Dried. Conflicts of interest can be complicated, and are almost always unintentional. In some cases no conflict actually exists, but the perception of a conflict of interest can be just as detrimental.

What Can Boards Do to Prevent a Conflict of Interest?

Having multiple systems in place to safeguard against conflict of interest ensures hospitals will minimize personal dilemmas covering a variety of issues, such as financial gain or business or family benefits. These safe-guarding procedures will help the hospital and its board to be prepared when real or perceived conflicts do occur.

Encourage Self-Monitoring. It may be uncomfortable to "call out" a board member on a potential conflict of interest. For "self-monitoring" to be effective, it is critical to have a clear policy in place and tools for board members to use to either declare a conflict of interest or to request consideration about whether a fellow board member has a potential conflict of interest. When this happens, the process of determining potential conflicts becomes less personal, and instead is simply a part of the board's standard processes and procedures.[11]

It is the board chair's responsibility to oversee this process. The chair should encourage board members to be transparent about any potential concerns they may have. The chair should meet with individuals to discuss potential conflicts, and determine if any issue needs to be re-opened or re-examined if an individual's conflict may have influenced the discussion or decision.[11] The board chair's understanding of the hospital's

Conflict of Interest Policy Components

The following is a general outline of the primary components that should be included in a conflict of interest statement:

- **Statement of purpose and duties of officers and trustees** – a brief overview of senior leaders' and trustees' responsibility to the organization, and the purpose of the conflict of interest policy. The policy's purpose is to both protect the organization and board members.

- **Direct or indirect financial or other material interest** – this includes a detailed description of the types of interests that must be disclosed by individuals covered by the policy. After an individual discloses a potential conflict outlined in this section, the interest must be reviewed by the full board or an appointed committee.

- **Co-investment interest** – individuals must also declare whether they (or a relative, as defined in the policy), have personal funds invested with an investment manager providing, or expected to provide, investing services to the hospital. Similarly, individuals must declare if they have personal funds invested in an investment fund in which the organization is currently investing in or considering investing in.

- **Failure to disclose** – this section describes the action the organization will take if an individual covered under the conflict of interest policy fails to comply with the policy and does not disclose a known conflict of interest.

- **Disclosure statement** – without an annual disclosure statement, the conflict of interest policy is just words on paper. The disclosure statement puts the conflict of interest policy into action, using the policies, procedures and definitions outlined in the conflict of interest policy to help individuals declare any conflicts they may have.

Source: Kurtz, D. and Paul, S. Managing Conflicts of Interest: A Primer for Nonprofit Boards. Board Source. Washington D.C. 2006.

policies and his or her role is critical to ensuring conflict-free board discussions and decisions.

Rural Hospitals Have Greater Challenges. Small and rural hospitals may find it more difficult to minimize or eliminate conflicts of interest because they generally have a smaller pool of potential candidates from which to choose. Often in a small community one individual may serve on multiple boards or be involved in some leadership or financial capacity with multiple organizations and/or community groups.

The key to ensuring conflict-free discussion and decision-making is to recognize and minimize conflict of interest as much as possible, even though it may not be completely eliminated. Ensuring that a comprehensive conflict of interest policy is in place that requires full disclosure is a critical first step, allowing for board members with conflicts to remove themselves from discussions and decisions when appropriate.

Physicians On Board. Physicians bring valuable knowledge and expertise to governance, and their inclusion as board members is also recognition of the stake they have in the delivery of well-integrated, patient-centered care. However, physicians may also confront significant conflicts of interest as trustees of hospitals or health systems for whom they are employed or part of the medical staff. They must enter trusteeship with a clear understanding that their contribution is one of leadership and clinical competency. Physicians should not expect, nor be expected, to serve as representatives of the medical staff. In observing their fiduciary duties, physician

trustees must put the organization's interests ahead of their own. In *Elements of Governance: Barriers to Physicians on the Board*, The Governance Institute identified the following examples of potential conflicts of interest for physicians:[14]

- Competitive situations between the hospital and private medical practices or ventures

- Physician compensation

- Medical staff credentialing and privileging

- Physician recruitment

- Medical staff development planning

- Managed care networks and compensation

- Capital investments in equipment, programs, service lines

- Any issues with implications for the physician and his or her colleagues and referral partners

Recruit Outsiders. Hospitals may find it difficult to recruit individuals with specific skill sets who do not have a conflict of interest due to other business, governance or family relationships. If the board seeks a new trustee with a desired skill or experience, recruiting someone from outside the service area may be a workable option. Non-local board members can often bring fresh perspectives to the board, and are less likely to have conflicts of interest. The board must be assured that

trustees recruited from outside the community are committed to the hospital and the community it serves.

Ensure a Proper Process for Recruiting and Selecting New Board Members. When selecting new board members, a primary objective should be to ensure a wide range of knowledge and experience. This should involve an evaluation of potential candidates' strengths, and discussion about how those strengths best complement existing board members' talent, knowledge and experience. Compiling a list of potential candidates and assigning a score to each candidate, based on their fit with the hospital's needs, is one way to prioritize the candidate pool.[13]

When governance candidates are interviewed, they should be asked about any potential conflicts prior to their appointment to serve on the board. Although conflicts may not necessarily disqualify a candidate, the candidate's willingness to talk candidly about and fully consider potential conflicts they may have should play a key role in the nominating committee's decision.

Reporting Conflicts of Interest

The best way to prepare for conflict of interest situations is to establish a process for declaring potential conflicts before they arise. Declaring real or perceived conflicts in advance ensures open communication amongst board members and senior leaders, and prevents potentially problematic situations down the road.

Disclosure Statements. Once a conflict of interest policy is in place, every trustee and senior leader should annually complete a conflict disclosure statement. While the conflict of interest policy defines what a potential conflict is, the disclosure statement is the mechanism for individuals to declare any potential conflicts they may have.

The disclosure statement is generally a standard form prepared by the organization that requires individuals to initial or agree that they: 1) Have read and are familiar with the conflict of interest policy; and 2) Either are not aware of any direct or indirect conflicts of interest, based on the definitions developed by the organization, or have attached a letter describing any direct or indirect conflicts of interest that exist, based on the definitions developed by the organization.[1] In addition, individuals should sign a statement agreeing to report any new conflicts that arise throughout the year in a timely manner. Each trustee should complete the statement annually.

Collecting and Reviewing Disclosure Statements. Organizations may designate a compliance officer who is responsible for reading the disclosure statements and monitoring for potential conflicts when they arise.[7] The compliance officer should be responsible for collecting disclosure statements from all board members covered by the policy. In addition, board members should report any new conflicts (whether actual or perceived) that arise during the year to the compliance officer. Board members should never wait until it is time to update their annual disclosure statement to declare a new conflict.

If the board has appointed a specific committee to address potential conflicts, the compliance officer may also be the chair of the group or committee charged with handling conflicts. In some cases, larger organizations may contract with a legal expert to handle the collection and review of disclosure statements and to help ensure compliance.

Addressing Conflicts of Interest After They Arise

Conflicts of interest may happen unintentionally if an individual does not recognize a potential conflict of interest or recognizes the conflict after the fact, or intentionally if an individual chooses not to reveal a known conflict. Regardless of the source of the breach, the board must have a process in place for dealing with these difficult situations before they occur.

Known Conflicts. If a conflict arises that has been disclosed through the annual disclosure statement, the board meeting minutes should reflect the conflict and describe the action taken. For example, did the board member remove himself or herself not only from the discussion, but from the board room? Did the board continue the discussion and determine their decision was in the best interest of the hospital despite the potential conflict? Although there are a few exceptions, in most instances the board should not allow conflicted board members to participate in the discussion or vote on any issue where a conflict of interest exists.[11]

Unknown Conflicts. The situation becomes more complicated if a conflict becomes apparent that has not been previously disclosed. According to Board Source, there are several steps that may be taken.[1]

If either the individual board member recognizes a potentially new conflict that has not been declared, or another board member perceives a conflict that has not been declared, a discussion should take place between the board member with the potential conflict and the individual or committee charged with monitoring conflicts of interest. Ideally, all participants in this discussion would be "disinterested" individuals, or individuals that can evaluate the situation objectively. If an agreement is reached about how to address the conflict, no further discussion is necessary. However, if the board member in question does not recognize the potential conflict, the issue should be brought before the full board for discussion.

If a problem arises during a board meeting discussion, it should be addressed at that time. If the conflict is related to the meeting progress and/or a decision to be made, the board must decide how to proceed and indicate that decision in the meeting minutes. If necessary, a re-vote may be taken at the next meeting.

Sources and More Information

1. Kurtz, D. and Paul, S. Managing Conflicts of Interest: A Primer for Nonprofit Boards. *Board Source*. Washington D.C. 2006.

2. Lauer, C. Beware of Conflicts of Interest. *Modern Healthcare*. June 2004.

3. Kazemek, E. and Bader, B. Turning Up the Heat on Institutional Integrity. *Trustee*. February 2007.

4. Jaklevic, M. Conflict Resolution. *Modern Healthcare*. July 2004.

5. Evans, M. Oversight Shortfall. *Modern Healthcare*. December 2005.

6. How do We Safeguard Against Conflict of Interest? *Board Source*. www.boardsource.org.

7. Robinson, M. (2007). Declaration of Independence. *Board Source*. March/April 2007.

8. Larson, L. How Many Hats Are Too Many? *Trustee*. February 2001.

9. Lister, E. Conflict of Interest: Questions and Answers for Trustees. *Trustee*. July/August 2003.

10. Tyler, L. Conflict of Interest: Strategies for Remaining 'Purer Than Caesar's Wife.' *Trustee*. March 2004.

11. Sandrick, K. Avoiding Conflict of Interest. *Trustee*. July/August 2003.

12. Orlikoff, J. and Totten, M. Conflict of Interest and Governance: New Approaches for a New Environment. Trustee Workbook. *Trustee*. April 2004.

13. Mitchell, G. Rural Hospitals: A Different Take on Conflict of Interest. *Trustee*. March 2008.

14. Elements of Governance: Barriers to Having Physicians on the Board. The Governance Institute. Fall 2012. www.Governance Institute.com.

15. Walker, Larry. Conflict-Free Governance. *Trustee*. January 2014.

Q: What are the most prominent health needs in your community?

Implementation of the Affordable Care Act, value-based purchasing, workforce shortages, transparency, governance scrutiny, health information technology, evidence-based medicine, changing demographics, economic challenges – these are just a few challenges facing hospitals and health systems in today's complex and rapidly changing health care environment. But in order to stay true to the hospital's community-centered mission, hospital trustees cannot let the challenges presented in today's turbulent health care environment overpower the importance of understanding and meeting community needs.

To successfully and effectively lead their organizations, boards of trustees must have a deep understanding of the issues, challenges and needs confronting them. They should have clear answers to questions such as:

- How dependent is our organization's success on the direction these issues take?

- If the hospital's mission is to improve the community's health, what is the health status of the community?

- Does our board have the evidence and information it needs to make effective, data-driven strategic decisions?

Community needs and environmental assessments help trustees answer these questions. In addition, they provide hospitals and health systems with unique opportunities to connect with the community and maximize partnerships, and develop opportunities for building public trust and confidence.

Why Conduct a Community Needs Assessment?

A comprehensive community needs assessment provides the hospital with first-hand information about the health care needs of the community it serves. With this "snapshot" of the community's health, the hospital can identify the most pressing health care needs of the community, populations of individuals in need, gaps in care and services, barriers and challenges to receiving services, and information about other organizations that may already be working to meet specific needs. This information provides the foundation needed to build strategic and operational plans that will advance the hospital's mission of service to the community. Using the data and information from the assessment, trustees can:

- Assess and evaluate where and how the hospital should direct its attention;

- Prioritize strategic initiatives; and

- Best determine the allocation of resources.

An Opportunity to Strengthen Community Relationships. A community needs assessment is also a prime opportunity to strengthen community relations and build community partnerships. For example, conducting an assessment provides opportunities for the hospital to collaborate with a variety of community organizations in the distribution of surveys and collection of data. In addition, conducting community-based focus groups and making a dedicated effort to solicit the views and opinions of community members can help build and strengthen positive perceptions of and trust in the hospital.

It's Now Mandatory for Not-For-Profit Hospitals. Conducting a community needs assessment is more than an important step in building community relationships and providing hospitals with the information they need to meet community needs—its also a requirement enforced by the Internal Revenue Service (IRS).

Understanding Your Environment: Practical Processes for Understanding Community Needs and Environmental Trends

The Patient Protection and Affordable Care Act (ACA) requires not-for-profit hospitals to conduct a community needs assessment every three years. In addition, hospitals are required to demonstrate that they have undertaken strategies to address the needs identified through the assessment.

While the ACA does not prescribe how hospitals should conduct their community needs assessment, it does specify that the assessment must 1) take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health; and 2) be made widely available to the public.[11] The Act also states that the community needs assessment may be based on information collected by a public health agency or not-for-profit organizations, and may be conducted together with one ore more organizations.

Hospitals will be required to submit their community needs assessment information on the Form 990, including a description of how they are addressing the needs identified in the community needs assessment, a description of any needs that are not being addressed, and why those needs are not being addressed.[11] Hospitals that do not fulfill the new community needs assessment requirements may incur a $50,000 excise tax.

The community needs assessment requirements of the new IRS tax code related to the ACA went into effect for tax years beginning after March 23, 2012. IRS Form 990 creates a window of transparency into the hospital's efforts to understand and meet community needs. Part IV, "Supplemental Information," of the Form's Schedule H asks hospitals to:

- Describe how the organization assesses the health care needs of the communities it serves;

- Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves;

- Describe how the organization's community building activities promote the health of the communities the organization serves;

- Provide any other information important to describing how the organization's hospitals or other health care facilities further its exempt purpose by promoting the health of the community; and

Some experts predict that the penalty for failure to comply with the new community benefit assessment requirements will be greater than the $50,000 fine—it could be the potential for the IRS to revoke a hospital's tax-exempt status.

- If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

Trustees should note the importance of this section as a critical opportunity to demonstrate and validate the hospital's efforts to assess and understand the needs of their communities. The IRS is inviting hospitals to describe in greater detail their methodologies for determining the community benefit and services provided and to convey how these benefits and services promote the health of the community. Trustees and hospital leaders should expect the IRS and lawmakers to use this information as they determine the need for future laws and regulations governing community benefit and tax-exemption.

In fact, some experts predict that the penalty for failure to comply with the new community benefit assessment requirements will be greater than the $50,000 fine—it could be the potential for the IRS to revoke a hospital's tax-exempt status.[12]

Promoting Community Health
The American Hospital Association (AHA) provides the following guidelines to assist hospitals in planning and communicating their efforts to meet community needs.

- Hospitals' commitment to community health as reflected in their missions, values, and goals should be understood and applied by everyone throughout their organizations.

- Hospitals should understand their communities' unique health needs, and work with others in the community to meet those needs.

- Hospitals should periodically conduct a community needs assessment and assign responsibility for the hospital's community benefit plan to a hospital employee.

- Hospitals should have ongoing processes for planning and monitoring how their commitment to community health is met through services and programs for the community.

- Hospitals should develop and make readily available to the public a comprehensive inventory of all the community programs and services offered, including

specialty services, extended care, and programs that address social and basic needs, access, coverage, and quality of life.

- Hospitals should understand and publicly communicate the impact of their programs and services on their communities.

Practical Steps for Conducting a Community Needs Assessment

Maximizing the value of your community needs assessment requires careful forethought and planning. The process should begin with a clear definition of the objectives of the assessment by the board and the hospital's executive leadership. Hospital leadership must then communicate the importance of the assessment throughout the organization, and engage the hospital's employees in support of data collection efforts. In addition, involving community leaders and key stakeholders in the process is particularly critical to a successful community needs assessment.

Although every organization's community needs assessment process will be different, the following steps provide an overview of the steps often undertaken in a community needs assessment.

Step 1: Determine a Project Sponsor and a Project Coordinator. The project sponsor is typically a member of the executive management team, but may be a board member. This individual serves as a liaison between the coordinator, the executive team and the board. The project sponsor provides oversight and high-level guidance, provides assistance in navigating threats or obstacles to the assessment, and is accountable for the successful and timely completion of the assessment.

The project coordinator is responsible for planning and implementing the logistics of the assessment.

Step 2: Clearly Define the Objectives of the Assessment. The general purpose of the community needs assessment is to identify health care needs that exist in the community, and to determine the role the hospital should serve in meeting those needs. A more clearly defined set of objectives will also identify:

- If the assessment will be used to set strategic direction, identify organizational initiatives and prioritize allocation of resources;

- If the assessment is or will be used in measuring progress against an established baseline of community need(s); and

- What elements of the assessment are required to be included in the assessment in order to fulfill any legal, contractual or regulatory requirements (for example, the board may want certain demographics to be collected and analyzed to substantiate the hospital's Form 990 filing).

In addition to defining the information needed and how the findings will be used, the objectives should also define the assessment's geographic reach, generally considered to be the hospital's primary and secondary service area.

Step 3: Identify Available Resources. Define the budget, number of employees and other resources available and dedicated for conducting the community needs assessment.

Step 4: Develop a Detailed Plan. The project plan should include specific milestones, actions, accountabilities, dependencies and timeframes for completion. The plan should include processes for conducting the assessment, sources and methodologies for collecting data and information, a process for analyzing the results, and a plan for communicating findings and outcomes to the board, key stakeholders and the community.

Step 5: Collect and Analyze Data. Once the goals have been identified and the work plan has been approved, the next step in the assessment is to collect and analyze data. Utilizing multiple methods of data collection is recommended to ensure the widest possible opportunity for community representation and a clear picture of the issues, and can generally be divided into primary data collection and secondary data collection.

Primary Data Collection. The three most common forms of primary data collection are surveys, focus groups and personal interviews.

Surveys. Surveys are most frequently used to gather input from a larger number of people at the same time. Surveys may be conducted in various forms – a written paper survey, an online survey, a telephone survey, or a survey completed in-person by a survey-taker. Regardless of the survey format, it is important to consider the primary languages spoken in the community and provide translated versions of the survey as needed by the community.

When deciding which format to use, consider the target audience and the format that is most likely to achieve the greatest response rate. Once the format is determined, make survey submission as easy as possible. For example, if it is a written survey, design the survey form to fold into a "self-mailer" with the delivery address and prepaid postage printed on the front. Set up "survey stations" at various sites within the hospital, such as the entrance, lobby and waiting areas, admissions and business offices, cafeteria and other public spaces. Supply each station with a free-standing sign publicizing the importance of the survey and the hospital's desire to hear from all segments of the community, and include copies of the survey and a drop box for submitting the survey.

Survey Design. Surveys typically consist of closed-end questions with multiple-choice responses. These types of questions are easier to quantify and analyze for a large number of respondents. Open-ended questions may also be included, but responses require qualitative analysis to identify key themes and issues. For example:

- A multiple choice question may ask something like: "Are there health care services that are not available in your community that you think should be?," which the following answer options:

  - Yes, there are some services that are not available in our community and should be

  - No, there are no additional local services I need

  - There are some services not available in our community, but that is okay

- A logical follow-up open-ended question may be: "If there are needed services, what are the top 3 services you think are most needed?"

- You may also want to ask questions that allow multiple responses, such as "When you or someone in your family needs health care, are any of the following a problem? (Check all that apply)," with the following answer options:

  - Childcare

  - Finding a hospital or clinic that provides care to people without insurance, or offers free or discounted care

  - Finding a hospital or clinic where the people speak my language

  - Transportation

Survey Promotion and Distribution. Oftentimes, traditional survey methods fail to engage important community populations and constituencies. These populations may include the homeless, those without available Internet or telephone services, individuals with disabilities, non-English speaking people and others. The needs and perceptions of these people are important when considering the health of the entire community and how health care needs are or are not being met. When determining your survey methodology, it is important to consider using more than one method in attempting to reach the broadest possible representation of the entire community.

To overcome a lack of widespread survey access and barriers for some populations, begin by identifying a broad network of partners willing to promote and encourage survey completion. Their participation may range from willingness to sponsor an on-site computer station for online survey completion to survey distribution and promotion. Ask employers if they will include the survey with payroll distributions, include a statement of survey availability with hospital billing statements, and ask retailers if they will allow distribution of surveys to customers at their store entrances. E-mail the survey to local chambers of commerce, civic organizations and others, asking if they will distribute it electronically to their members.

The survey should be available in multiple formats, including an online version with a link directly on the hospital's Web site, as well as a written version that can be handed out or distributed via email. The survey should be translated into multiple languages if necessary to ensure that all sub-sets of the community respond.

In addition to distributing surveys through local employers and retailers, other alternatives to consider for survey promotion and distribution include:

- Your hospital's Web site (the survey may be available to fill out online, or as a downloadable document to print and mail in);

- Distribution to hospital employees, volunteers, trustees, foundation members and other hospital

or hospital related entities. Encourage employees to distribute the survey to friends, neighbors and acquaintances;

- Inclusion with other hospital mailings and public notices;

- Internal hospital communications;

- Local media - newspaper, TV and/or radio coverage and announcements;

- Distribution through physician offices, federal, state and/or county health clinics, other providers of health care and Medicaid programs;

- Local health insurers and agents or brokers;

- Health fairs and job fairs;

- Food banks, homeless shelters and other locations where people of limited means gather to secure resources;

- Community organizations and other entities such as senior centers, libraries and churches;

- Chambers of Commerce, Rotary clubs and other civic organizations;

- Local employers;

- Local health and fitness centers;

- Local pharmacies; and

- Other local opportunities as identified.

Focus Groups. Focus groups provide another opportunity for input from people who work with community groups and under-represented populations. Generally limited in size, focus group participants respond to open-ended questions presented by a group facilitator. Views and perspectives are discussed in greater depth than can be accomplished in a survey. A focus group may be best conducted in follow-up to a survey, allowing themes and issues identified in the survey to be further explored and validated. Sample topics or questions that may be posed to a focus group include:

- Describe what a healthy community would look like 5-10 years from now;

- Identify the ten most serious health care problems that could prevent that vision from becoming reality;

- Identify the groups of people most at risk; and

- Identify whose accountability it is to find and implement solutions to improving the health of the community.

Focus group constituencies to consider include, among others:

- Members of the medical staff;

- Clinical care providers and managers of free clinics;

- Social services agency representatives;

- Civic leaders;

- School representatives; and

- Faith-based representatives.

Interviews. Like focus groups, interviews offer an opportunity to explore and validate themes arising from survey and focus group results. Brief, highly-focused interviews may be used as a means of gathering insights from individuals, such as physicians and others, for whom scheduling focus group time is difficult. Sample interview questions that might be asked of physicians and providers include, among others:

- What top five symptoms do you treat in your office that indicate community health problems or needs?

- What do you see as the root causes or primary forces that create these health problems?

- What do people in your community encounter that keeps them from getting necessary health care?

Secondary Data Collection. In addition to collecting data directly from surveys, focus groups and interviews, organizations should supplement their findings with secondary data. This information is readily available from various sources and can contribute to the overall strength of the assessment findings.

When collecting secondary data, it is important to determine what information has the most significance and to seek out local as well as state, regional and national level data. When possible, local health information should be benchmarked against state, regional and national trends. Benchmarking allows hospital leaders to explore questions such as: "Does our

AHA's Community Connections Strategy Checklist for Leaders

The American Hospital Association has identified the following questions for hospital leaders to consider as they conduct a community needs assessment and strive for strengthened community connections.

- Have you identified the communities you serve by geography and/or by those served?
- Does your organization conduct a community needs assessment?
- As part of that assessment, does your organization collect data on the demographics of your community, including population; income statistics; percentage of uninsured; percentage of Medicaid and Medicare recipients; medically underserved populations; the number of hospitals serving the population; and other factors relevant in your service area?
- Does your organization collect data on the economic, social, cultural, and/or geographic barriers to care that exist in the community?
- Does your organization have a process to assess the health care needs of the "communities within the community" you serve, in particular highly vulnerable populations?
- Does your organization work with others in the community, such as governmental, community, and/or social service organizations, to conduct your community needs assessment?
- Do you share the results of your community health assessment with other organizations and agencies in the community?
- Does your organization use the results of the community needs assessment to set priorities for community benefit efforts and programs?
- In setting the priorities for community benefit efforts and programs, does your organization work with others in the community, such as governmental, community, and/or social service organizations, and partner on needed health initiatives?

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community exceed averages for various indicators of community health?" and "Is our community's health status better or worse than that of similar communities?"

Identifying the potential causes and reasons behind these findings will help the board uncover potential opportunities and strategies for addressing the community's health care needs. Typical categories of secondary data and information to research include:

- Population growth trends and projections;
- Age trends;
- Race and ethnicity trends;
- Gender information;
- Income levels;
- Education levels;
- Uninsured rates;
- Unemployment trends;
- Rates of physical activity;
- Rates for preventive screening measures;
- Incidents of chronic disease; and
- Health care utilization.

Step 6: *Develop a Summary Report of Findings.* A summary report pulls together all of the findings, and should include the objectives of the assessment, the methodologies employed, findings, implications and recommendations. The findings from the needs assessment survey, focus groups and interviews should be synthesized and compiled in an organized and logical manner that allows the board and the hospital's executive leadership to identify and evaluate the implications and develop potential strategies.

Step 7: *Follow-Up.* Trustees are responsible for making decisions about how the assessment results will be used. The assessment process should give the board a strong foundation for strategic planning by providing clarity about needed services and identifying specific, attainable goals for meeting community needs. Part of this process may mean determining if it is necessary to provide additional services or create new programs. Some services may benefit the hospital with additional income, while others may result in minimal or no profit. When evaluating potential new services, the board must decide if adding the services:

- Provides a substantial benefit to the community;
- Is important in fulfilling a specific community need;
- Contributes toward the community benefit activities required of tax-exempt hospitals; or
- Directly contributes to the achievement of the hospital's mission.

Communicating the assessment results to stakeholders, partners in the assessment process and other community members is an important step in engaging their continued interest, support, trust and ownership of solutions to meeting needs and improving the health of the community.

What Does an Environmental Assessment Achieve?

In addition to conducting a community needs assessment, a good environmental and market trend assessment can provide boards of trustees with new insights and help drive sound strategic decision-making. Comprehensive environmental assessments offer:

- Relevant and reliable data needed for strategic analysis and evaluation;

- "Early warnings" of changes on the horizon;

- A consistent context for discussion, debate and decision-making;

- An integrated, holistic perspective of the health care environment;

- Improved organizational responsiveness to the environment; and

- Greater opportunity for successful achievement of strategic plan initiatives.

An environmental assessment should provide not only an outside look at the surrounding environment, but should give trustees a complete perspective by including an inward view as well. As with a community needs assessment, a variety of primary and secondary sources of information and data should be accessed to provide the greatest possible breadth and depth of relevant information. When possible, organizations should use the information, data and reports they already gather and produce, but which may not have been historically compiled into a single resource. This will minimize duplication of effort and ensure that all available information is included in one comprehensive and integrated location.

Conducting an Environmental Assessment

Environmental assessments typically focus on health care trends and forces for change in the health care field, providing hospital leadership with a more in-depth understanding of the issues and trends occurring in key areas. The areas of focus may change over time, but a good assessment will typically highlight:

- Health care trends;

- Local demographics;

Inside and Outside Perspectives

Examples of data and information that should be collected and evaluated in the environmental assessment include:

The Outside View

- Reform efforts, new or proposed regulatory and legislative changes occurring in the health care field
- Demographic trends
- Community health and health care access information
- The economy, finance, and economic development
- Information technology trends
- Medical technology trends
- Trends in consumerism
- Payer trends
- Political issues
- Physician and other provider changes and trends
- Quality and patient safety mandates and developments
- Competitive information including statistics, market share trends, areas of excellence, and facility development

The Inside View

- Workforce trends, such as nursing and physician shortages, aging and retirement
- Service utilization
- A portfolio of the services offered by the organization including utilization trends, market share by service line and a SWOT (strength, weakness, opportunity and threat) analysis
- Foundation and other financial resource data
- Organizational access to and utilization of technology
- Facility development needs
- Quality, patient safety and patient satisfaction measures
- Financial performance
- Medical staff development status, trends and progress against plans

- Competitor information;

- An organizational profile;

- Quality and patient satisfaction performance;

- Financial performance;

- Information about the medical staff; and

- Human resource issues, such as projected shortages, turnover rates and vacancies.

Health Care Trends. Health care trend information highlights the forces for change that are projected to influence the direction of health care. Examples of current health care trends to consider include growing rates of uninsured and underinsured, health care reform efforts, rising consumer activism, increased hospital scrutiny and demands for transparency, rapid advances in science, technology and IT, workforce changes, including nursing and physician shortages, and the expansion of integrated delivery systems.

Demographics. The demographic section of an assessment provides a snapshot of local market demographics. Useful demographic information should include an overview of the organization's primary and secondary service area, population growth projections, household income overviews, local area employment, unemployment and uninsured rates, etc.

Competitors. Competitive information provides a more complete evaluation of potential unmet community needs and opportunities, and allows the hospital to monitor potential competitive threats. This section of an assessment should include comparative statistical information on competitors' number of beds, discharges, emergency department visits, occupancy, and revenue statistics. Margin trends, profitability, an assessment of range of services and market share trends should also be evaluated.

Organizational Profile. A strong summary of the organization's profile ensures that each member of the board as well as the executive staff is working with the same understanding and knowledge about the organization's current performance. A profile can also provide context regarding the resource capabilities of the organization and its ability to take advantage of emerging opportunities or to weather potential challenges to its operations. A comprehensive profile should include information about recent growth and development accomplishments such as new facilities or implementation of services. Technological capabilities and growth in patient volume should also be captured in the profile, as well as a portfolio of services and

utilization trends for surgery, outpatient services, emergency department services, maternity care and other services available.

Quality and Patient Satisfaction. Quality and patient satisfaction belong at the forefront of the board's attention. Quality, safety and satisfaction performance measures, initiatives and accomplishments should be captured and their implications should be continuously reviewed and evaluated by the board. Consumer preferences and perceptions as measured by a national standardized survey of hospital patients commonly referred to as HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems), state reporting centers and other research sources are an important component of a comprehensive environmental assessment.

Financial Performance. The hospital's financial status and resources are critical to the organization's ability to carry out strategic initiatives and realize its vision. An assessment should address income and margin statistics and trends, inpatient and outpatient revenue statistics and trends, and financial and operating ratio analyses that identify resulting trends and implications. The assessment should also include an analysis of the hospital's payer mix.

The Medical Staff. To complete an organization's profile, an assessment should include statistical information about its medical staff. This data should include medical staff composition by specialty and membership type, recruitment planning goals and recent recruitment results, discharges by specialty, and physician referral information derived from the percentage of discharges by physician.

Human Resources. Workforce shortages are a significant health care concern today and for the foreseeable future. An environmental assessment should provide the board with the information and data necessary to stay abreast of this issue, including the measurement of any efforts on the part of the hospital to counter critical shortages. This portion of the assessment should identify hospital employee issues and concerns, and should compare vacancy and turnover rates to national trends. The implementation and progress of leadership development and other workforce initiatives should also be measured, analyzed and included in the assessment.

Steps in the Environmental Assessment Process. The steps to conducting an environmental assessment are similar to those of the community needs assessment:

- *Step 1:* A project sponsor and project coordinator should be determined.

- *Step 2:* Clearly defined objectives for the assessment should be established.

- *Step 3:* Necessary financial and employee resources should be identified.

- *Step 4:* A work plan should be developed and implemented, and the work of the assessment completed.

Putting the Assessments to Work

Armed with the information provided in the assessments, the board should first ask: "What impact will trends and forces for change have on health care and on our hospital?" For example, when faced with changing medical staff demographics trustees might ask: "What are the critical projected changes in our physician workforce demographics?" and "based on these changes, what will be the key demands on the healthcare system in the next five years?"

Once the questions are framed, the organization must make astute assumptions about the implications and impacts these issues hold for the future of the hospital. The board should work with the senior leadership team to evaluate the organization's resources, abilities and capacity to successfully respond in face of these assumptions. The outcomes of the assumptions and evaluations will lead the board and management in determining critical strategic opportunities, threats and resource gaps.

Trustees are responsible for making decisions about how assessment results will be used. The assessment process should give the board a strong foundation for strategic planning by providing clarity about health care trends and needed services, and help identify specific, attainable goals for meeting community needs. The board must decide if adding (or eliminating) services:

- Provides a substantial benefit to the community;

- Is important in fulfilling a specific community need;

- Contributes toward the community benefit activities required of tax-exempt hospitals; or

- Directly contributes to the achievement of the hospital's mission.

Communicating the assessment results to stakeholders, partners in the assessment promotion and other community members is an important step to engaging their continued interest, support, trust and ownership of solutions to meeting needs and improving the health of the community.

Making the findings of the community health needs assessment widely available to the public is also a requirement of the ACA, which can meet by posting the written community needs assessment report on the hospital's website.

Three Ways to Maximize Your Investment

Leverage the Work. The environmental assessment is a significant resource of information that can be used in multiple ways by individuals and departments throughout the organization. It should become a dynamic "go to" document that is shared widely within the hospital. As requests for information and data are made throughout the year, they should be noted and evaluated for relevance. If deemed appropriate, new information and data should be incorporated into the assessment to continue building and improving on the strength, relevance and usefulness of the organization's environmental intelligence.

Put the Assessments to Work at Board Retreats. Community needs and environmental assessments provide a strong, evidence-based foundation upon which the board can build its strategic plan. Entering a retreat armed with assessment data and information, trustees can envision and develop critical assumptions about the trends and forces expected to influence the health care field in coming years. Required capabilities and resources to meet those assumptions can then be identified, and the organization's readiness can be assessed. Assessment knowledge and the assumptions derived from it allow trustees to better evaluate current strategies and to develop new, targeted strategies for achieving its mission and vision.

Ask "What Do We Know?" Assessment work does not end with a board or leadership retreat. Staying attuned to the community and the health care environment requires on-going effort. Trustees must continually ask "What do we know today that we didn't know at our last board meeting? Does this new knowledge in any way change any of our assumptions?" And "If so, how does that change affect our capabilities and strategies moving forward?"

Sources and Additional Information

1. Moore, Dianna. Comprehensive Community Needs Assessment Template. June 2007.

2. Becker, Cinda. Community Center of Attention. *Modern Healthcare.* July 23, 2007.

3. Francis, Theo. Lawmakers Question if Nonprofit Hospitals Help the Poor Enough. *Wall Street Journal.* July, 20, 2007.

4. Felix, M. and Burdine, J. Taking the Pulse of the Community. *Healthcare Executive.* July/August 1995.

5. Billings, J. and Crowley, S. Approaches to Community Needs Assessment: A Literature Review. *Journal of Advanced Nursing.* 1995.

6. Horne, M. and Costello, J. A Public Health Approach to Health Needs Assessment at the Interface of Primary Care and Community Development: Findings From an Action Research Study. *Primary Health Care Research and Development.* 2003.

7. Escoffery, C. et al. Conducting Small-Scale Community Assessments. *American Journal of Health Education.* July/August 2004.

8. Sandrick, K. Defining & Measuring Community Benefit. *Trustee Magazine.* November, 2006.

9. Association for Community Health Improvement. ACHI Community Health Assessment Toolkit. www.assesstoolkit.org.

10. Bilton, Michael. An Excellent Investment. *H&HN.* www.hhnmag.com. May 2008.

11. Internal Revenue Service. Request for Comments Regarding Additional Requirements for Tax-Exempt Hospitals. Notice 2010-39.   Comments Submitted by July 22, 2010.

12. Sherry, Mike. Reform-Driven Assessments May Improve Care, Cut Costs. *Puget Sound Business Journal.* April 30, 2010.

Q: What is the board's responsibility to ensure the best care for all?

The mission of most not-for-profit hospitals is ultimately to improve the health of the communities they serve. For many hospitals across the country, the racial and ethnic diversity of communities is changing and cultural disparities in health care are becoming more and more evident. It is trustees' role and responsibility to ensure the hospital knows what the community's health needs are, and how to best deliver care that meets the needs of those who live in the community.

In the ten years between 2000 and 2010, the population of the United States increased by more than 27 million people. According to the 2010 census, over one-third of the U.S. population reported their race or ethnicity as other than "non-Hispanic White." Results of the 2010 census indicate that minority populations represent nearly half the total population in the Western region of the United States, 40 percent in the South, nearly one-third of the population in the Northeast, and about one-fifth of the population in the Midwest.

The Health Disparity Gap

Diversity has the potential to cause a number of disparities and inequities in health care. This is driven by differences in socioeconomic status, language barriers, varying consumer health behaviors when seeking care as well as adhering to treatment guidelines, discrimination and stereotyping by providers, lack of cultural knowledge and sensitivity by providers, lack of a culturally representative health care workforce, and differences in insurance coverage. In November 2013, the Centers for Disease Control (CDC) released its second agency report on health disparities and inequalities in the United States, the *CDC Health Disparities and Inequalities Report — United States, 2013*. CDC Director Thomas R. Frieden observed that "four findings bring home the enormous personal tragedy of health disparities," including:[1]

- "Cardiovascular disease is the leading cause of death in the United States. Non-Hispanic black adults are at least 50 percent more likely to die of heart disease or stroke prematurely (i.e., before age 75 years) than their non-Hispanic white counterparts.

- The prevalence of adult diabetes is higher among Hispanics, non-Hispanic blacks, and those of other or mixed races than among Asians and non-Hispanic whites. Prevalence is also higher among adults without college degrees and those with lower household incomes.

- The infant mortality rate for non-Hispanic blacks is more than double the rate for non-Hispanic whites. Rates also vary geographically, with higher rates in the South and Midwest than in other parts of the country.

- Men are far more likely to commit suicide than women, regardless of age or race/ethnicity, with overall rates nearly four times those of women. For both men and women, suicide rates are highest among American Indians/Alaska Natives and non-Hispanic whites."

The combined cost of health disparities and subsequent deaths due to inadequate or inequitable care in the United States is $1.24 trillion, according to the U.S. Department of Health and Human Services (HHS).[2]

A number of organizations are working to raise awareness of inequalities in health care and develop resources to ensure everyone receives the best care. Together, the American Hospital Association (AHA), American College of Healthcare Executives, Association of American Medical Colleges, Catholic Health Association of the United States, and National

Association of Public Hospitals and Health Systems, issued a call in 2011 to eliminate health care disparities. The AHA's *Hospitals in Pursuit of Excellence* has released a "Signature Leadership Series" of documents focused on reducing health care disparities and building cultural competency. The Institute of Medicine has also acted, convening a "Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities."[4]

Defining the Community's Health Care Disparities and Needs

Improving the health of a community begins first with understanding what the community is and what the needs are. Establishing additional ways to identify and address health disparities was one factor behind the Patient Protection and Affordable Care Act (ACA) requirement that not-for-profit hospitals regularly conduct community health needs assessments. In carrying out the assessment, hospitals must seek input from representatives or members of the community's medically underserved populations, low-income populations, minority populations and the public health department. Identifying the community's health care needs should include digging deeply enough to identify its health disparities and inequities. As an additional resource, the ACA also requires federally-funded health programs and population surveys to collect and report data that will help to identify and analyze health disparities, including information on race, ethnicity, and primary language among other demographic data. The Secretary of HHS is required to analyze, monitor, and report trends in health disparities to federal agencies and the public.[2, 5]

Trustees are responsible for ensuring the hospital has a sound understanding of the community's health needs and its disparities, They are also responsible for determining the strategies and resources their organizations will use to address health needs, and evaluate the impact of those programs.

Developing Cultural Competency – A Governance Accountability

As a part of their accountability for mission fulfillment and for the leadership of hospitals and health systems, trustees are being called upon to address their community's health care disparities and strengthen cultural competency. With oversight responsibility for the hospital's strategic plan, trustees committed to reducing and eliminating inequities in health

care must ensure their plan takes into account cultural competency. This includes setting appropriate strategic goals for strengthening the organization's measures of cultural competency as well as goals for meeting the health care needs of all populations in the community.

CLAS Standards. The Office of Minority Health, U.S. Department of Health & Human Services, first published the National Standards for Culturally and Linguistically Appropriate Services in Health Care (National CLAS standards) in 2000. Revised in 2010, the 15 national CLAS standards are designed to advance health equity, improve quality, and help to eliminate health care disparities by establishing a guide for health and health care organizations. In addition to the principal standard to "provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs," the remaining 14 standards address governance, leadership and workforce; communication and language assistance; and engagement, continuous improvement, and accountability. The Joint Commission and other legal and regulatory entities look to the CLAS standards when considering their own oversight requirements. The board, too, should take these standards into account as it seeks to fulfill its responsibilities to the community. However, standards cannot replace the value of first-hand insights, understanding and information available by ensuring a diverse board membership, leadership and workforce, and a comprehensive community health needs assessment.

Actions the Board Can Take. Steps the board can take to strengthen the hospital's cultural competency include:

- Ensure the board's composition represents the diversity of the community;

- Ensure the organization's leadership and workforce represents the diversity of its community;

- Include cultural competency training in new trustee orientation and on-going governance education;

- Ensure cultural competency is an active component of the organization's workforce training program;

- Promulgate policies and practices that set a tone of leadership and support for cultural competency;

- Monitor conduct of periodic comprehensive community health needs assessments;

- Identify strategic plan goals that will strengthen the organization's cultural competency and address the community's health care needs, disparities and inequities; and

- Allocate the resources needed to achieve the plan's goals of cultural competency and eliminating health care disparities.

The National CLAS Standards

The National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care are intended to advance health equity, improve quality and help eliminate health care disparities. Of the 15 standards, the following three focus on governance, leadership and workforce:[7]

- Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.

- Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.

- Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Sources and Additional Information

1. Thomas R. Frieden, MD, MPH. Morbidity and Mortality Weekly Report, November 22, 2013/62(03); 1-2.

2. Dennis P. Andrulis, Ph.D., MPH, Nadia J. Siddiqui, MPH, Jonathan P. Purtle, MSc, Lisa Duchon, Ph.D., MPA. Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations. July 2010. www.jointcenter.org.

3. Health Research & Educational Trust. Becoming a Culturally Competent Health Care Organization. Chicago, IL. Illinois. Health Research & Educational Trust. June 2013. www.hpoe.org.

4. Institute of Medicine. Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.

5. Patient Protection and Affordable Care Act. Understanding Health Disparities: Data Collection and Analysis. Section 4302. March 2010.

6. Health Research & Educational Trust, Institute for Diversity in Health Management. Building a Culturally Competent Organization: The Quest for Equity in Health Care. Chicago, IL Health Research & Educational Trust. July 2011.

7. U.S. Department of Health & Human Services, Office of Minority Health. Accessed January 14, 2014. www.thinkculturalhealth.hhs.gov.

Q: What is community benefit and what's the board's role in ensuring it?

Congress often questions what taxpayers are getting in return for the tens of billions of dollars per year hospitals receive in tax subsidies as a result of their not-for-profit charitable status. In past years, the Senate Finance Committee and the Internal Revenue Service have stepped up their efforts to evaluate whether hospitals' community benefit programs and services are adequate to support their tax-exempt status.

In 2008, the Internal Revenue Service (IRS) released the revised Form 990 and an initial set of 16 new schedules, including Schedule H, a brand-new schedule for completion by tax-exempt hospitals.

The IRS described its efforts to develop the new form and schedules as a resource for improving transparency, promoting compliance and minimizing filing burdens for not-for-profit organizations. The agency stated that the new Schedule H for hospitals was an attempt to "combat the lack of transparency surrounding the activities of tax-exempt organizations that provide hospital or medical care."

Connecting with the Community is Essential

In addition to the IRS' new Schedule H highlighting the government's desire for additional information about the community benefit provided by hospitals, consumer frustration about health care is driven by a lack of awareness and understanding of the current system and its challenges, something that an effective community benefit report and community engagement effort can address.

Most people do not understand how hospitals are organized and managed, how they work, what they do to provide charity care, or what they do in their communities as a part of their mission to provide community benefit and improve community health. They do not understand the magnitude of the forces that are changing health care, including payment inadequacies, the negative impacts of overregulation, the dramatic increase in "disruptive technologies," changes in the workforce and more.

In the absence of information and evidence, people rely on personal experiences, their own intuitive beliefs and personal opinions to shape and sustain their belief structure about what's good and bad about health care. Once in place, it is extremely hard to impact peoples' strongly-held beliefs and perceptions.

Hospital leaders have an opportunity to help shape positive public perceptions about their hospital. They have an obligation to communicate the unique challenges they face, how they are dealing with those challenges in a very difficult environment, and why their hospital relies on the commitment and loyalty of its community to ensure its ability to continue providing high quality health care services well into the future.

Getting the Right Mindset

A community benefit report is not simply a report that itemizes the total dollars spent on charity care and bad debt, the number of people employed, or the number of births or emergency room visits in the past year. In fact, best practice community benefit reports are much more than a list of statistics and numbers required to be reported on Schedule H.

Instead, hospitals that produce best practice community benefit reports view the report as an opportunity to tell their full benefit story. Their reports include pictures and personal stories about patients, families, and communities impacted by the hospital. Their reports are colorful, easy-to-read, and include graphs and statistics highlighting important information, while using narratives and pictures to tell the story.

What Counts, What Doesn't

As hospitals work to create a community benefit report, a number of questions must be addressed concerning what activities hospitals should include. The following are points to consider for inclusion:

- *Community Health Education.* Education on specific disease conditions, health promotion and wellness programs, prenatal classes serving at-risk populations

- *Community-Based Clinical Services and Subsidized Services.* Free or low cost care to the uninsured, vans and mobile units used to deliver primary care services, hospice and home care, charity care and bad debt, free or discounted immunizations at a health fair or mall presentation

- *Financial Contributions.* In-kind services donated by staff during working and non-working hours, donated space to community groups for meetings, fund-raising costs for community programs

- *Community-Building Activities.* Financial support for community health programs and partnerships, participation in economic development council, community forums and reports

- *Health Professions Education.* Internships, residencies, scholarships, tuition reimbursements as an employee benefit, subsidized on-site training for nurses, nursing students and technicians, training for medical translators

Source: Catholic Health Association

Hospitals producing best practice community benefit reports don't stop with the report. They use the information to build relationships with the community. Some send copies of their report to every member of the community. Others publish stories in their local newspaper and post their report on their Web site so that it is easy to find. Still others share the information through presentations at town hall meetings, local community gatherings, and personal meetings with key stakeholders and legislators. The IRS' considers the ACA requirement to make community health needs assessment findings "widely available" to the public fulfilled if a written report is posted on the hospital's website.

Although every organization may employ a slightly different approach to communicate its story, one success factor is constant: their mindset is to use their community benefit report as an opportunity to build relationships and strengthen trust with the community.

Preparing Your Community Benefit Report

The American Hospital Association (AHA) has developed a comprehensive resource to help hospitals develop a community benefit report, called "Telling the Hospital Story: Going Beyond Schedule H." The toolkit includes case examples, sample completed written and PowerPoint® reports, and worksheets to guide hospitals in the process of developing their own reports and communication process.

The AHA stresses the importance of making community benefit programs "real" to people via stories, examples and successes, explaining that the "information required by the IRS on the new Schedule H provides communities with only a limited view of what hospitals do for the communities they serve." It is essential that hospitals communicate that they do more than treat injury and illnesses—each hospital's programs and services meet their community's unique needs, whether it is transportation for elderly patients, dental care for children, or a center serving the homeless.

The sample community benefit report developed by the AHA includes:

- A graphical summary of expenses, including items required in the Schedule H, such as charity care, bad debt, unreimbursed Medicare and Medicaid costs, community health improvement programs, education, research, and community-building activities;

- A letter to the community from the CEO and board chair;

- An overview of services provided to the community, including charity care and financial assistance, need-based programs such as a dental care clinic, elder care program and women's resource center, educational classes for community members, and employee volunteer time;

- Personal testimonials and quotes about community programs offered by the hospital, and their impact on individuals and families; and

- A list of organizations the hospital partners with in the community.

Questions to Consider: Are You Prepared?

In light of the current environment and ACA and IRS requirements, discussing the organization's community benefit report should be a top board priority whether the hospital develops a report every year or once every three years. As the board prepares, questions to consider include:

Best Practice Case Examples

Below are examples of what some hospitals are doing to prepare for the development of their community benefit report, and to communicate the benefit provided. For more information go to the American Hospital Association's Web site, www.caringforcommunities.org.

- *Munson Healthcare*, Traverse City, MI, conducts a community needs assessment nearly every five years. The system also uses the Community Benefit Tracker software tool created by the Michigan Hospital Association to capture community benefit activities in one place in a user-friendly manner. The information entered into the program is combined with financials itemizing the community benefit provided (such as subsidized programs) to provide a complete and accurate picture of the total community benefit provided. Munson shares its detailed community benefit information annually through a printed report that highlights personal stories about the lives touched and the programs and services provided to the community. It is distributed to nearly 250 community partners, posted on the Munson Web site, and printed in surrounding newspapers.

- *Glendive Medical Center*, Glendive, MT, believes that part of its mission includes communicating the hospital's community benefit story. Every year the Critical Access Hospital develops a full-color, easy-to-read community benefit report and corresponding PowerPoint® presentation. The report is mailed to 11,000 households in the hospital's service area, and is published on its Web site. The hospital also shares its story through personal presentations, such as the local Speakers' Bureau, and through quarterly employee forums with time dedicated to the organization's community benefit.

- *North Shore-Long Island Jewish Health Care System*, Long Island, NY, encourages employees to share with their managers personal stories they observe, which are often used when the organization develops its annual community benefit report. The report also includes stories derived from letters written by patients and families. The community benefit report is disseminated to local civic community leaders, elected officials, thought leaders and opinion makers, and other key stakeholders. In addition, the personal stories and letters are shared throughout the year with employees through e-mails and newsletters, and play a vital role in the organization's new employee orientation process. Finally, individuals represented in the stories serve as spokespeople for the hospital at community and town hall meetings, sharing their personal experiences with the hospital.

- *Sutter Medical Center*, Sacramento, CA, uses its community partnerships to tell its community benefit story. As part of its mission, the medical center offers grants to local community agencies, helping the organization to have a greater impact on the community and also form strong partnerships with local not-for-profit organizations and community stakeholders. Each year the medical center distributes its community benefit report to more than 500 community partners and elected officials. Local partners play a key role in the medical center's communication with the community, sharing the medical center's benefit provided with their constituents using the language and communication style that is most effective for their target population.

- Does the board review and understand the requirements of the Form 990 and Schedule H?

- Is the board committed to go beyond the basic requirements and use the community benefit report as an opportunity to strengthen community ties?

- Has the organization's leaders reviewed the AHA toolkit to help prepare a comprehensive community benefit report?

- Does the hospital have a communications plan for using the community benefit report once it is complete? Who will the hospital communicate directly with?   Has the organization shared the information directly with stakeholders and others? If the hospital holds or attends local community meetings, who will present, and what is the role of the board?

- Does the board have a long-term plan for identifying community needs? Has it prioritized opportunities to meet the community's needs, incorporating initiatives into the hospital's strategic plan? Has the hospital shared the findings of its community health needs assessment by posting the written report the organization's website?

Q: What is population health and why is it significant?

Improving the health of the community is the driving mission for most, if not all, hospitals. The goal of population health management is closely aligned with that mission and may seem to be a logical and perhaps easy step for hospitals and health systems to take. Managing the health of a population has significant implications for hospitals and health systems that are important for trustees to understand.

The topic of population health has become a presence in health care media and on conference agendas as hospitals and health systems seek to cross the gap from the first curve to the second curve in health care transformation. Accountable for hospital and health system strategic success, trustees must have a solid grasp of the meanings and implications of population health management and why it's important to the future of their organization and the community as a whole.

What is Population Health?

In the American Hospital Association's (AHA's) Signature Leadership Series 2012 report, *Managing Population Health: The Role of the Hospital*, population health is defined as "a strategic platform to improve the health outcomes of a defined group of people, concentrating on three correlated stages:

- The distribution of specific health statuses and outcomes within a population;

- Factors that cause the present outcomes distribution; and

- Interventions that may modify the factors to improve health outcomes.

Population health resides at the intersection of three distinct health care mechanisms. Improving population health requires effective initiatives to: 1) increase the prevalence of evidence-based preventive health services and preventive health behaviors; 2) improve care quality and patient safety; and 3) advance care coordination across the health care continuum."[1]

The AHA also notes that a common description of population health is "the health outcomes of a group of individuals including the distribution of outcomes within a group." Very simply put, population health management means improving the overall health of a population. This includes identifying individuals with the highest-risks (the most acute and complex conditions) and those with chronic conditions, and determining the best means for keeping them healthy. It also means determining and addressing the preventive and wellness needs of the rest of the population.

Why is Population Health So Important?

One of chief drivers behind today's efforts to manage population health is the shift from a volume-based, fee-for-service payment system to a system based on value. New payment structures with shared savings and risk, bundled and capitated payments, and penalties for low quality of care scores and high readmissions contribute to the rising investment in population health management by health care organizations.

The ability to deliver high quality care and improve health outcomes while managing costs will significantly affect hospitals' and health systems' ability to succeed in a value-based health care environment.[1] The Institute for Health Technology Transformation predicts that population health management will be a required core strategy for health care providers,[3] and nearly all hospital CEOs (98 percent) responding to the AHA's 2012 Annual Survey of Hospitals believe hospitals need to be implementing population health strategies.[4]

What Is In the "Population"?

One of the first and most important steps in managing the overall health of a population is to define who's included in the "population," or group of people whose health is to be "managed." A population can be defined in multiple ways, including: 1) individuals within a specific geographic area, such as the hospital or health system's community or service area; 2) a patient population, such as a physician practice group's patients or a hospital's discharged patients; or 3) a payer group, including Medicare patients assigned to an Accountable Care Organization (ACO), patients covered under a particular insurer's benefit plans or employees of a particular employer. A population may also be defined by a particular health condition, such as diabetes, asthma or cardiac conditions.

There are a number of ways to define a group of individuals whose health the hospital or health system wants to best manage and improve. The key is to ensure a clear definition of the population in question from the start. The ability to measure the impact and outcomes of various health care interventions is dependent on knowing exactly what the target population is. Without the ability to establish a credible baseline and demonstrate measured improvement, the hospital will sacrifice financial reimbursement in a value-based system.

What Does It Take?

Many hospitals are already taking steps to improve the health of various populations, including focused attention on improving quality and patient safety, better coordination of care and delivery of preventive and wellness services.1 The size and resources of a hospital or health system and its community may define the scope of the population health strategies the organization is able to undertake. Regardless of scale, below are several primary factors to consider.

Common Vision. When the board and the CEO agree upon a common vision for community and population health, and all key players, including the medical staff, are working toward that same vision, the path to achievement becomes a little easier and the outcomes are more effective. To get there, the board and CEO must agree upon and clearly articulate the extent of the commitment and engagement of the organization in community and population health efforts.

Targeted Health Needs. Identifying targeted health needs is a first step in population health management. Hospitals and health systems may choose to target quality and patient safety by selecting an area in which the organization's health

Collaboration to Improve Overall Health. The Partnership for a Healthy Community is a Florida not-for-profit corporation formed in 1994 with the mission of assessing health status, identifying priority health needs, and supporting collaborative efforts to address those needs to improve health and quality of life for the residents of Escambia and Santa Rosa Counties in Northwest Florida. The Partnership performed comprehensive health status assessments for the Escambia and Santa Rosa Counties in 1995, 2000, 2005 and 2012, and used the results to develop priority health needs strategies in three areas: health weight, quit tobacco, and "stay well." The Partnership includes more than 70 community organizations, including Baptist Health Care and Sacred Heart Health System. For more information, see http://livewellnwfl.org.[9]

Partnerships for Asthma. Parkview Health System in Fort Wayne, Indiana established the Asthma ER Call-Back Program as an effort to address local asthma challenges. Focused on reducing the costs of asthma and improving quality of life, the hospital credits collaboration with its community partners for the program's success. The Allen County Asthma Coalition supplies the program with educational materials, donor support provides pillow and bed encasements, and medical interpretation for families is made possible by a coalition of local health organizations. Grant dollars from the Indiana State Department of Health (ISDH) contribute to the program's financial sustainability and an ISDH epidemiologist helps to quantify the program's results. Representatives of the Asthma ER Call-Back Program encourage others to ensure strong, collaborative relationships with community partners as their starting point.[8]

Prescriptions for Hiking. In a unique effort to address the community's obesity and diabetes concerns, physicians at Columbia Valley Community Health (CVCH) in Wenatchee, Washington have partnered with Chelan-Douglas Land Trust in a collaborative program called the Foothills Hiking Challenge. Doctors at CVCH write hiking prescriptions for patients, encouraging healthy exercise and raising patients' awareness of this free, natural resource just minutes from their homes.[2]

outcomes measures fall short. A hospital or health system may also want to focus its efforts on one or more of the health needs identified in a community health needs assessment, or where it experiences a high rate of admissions. Many

organizations are also working to improve the coordination of care between providers.

Interventions. Once a target health care need has been identified, the contributing causes or factors must be identified, and possible strategies for addressing them must be evaluated. Hospitals and health systems must assess and prioritize efforts to pursue. This includes consideration for where the organization can have the most critical impact or influence. It is also an opportunity for trustees to consider the long-term goals for a healthy population, to challenge common assumptions and the status quo, and to seek out new and creative partnerships and collaborations that will engage, motivate and inspire patients and the community.

Partnerships and Collaborations. Multiple factors influence the health of an individual or population, including socio-economic factors, which often affect access to care or ability to comply with treatment plans. Many factors are outside the hospital's control or they may exceed the hospital's resources. This reality is prompting many health care organizations to consider the partnerships or collaborations they will need to succeed. The network of partners and collaborative relationships that were established when the hospital conducted its community health needs assessments is a good place to begin when identifying opportunities to address a population's health concerns. Public health departments and other social service agencies have years of experience and expertise to contribute to collaborative public health efforts.

Trustees should recognize that they themselves are a good resource for identifying potential partnerships and collaborations. Lay trustees in particular can contribute new,

different and community-based views of unique partnerships and collaborations. Trustees generally have networks of community contacts that can lead to new and innovative alliances for improving the community's health.

Clear Accountabilities. As hospitals and health systems forge new relationships with others in the community, the ability to navigate a path to success is often dependent on clear expectations set from the beginning, which are understood and agreed to by all parties. Expectations should include roles, responsibilities, goal and objectives, and project plans, all well-defined and agreed upon.

Measured Outcomes. To demonstrate improvement and ultimately earn revenue in a value-based system, the organization must have the ability to establish a baseline of measurement and track and measure outcomes and improvements in quality, patient safety and health.

Data and Technology. Data and technology may well be among the most important resources for successful population management. In its report on population health management, the Institute for Health Technology Transformation noted that electronic health records and automation support "essential population health management functions, including population identification, identification of care gaps, stratification, patient engagement, care management, and outcomes measurement."3

Available Resources. Investment in hospital infrastructure in support of population health comes at a time when hospitals are also facing lower patient volumes, reduced operating revenue and growth in expenses that outpace revenue.6 Hospitals must carefully assess their resources and prioritize

Critical Actions for Trustees

Hospital CEOs overwhelmingly agree that hospitals need to implement population health strategies; others in the health care arena predict that population health management will be a required core strategy.[3,4] Are you and other members of your board prepared for this leadership responsibility?

1. Does your board have a good understanding of population health management and its importance to your organization?

2. Does your hospital or health system have the infrastructure necessary for managing population health? If not, what actions does the board need to take to ensure the hospital or health system is able to develop population health management as a competency?

3. Do you know what strategies the organization is pursuing to manage and improve population health? Does the board maintain adequate oversight to ensure successful outcomes?

4. Do you know what efforts others in your community or region are pursuing to manage and improve population health? Are your efforts well-aligned or are they duplicative? Could joining forces create a more successful outcome for the community?

5. Is your organization maximizing its resources, efforts and potential impact through partnerships and collaborations? If "the whole is greater than the sum of its parts," what opportunities should or could the organization pursue?

health improvement initiatives accordingly. The board must lead the way in establishing partnerships with others who will share the responsibility for improving the community's health and best maximize the benefit of scarce resources.

system, success is increasingly defined not only by financial viability, but by the organization's ability to fulfill its promised mission to positively impact and improve the health of its community.

How is Success Defined?

Ultimately, the hospital or health system's board of trustees is accountable for the organization's success. In a value-based

Sources and More Information

1. Managing the Population Health: The Role of the Hospital. Health Research & Educational Trust, Chicago. April 2012. Accessed at www.hpoe.org.

2. King, Anna. Wenatchee Latino Population Encouraged to Hike Outdoors for Health. *NW News Network.* June 9, 2014.

3. Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare. Institute for Health Technology Transformation. 2012. http://ihealthtran.com/pdf/PHMReport.pdf.

4. Association for Community Health Improvement. Trends in Hospital-Based Population Health Infrastructure: Results From an Association for Community Health Improvement and American Hospital Association Survey. December 2013. Chicago: Health Research & Educational Trust. Accessed at www.healthycommunities.org.

5. Jarouse, Lee Ann. IT and the ACO. *Hospitals & Health Networks.* June 10, 2014.

6. Moody's Investors Service. US Not-for-Profit Hospital Medians for FY2012 Show Weaker Performance, Rising Expenses. August 23, 2013. www.moodys.com.

7. The Second Curve of Population Health. Health Research & Educational Trust, Chicago. March 2014. Accessed at www.hpoe.org.

8. American Hospital Association. CEO Insight Series: The Importance of Community Partnerships. Community Connections. November 2012. www.ahacommunityconnections.org.

9. Live Well Northwest Florida. http://livewellnwfl.org.

Q: What is the board's responsibility for ensuring a positive workplace culture?

Attracting and retaining motivated, dedicated, high-quality employees is a continual challenge, one that will become even more critical as the workforce ages, demand for success escalates, and competition for qualified health care workers intensifies.   The board of trustees plays a pivotal leadership role in ensuring their hospital has a workplace culture that will attract and retain a high-quality workforce prepared to meet both today's and tomorrow's community needs.

Without enough qualified caregivers and support staff, hospitals will not be able to successfully meet the growing health care needs of their communities. With the passage of health care reform legislation and an aging population, hospitals must be well-prepared for increasing service demands at the same time that physician, nurse and allied health professional workforce shortages are looming.

The shortage of needed hospital professionals is a critical challenge for hospitals, and should be a priority for their boards of trustees. According to American Hospital Association (AHA) research, the pipeline of new graduates from nursing, pharmacy, and allied health education programs is insufficient to meet emerging demand across the nation. Resolving the workforce shortage will take action on many fronts, very importantly through retaining valued and essential health care workers by improving employee commitment and loyalty to the organization and its community health improvement mission.

Today's health care workforce is changing, and the way people access health care services in the future will change – from new technology to in-home care to medical homes. As the field moves forward to embrace a new generation of caregivers and new ways of providing care, boards of trustees must set the agenda and provide the will and resources to ensure their organizations' success. Employee motivation, dedication, commitment and loyalty, as well as encouragement of creativity and employee empowerment to use technology and people in new and innovative ways, will play critical roles in

quality and patient satisfaction improvement, and employee recruitment and retention. Hospitals' ability to successfully meet patient, payer and community needs will be dependent on hospitals' ability to ensure a workplace culture in which employees are valued, involved, engaged and empowered to play a vital role in achieving the mission and strategic objectives.

New Times, New Workforce Needs

Health care organizations have been coping with a workforce shortage and the impending retirement of the baby boomers for many years, but the causes of and solutions to the continuing shortage are evolving, driven by the direction of health care transformation, technology innovation and consumer expectation. While in the past the shortage was in large part addressed by increasing the supply of caregivers, trustees and hospital leaders must re-think the ways they will prepare for and address solutions to future workforce shortages.

The American Hospital Association's 2009 Long-Range Policy Committee evaluated the workforce issues that health care organizations will likely face in the coming decade, and developed recommendations and tools for hospitals to develop successful workforce strategies in the AHA report, *Workforce 2015: Strategy Trumps Shortage*. As trustees work with senior leaders and medical staff leaders to develop a workplace culture and workforce development strategies that will ensure success in meeting future needs and opportunities, they should be prepared for the changes in the way health care

is delivered. Trustees and senior leaders need to understand the imperative to use employees and technology differently in a transformed and technology-driven environment. Key findings included in the AHA *Workforce 2015* report include:

- New scientific developments are occurring in the area of biomedical sciences, biomedical materials, medical devices, and computer services;

- Reimbursement is shifting from payment for individual services to payments for episodes of care, requiring coordination amongst multiple providers;

- Payments will be based on achieving quality measures, and penalties will be experienced for poor outcomes;

- There may be fewer uninsured patients, and more patients will be covered by governmental programs, particularly in the wake of the Patient Protection and Affordable Care Act (ACA);

- New care models, such as ambulatory, home and community care will become more prevalent, replacing traditional inpatient care, and new communication and monitoring technologies will be increasingly used; and

- Broad implementation of electronic record keeping, monitoring and reporting will enable patients and providers to communicate real-time.

Although There Are Fewer Employment Vacancies Today, the Long-Term Outlook Remains the Same. Experts have predicted a shortage of nurses, pharmacists, primary care physicians, and allied health professionals for years. The recent recession temporarily alleviated health care workforce challenges for some organizations, in part because demand for services was also down in some areas, and many hospitals reported having to lay off employees.

The greatest current shortage of physicians is in primary care, with only 30 percent of U.S. doctors specializing in that field.[1] Reports estimate that 65 million people presently live in areas designated by the federal government as having a shortage of primary care providers—and those estimates are before more people receive insurance coverage through implementation of the ACA. The American Hospital Association reports that by 2020, the U.S. will face a shortage of 91,000 physicians, divided about evenly between primary care physicians and specialists.[2]

All Business Sectors Will Face a Tighter Labor Market, Not Only Hospitals. Over the past several decades the U.S. workforce has fared well for several reasons: a large number of women have entered the workforce, and the number of baby boomers working far out-weighed the small number of people born during the Great Depression who were retiring. Requirements for the future health care workforce are different for two compelling reasons: 1) the aging population will need more health care services, and 2) there simply aren't enough up-and-coming health care workers to off-set the large numbers of retiring baby boomers. According to the U.S. Bureau of Labor Statistics, projections for the decade from 2006 – 2016 estimate that 15.6 million jobs will be available, but the civilian labor force will only increase by 12.8 million people. This disparity means that health care organizations across the nation will be seeking additional caregivers to meet an increased demand for services at the same time that all other industries will also be developing initiatives to attract the same labor force.[3]

The challenge for health care organizations is amplified by the projected increase in demand for services, resulting in greater shortages of physicians, nurses and other allied health professionals.. And while an increase in enrollment in medical schools is anticipated over the next ten years, most of those students will not have completed their training by 2020. In addition, training for nurses, therapists, and other health care providers is limited by school budget challenges, faculty shortages and space limitations.

The combination of increased competition for qualified, skilled health care employees and the fact that higher education programs turning out health care providers will not be able to keep up with market demand places a new challenge on health care leaders: not only is recruitment and retention more important than ever, but the way that health care leaders think about how the future workforce will be used and managed will require greater creativity, foresight and leadership thinking.

Traditional Staffing Practices Will Change. Because of the long pipeline for training and producing health care professionals, the supply of graduates increases slowly. Many hospitals and health systems simply won't have enough physicians and other caregivers in the next decade to provide the care that will be demanded.

As hospitals anticipate a tighter labor market and more competition for highly qualified health care workers moving forward, they will not be able to successfully recruit and retain staff to work in a work environment known for being stressful, hectic, unappreciative or threatening. Boards of trustees have the power to demand an environment that improves efficiency and effectiveness, nurtures workforce loyalty and dedication, and improves the patient experience.

Hospital boards of trustees can play a vital role in encouraging

Workplace Problems the Board of Trustees Should Provide Leadership to Avoid

The following challenges have the potential to be detrimental to employee morale and ultimately to the organization's overall performance.

1.	*Dysfunctional leadership team.* Lack of a cohesive, unified leadership team sends a mixed message to employees and can cause divisiveness among the leadership team as well as employees that take "sides" with specific members of the leadership team.
2.	*Uneven and inconsistent performance evaluation process.* Lack of consistency in the manner in which employee evaluations are conducted can not only result in employee perceptions of unfair promotions and a poor employee-management relationship, but it also tends to coincide with employees receiving little feedback (positive or negative), limiting employees' ability to improve their performance.
3.	*Lack of organizational transparency and sharing of information.* Building employee morale and a sense of trust is difficult when employees do not feel included in organizational decisions. For example, employees should never read about organizational news in the newspaper before hearing it first at work.
4.	*Unclear mission, vision and strategic direction.* Although the board and leadership team may have a clear direction for the future, if it is not clearly communicated to employees they may feel that the organization has no direction and/or decisions are made without a "bigger picture" in mind.
5.	*Confusion in organizational structure and functions.* Employees must know who they report to, who conducts their annual evaluation, and understand the "chain of command" if they need to discuss an issue with someone above their immediate manager or supervisor.
6.	*Lack of a sense of value.* Employees must feel valued and appreciated; although constant feedback from co-workers is critical, positive feedback from management as well as the executive team plays a crucial role in ensuring that employees feel appreciated.
7.	*Culture of blame.* Developing workable solutions to problems without placing blame is a key factor in quality improvement. Likewise, employees and managers should not engage in "finger-pointing" and placing blame on one another when problems arise, but should rather use the occasion as an opportunity to pinpoint a performance gap that must be closed.
8.	*Inconsistent and mixed communication.* Employees must feel that they are valued enough for the leadership team to share current issues and decisions, as well as seek employee ideas and input before making decisions that significantly impact employees and their patients.
9.	*Lack of interaction and decision protocols.* Lack of a clear definition and adherence to simple protocols addressing reporting relationships can create animosity among employees, supervisors or managers that believe their authority and responsibility has been undermined.
10.	*Rumors, misinformation and mixed messages.* Lack of effective communication can result in rumors about the organization or mixed messages from the leadership team, leading to a confused workforce and a perceived lack of management consensus and cooperation.

the right environment, providing the resources necessary and asking key questions of organizational leaders about what they are doing to be creative in redesigning work processes, using new technologies to increase efficiency, effectiveness and employee satisfaction when possible, and making the workforce the hospital's most vital quality and patient safety asset. The most successful work redesigns are developed by front-line workers who create solutions customized to their work environment, culture and patient needs. Recent studies provide additional information about innovative work models, including the Transforming Care at the Bedside Project conducted by the Institute for Healthcare Improvement and tools on the Agency for Healthcare Research and Quality website focused on work design (http://teamstepps.ahrq.gov).

Workforce Shortages Have Quality and Safety Implications

Shortages of personnel have many potential implications. Not least among them is a higher likelihood of errors. Labor shortages may force organizations to require overtime, which is not only expensive, but for some categories of health care professionals poses a risk to patient safety. In November 2003, the Institute of Medicine (IOM) stated that the long hours many nurses work is one of the most serious threats to patient safety as decreased reaction times and energy can result in a reduced attention to detail. A study by the University of Pennsylvania School of Nursing found that nurses who worked shifts lasting more than 12 hours (at least 12.5 hours) were three times more likely to make an error than nurses who worked less than 8.5 hours.

Retention and recruitment become more difficult as health professionals seek to avoid an environment in which they are over-worked. Workforce shortages may also force organizations to utilize contract employees. The use of contract employees, such as "agency" nurses, is expensive and places additional strains on employees as they assist non-employed health care workers who do not understand the organization's policies, procedures and protocols.

Creativity in Retaining Current Staff

Retaining current valued health care professionals is the first and most vital step in preparing to succeed despite coming workforce shortages. Creating an environment that strengthens employee commitment and builds employee loyalty reduces turnover and makes recruitment of new employees less expensive and time-consuming. Hospital leaders should consider several approaches as they develop retention strategies.

Find Ways to Motivate and Retain Employees on the Edge of Retirement. Retaining employees close to retirement is an opportunity to minimize shortages while simultaneously capitalizing on their years of training and workplace experience and expertise. While older employees may not be able to or be interested in working the same rigorous schedule as younger employees, they can bridge a critical gap by providing training, mentorship, and other roles that utilize their extensive experience and expertise.

The current economic downturn may strengthen this opportunity for health care organizations, as many employees nearing retirement may choose to postpone their retirement due to declines in their retirement funds and other investments. According to a 2009 survey conducted by the Employee Benefit Research Institute (EBRI), 72% of workers report that they expect to work for pay in retirement. Although it is unknown whether current economic challenges will alter these predictions, some experts predict that the percentage of workers interested in working past the typical retirement age will increase even more.

Understand and Adapt to the Needs and Goals of Different Generations. Today's workforce is generally comprised of four unique generations: 1) Traditionalists (born before 1945); 2) Baby Boomers (born between 1946 – 1964); Generation X (born between 1965 – 1978); and Millenials (born 1979 – present).

> **Boards of trustees and senior leaders must continually strive to find new and innovative ways to seek employee feedback, and demonstrate that employee ideas and opinions are highly valued.**

Each generation has unique workplace priorities and preferences, and successful workplace cultures must respond to each of these generations at the same time. The board must ensure the necessary flexibility and creativity that ensures that each generation's unique needs and desires are met – whether it's more flexible schedules, employee empowerment, encouraging innovation, or simply more enjoyment in the workplace.

According to the AHA report, the typical hospital culture does not match the work expectations of the Millennial generation (the generation born between 1979 and the present). For example, while the typical hospital culture is hierarchical, with fixed schedules and hours, the younger generation seeks greater workplace flexibility. In addition, the Millennial generation is more likely to seek to use computers, virtual networks, texting and other technology tools in their work. Hospitals must evaluate their cultural capacity, and determine their ability to attract employees in this generation.

New Opportunities for Care Delivery. Many health professional associations are raising education requirements an seeking to expand their opportunities to practice. Physical therapists may now earn a Doctor of Physical Therapy (DPT), and envision opportunities for direct access and patient referral in the future. Similarly, nurse anesthetists seek to administer anesthesia without physician supervision, and nurse practitioners seek to be recognized as licensed, independent primary care providers. The role of the pharmacist as a health provider is also garnering increasing attention.[4, 5]

As health care providers' roles evolve and the health care field shifts to an environment focused on coordinated care, bundled payments, ACOs and medical homes, hospital leaders must be forward-looking and creative, preparing for a changing industry combined with the impending increase in demand for health care. The shortage of primary care physicians is rapidly advancing deliberations to expand the nation's delivery of care to encompass broader roles by other professions; however, many of these professions are expecting shortages of their own. According to the American Hospital Association, the largest percentage of unfilled, budgeted positions in U.S. hospitals are registered nurses (RNs), followed by licensed practical nurses (LPNs), pharmacists, imaging technicians, nursing assistants and laboratory technicians. The combination of workforce shortages and a greater emphasis on coordination

of care across provider types and care settings is a trend that hospital leaders should be preparing for today. Health care reform will continue to push hospitals in this direction, and it is an opportunity for hospitals to capitalize on now to stay ahead of the curve.

Being Proactive in Today's Environment. Resolving the shortage on a national basis will require action on several fronts locally—from new opportunities for care delivery to new recruitment and retention strategies. Experts agree that one of the most significant challenges associated with health care reform is the projected increase in demand combined with the expected shortage of providers. To address this, the ACA included the development of the National Healthcare Workforce Commission, a 15-member commission created to investigate health care workforce challenges and potential solutions. While the members of the non-partisan commission were appointed in 2010 after the ACA was passed, the group has never met. Republicans have blocked funding of the Commission, preventing the group from meeting or having any work or contact with one another until funding is implemented.[6] Despite political gridlock preventing federal action, health care organizations across the country are increasingly exploring alternative options. The American Hospital Association predicts that new delivery models will include "more primary care-based, easy-access, low cost models for patients to receive certain services such as immunizations and school physicals." Realistically, the current primary care system of physician offices and hospital emergency departments is not practical—physician offices will be overloaded, and emergency departments are too expensive and unnecessary for non-emergency care. One low-cost alternative predicted by the AHA and others is retail-based clinics, which can provide vaccines and basic primary care in a more cost-effective, timely manner.[2]

Physician Integration. Whether hospital leaders are considering an ACO or simply preparing for payment incentives that are based on patient outcomes, hospital/physician relationships are essential. Health reform encourages more than hospitals and physicians cooperating to care for patients. It requires hospitals and physicians to provide integrated care - care that is coordinated, uses seamless technology, and involves providers across the spectrum working together to care for each patient as an entire "episode of care." This is a new shift in thinking for most health care leaders, but a necessary shift for both predicted changes in reimbursement and provider shortages. Trust has been a longstanding barrier in hospital/physician relationships, and a

recent study by the PricewaterhouseCoopers Health Research Institute shows it continues to be. When asked whether they trust hospitals, 20 percent of physicians surveyed said "no," and 57 percent said "sometimes." At the same time, physicians are seeking to reduce their risk and increase financial security. In the same survey, nearly three-quarters of physicians said they are already aligned financially in some way with hospitals, including directorships, employment, and joint ventures.[2] Hospital trustees and leaders should be preparing for these growing partnerships, working jointly with their medical staff and other community providers to develop shared solutions and forge relationships that will provide better care and prepare all health care providers for a more stable and effective future.

Governance Leadership Actions to Help Ensure a Positive Workplace Culture

Be Involved At the Right Level. The board of trustees should ensure that the executive team has a plan of action to achieve specific organizational goals, such as employee and provider loyalty and satisfaction, living the organizational ethics and values, employee empowerment, growth, quality and patient safety, etc.

Ensure Meaningful Performance Evaluation Methods and Results. The employee performance evaluation process should ensure that:

- Managers conduct employee evaluations at least annually;

- All employee evaluations include a dialogue between the manager and employee, providing positive and constructive feedback;

- The process effectively evaluates employees' performance in meeting their job descriptions, overall organizational expectations, and assisting the organization in achieving its mission, values and vision; and

- Employee evaluations are conducted fairly and equitably, including if or how employee compensation is affected based on employees' annual review process.

Involve Employees in Organizational Decision-Making, and Recognize High Performance. Boards of trustees and senior leaders must continually strive to find new and innovative ways to seek employee feedback, and demonstrate that employee ideas and opinions are highly valued. When seeking employee ideas, management must follow-up on the feedback received,

take action and update employees on the status of their ideas and suggestions, and keep the board of trustees aware of trends in employee satisfaction and engagement.

Management recognition of individual accomplishments and achievements is also essential; while praise from co-workers is meaningful, and receiving rewards and recognition from the executive team and/or the board is a critical component of employee morale. Developing cross-functional teams comprised of employees and managers can help organizations develop approaches to recognize and reward their high-performing employees.

Ensure Organizational Transparency. Increasing the transparency of operations can help organizations to improve employee satisfaction. For some organizations, becoming transparent requires a cultural change. Transparent organizations allow employees to see and share information and make suggestions. They communicate strategies and objectives to employees, and provide regular updates about progress toward achieving those objectives. Updates may include specific metrics the organization is striving for, challenges identified for the future, financial information, and the organization's progress in meeting community needs.

Identification and recognition of the challenges facing the workforce enables hospitals to redesign work and workplace environments so that they are able to offer careers that attract, retain, and develop the "best and the brightest" in adequate numbers. Nurturing a positive workplace culture should be a prominent part of the board's strategic agenda.

Sources and More Information

1. Neergaard, Lauran. Law Will Make Doctor Deficit More Acute. The Associated Press. March 29, 2010.

2. American Hospital Association. 2013 Environmental Scan. www.aha.org.

3. American Hospital Association. Workforce 2015: Strategy Trumps Shortage. www.aha.org.

4. Mertens, Maggie. Primary Care Shortage Could Crimp Overhaul. Kaiser Health News. March 22, 2010.

5. The American Academy of Nurse Practitioners. www.aanp.org.

6. Pear, Robert. Panel on Health Care Work Force, Lacking a Budget, Is Left Waiting. The New York Times. February 24, 2013.

Q: What is the board's accountability for ensuring the right organizational structure?

The health care system is under transformation. Hospitals are seeking new ways to deliver value-based care and improve the health of their patients and communities. The lingering effects of the economic recession and now health care transformation on hospitals are well-evident, and trustees must demonstrate strong leadership to navigate through the challenges. Many hospitals and health systems are aligning and integrating services across the continuum of care, but at the same time are confronting significant financial pressures as they seek to cross the chasm from a fee-for-service based system to a value-based payment system.

The need to make changes and to ensure long term financial stability and services for the community is leading many hospitals and health systems to consider some form of affiliation with another organization that can bring financial strength and resources to help them achieve their mission and vision. In order to determine the alternative that best suits a hospital, it is imperative for the hospital's governing leadership to take a long-term view, and carefully determine the approach that will best ensure the development, continuity and security of the community's health care. The organization must be operated and structured to provide flexibility and responsiveness to the community's current health needs, and be able to effectively and successfully respond to emerging health needs.

The hospital's board of trustees should consider the following key questions as it evaluates any change to its present organizational structure:

- What is the organization's most viable and valuable health care role, both now and in the future?

- What is the organization's position in the regional health care continuum, and how can that position be solidified?

- What strengths and assets are most critical for the organization to possess?

- What types of management and operating resources does the organization need to have access to in order to meet future community and organizational needs?

- How should the organization be structured to be able to best meet the health needs of the community? Is the status quo the best alternative, or something else?

Overview of Operating Structures

Hospitals have several options for changing ownership, affiliations and structure. The best option will be determined as a result of a careful examination of the hospital's current operating performance, resources and needs, projections of future needs, challenges and opportunities, assessment of national and local health care trends, and community needs. Below is a brief summary that describes four basic organizational alternatives, which is followed by a summary of the advantages and disadvantages of each alternative.

Independence. Some maintain that an independent hospital cannot be fully effective and successful in meeting the community's health care needs in today's complex and rapidly-changing health care environment. However, a case can also be made that an experienced, professional and capable CEO, working closely and effectively with an educated, motivated, responsible and committed board of trustees and medical staff, can still be successful in today's challenging environment.

The keys to success as an independent hospital are leadership, vision, capital, and community loyalty and commitment. The administration and the board must be able to anticipate and aggressively and effectively deal with the multitude of complex issues facing the hospital, operate successfully in a climate of

rapid change, offer uniqueness and distinctiveness in services and customer service, deliver high quality that meets or exceeds patient needs and earns patient and community loyalty, and be able to preserve or expand market share in the service areas provided.

Advantages of independence may include:

- Continued status as community-owned and community-governed;

- CEO reports directly to the board of trustees, ensuring clear and direct lines of local responsibility and authority;

- Flexibility in making operating decisions and changes without outside interference; and

- Preservation of current structure and identities.

Disadvantages of independence may include:

- Current financial and utilization trends may inhibit ability to improve services and long-term viability;

- Potential for narrow, isolated decision-making may cause the hospital to miss opportunities;

- Fewer options to access capital;

- Greater vulnerability to competitive threats; and

- Lack of immediate, ready access to needed personnel.

Management Contract. Operating successfully under a full-service management contract requires strong communication between the organization, its board and the management entity, and a clear understanding of and agreement to mutual objectives and expectations.

When management contract arrangements fail it is often because the hospital client does not adequately analyze and understand its true needs, select the appropriate management firm, structure an appropriate, mutually-beneficial contract, and then manage the contract to ensure that the hospital's goals, services and actions are directly related to those needs.

There are two types of management contracts a hospital could consider: 1) full-service management contract with a hospital management company; and 2) management contract with a regional hospital or hospital system that can offer access to the range of management services the organization needs.

Advantages of a management contract may include:

- Continued status of the hospital as a community-owned, community-governed and locally-managed organization;

- Governing autonomy and flexibility preservation;

- Management company experience provides access to proven and tested systems and programs that may be successfully adapted to the hospital's needs;

- Easy and immediate access to a broad range of key personnel and management company resources makes it convenient for the organization to access needed assistance quickly;

- Opportunity for information exchange with other managed hospitals with similar needs; and

- Flexibility to terminate the management contract if the board of trustees becomes dissatisfied with the management company's performance.

Disadvantages of a management contract may include:

- Added cost of the contract to already strained financial resources;

- Loss of decision-making autonomy and flexibility (based on contractual provisions);

- Potential to develop a "dependency" on the management company's products and services making any necessary return to proprietary management difficult;

- Potential to lessen somewhat the board's sense of community and fiduciary responsibility and accountability;

- Key personnel are employees of the management company, not the hospital. Management "loyalty" is to both the board of trustees and the management company; however primary loyalty will likely be to the actual employer (the management company), on which key personnel rely for future opportunities;

- The organization pays for broad access to a range of services it may not need or utilize;

- May reduce or eliminate "comparison shopping" for vendors in key areas where the management company provides products and services.

Lease to or Merger With Another Health Care Organization.
A hospital lease is essentially a contract that gives possession of hospital land, buildings, equipment and services to a lessee for a specified period. Under a lease arrangement the organization gives full use and responsibility for the facility to another party to manage and operate as it sees fit, within the parameters specified in the lease agreement. A merger is essentially a transaction through which one corporation acquires the assets and assumes the liabilities of another corporation.

Advantages of a lease to, or merger with another health care organization may include:

- Access to new sources of capital for equipment, salaries, physician recruitment, etc.;

- Streamlined, fully integrated decision making may create greater operational flexibility;

- Ability to improve competitiveness in the areas of cost, quality, and outcomes;

- Proceeds from the transaction, if any, to a newly-formed foundation (or other not-for-profit entity), which may be used in a variety of ways consistent with the hospital's mission;

- Predictable source of income over the life of the lease;

- Potential role for some form of local advisory board governance;

- Elimination of business risk;

- Single point of decision-making streamlines and speeds the decision process;

- Improved ability to align services and operations; and

- Opportunity to streamline governance and operational decision-making and direction.

Disadvantages of a lease to, or merger with another health care organization may include:

- Loss of control: policy control is in the hands of the lessee or new entity;

- At some point the hospital may seek to regain control of operations, and could be required to assume significant costs to do so successfully;

- Under a lease, the philosophy and standard of care of the lessee prevails; there is no absolute assurance that services provided will match community needs;

- Under a lease, the cost of payments to the lessor becomes a new cost to the lessee, making it more difficult for the lessee to build a positive bottom line;

- Potential reduction in autonomy and identity; and

- Community preference for an independent hospital.

Strategic Affiliation. A strategic affiliation is typically a looser arrangement under which two organizations agree to work together contractually to achieve a broad set of objectives. Strategic affiliations may take many different forms, with a variety of mutual commitments.

A strategic affiliation, under the right circumstances, may enable economic, governance and programmatic integration that could benefit a hospital and its employees, physicians and patients. It could also enable more streamlined payer contracting, and better coordinated management, governance and strategic planning. Services could be integrated and broadened, and managed care contracting strength could be enhanced.

Advantages of a strategic affiliation with another health care organization may include:

- Ability to benefit from the name and reputation of a larger, well-respected organization;

- Improved professional advancement potential for employees;

- Ability to improve competitiveness in the areas of cost, quality, and outcomes;

- Improved access to capital;

- Ability to reduce unnecessary duplication of services through appropriate service consolidation;

- Ability to be a part of a broader network of providers;

- Ability to be part of a unified managed care contracting effort; and

- Ability to develop seamless joint initiatives.

Joining Forces: A Trustee's Guide to Organizational Affiliations

Disadvantages of a strategic affiliation with another health care organization may include:

- Potential reduction in hospital autonomy and identity;

- The philosophy and standard of care of the controlling entity prevails; there is no absolute assurance that services provided will match community needs, or how and where services will be delivered; and

- Community preference for an independent hospital.

Regardless of the organizational structure choice made in today's difficult economic environment, it is the board's responsibility to ensure that the choice strengthens the hospital's ability to achieve its mission and vision, and secures the long-term health care future of the community.

Questions to be Addressed

- How satisfied is the board with the progress the hospital has made in the last five years?

- Is the hospital mission still an accurate description of the hospital's purpose? If not, what should be changed?

- Is the vision an accurate picture of what the hospital should be striving to become? If not, what should be changed?

- What are the most significant characteristics of the hospital's current situation (e.g. market position, financial position, competition, opportunity for expansion, etc.)?

- What are the most dominant issues facing the hospital today? Short-term (next 12 months)? Mid-term (1 to 3 years)? Long-term (over three years)?

- What are the unmet or under-met health care needs of residents of the hospital's service area?

- What local market trends are most critical to understand in shaping the hospital's strategic future?

- What major assumptions should be made about the environment that will impact the hospital's ability to achieve its strategies (e.g. the economy, competition, reimbursement, inflation, etc.)?

- What is the hospital's unique, market-based vision in key success areas (e.g. managed care, community health status, premier provider, delivering value, affiliations, community leadership, public trust, accessibility, appropriate services, innovation, financial health, etc.)?

- What factors are most critical to the hospital's success over the next 1 – 3 years (e.g. cost efficiency, quality, technology, community support, information systems, patient and payer satisfaction, employee development, service innovation, consolidation, external relationships, market coverage, etc.)?

- What limiting factors will the hospital have to overcome to be successful?

- Where does the hospital have the most potential for growth? What services should the hospital consider in order to further solidify its market position?

- What are the hospital's major strengths and competitive advantages? What are its significant weaknesses and competitive liabilities?

- What market niches or opportunities are most critical for the hospital to capitalize upon (short-term, mid-term and long-term)?