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Building a Better Healthcare Board

Philip Betbeze, for HealthLeaders Media, May 13, 2013

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For decades, healthcare has been a complex, highly regulated enterprise. However, senior leaders and the boards that supervise their work could at least count on an industry of relative stability and predictability.

In 2013, that's no longer the case.

With unprecedented upheaval in reimbursement and changes in quality and safety standards already under way, with more to come, organizations are under pressure to either remake their business and clinical processes themselves or find a willing partner that can help. As the industry consolidates around them and as dance partners for the future are chosen, proactive boards are starting to realize where they are falling short.

And falling short they are.

The HealthLeaders Media Industry Survey 2013 finds that while 66% of CEO respondents say their boards are strong or very strong, 11% say their boards are weak or very weak. While that latter figure may not seem like a high percentage, only 2% of CEOs have the same low opinion of their leadership team and only 5% give such weak ratings to their physician, nursing, and finance staffs.

Whether boards are too large, too unwieldy, or in some cases have members who are underqualified to effectively provide strategic direction in conjunction with executive leadership, many of them need help to deal with the new realities of healthcare.

Uncertainty and a declining future revenue picture have a funny way of kick-starting action. Many healthcare boards, realizing they may have a deficit of skills and savvy, are now running at top speed to gain the knowledge and depth of expertise necessary to help lead their organizations.

"We're all going into a new world here that is really not well defined," says David Goldsmith, board chair at John Muir Health in Walnut Creek, Calif.

A crisis situation?

Gary Ahlquist is a senior partner at the Chicago location of Booz & Co., a global management consulting firm, and specializes in healthcare strategy and organization development. He says the level of uncertainty surrounding future reimbursement and quality and safety standards has pushed boards to seek to work directly with his team, where in the past, most of that work was done with senior management exclusively.

"Generally you would do strategy with the CEO and the executive team, but boards are apoplectic," he says. "It's not that they distrust management, but they feel such a level of uncertainty that they want us to help assess strategy together with management."

Ahlquist says his research shows that the healthcare sector, especially hospitals, could see a 20%–25% net revenue decline in the next five to 10 years.

"One result of that, plus other factors, is that we expect somewhere around 1,000 hospitals to be realigned or reaffiliated," he says.

That number represents about a fifth of the current number of now-independent entities, mostly hospitals, that Ahlquist says will no longer be so, depending on the posture of the federal government surrounding consolidation. That's a lot of hospital boards facing the possibility of their dissolution and considering a very different future for their organizations.

But first, many boards have to get educated to be equipped to thoughtfully consider the long-term viability of their organization. In addition to owning and leasing hospitals, Community Hospital Corp., based in Plano, Texas, runs a consulting arm that spends about half its time with boards considering strategic alternatives to independence.

Mike Williams, the company's president and CEO, says getting to the point of understanding the forces acting upon those hospitals related to the Patient Protection and Affordable Care Act requires some remedial work with board members.

When they or their CEOs hear about big systems merging for protection, offering as an example the Baylor and Scott & White Healthcare merger in Texas that was announced recently, Williams says boards are wondering what the big organizations know that they don't.

"We're spending a lot of time educating them as to the impact of the ACA, the impact of bundled payments and alignment with medical staffs, and we're challenging them to test factually and quantitatively the viability of their organization on a standalone basis."

Williams says changes to the way boards conduct their business are myriad, but that in many cases, the changes aren't happening fast enough. For example, nominating committees are looking at competencies and asking whether certain individuals are

capable of understanding this complex industry, whether they are willing to make tough decisions, whether they are able to invest the vast amount of time that being a hospital board member takes, "because the one-and-a-half-hour lunch board meeting is history."

Progressive boards are making the effort to ensure there is a rotation of terms and an opportunity for members to become educated about healthcare. That means maintaining their position for enough time to make a difference. Increasingly, best practice recommends three three-year terms as a commitment.

"It takes one to two years to understand what's going on," says Williams.

Once a committed, well-rounded board is in place, the committee structure is much more robust than ever before, particularly in the quality committee, he says.

"Ten years ago, how many boards had an active quality committee? Very few," he says. "Now, boards not only have one, but it's the most active of the committee structures," Williams says.

The quality function traditionally had been relegated to the chief medical officer and physician representatives on the board. Now, quality committees have multidisciplinary clinical representation and are actively looking at criteria-based results, especially when it comes to public data. And audit and compliance committees are more active than ever before.

Historically, one of the first reports in the board meeting was from the finance committee, Williams says. Now, quality and compliance are at the top of the agenda.

In the past, competent board members who looked at themselves as business leaders delegated clinical matters to the physicians. "But now they really have to understand clinical outcomes, how they're being graded, and how it affects reimbursement," Williams says.

When their education about the forces acting upon their organization in today's healthcare marketplace is sufficient, Williams says board members can be a big help in working in the public arena on advocacy and the education of legislators.

"Once they really understand what's happening in healthcare due to the ACA and other business imperatives, they can call legislators and explain how their decisions will affect the hospital with which they serve on the board," he says. "A lot of these people are highly influential anyway, and if they can speak with understanding to the issues, that makes a lot of difference to the elected official."

The most obvious change in boards Williams has dealt with is the sense of accountability they now place on the CEO. Historically, the board may have been led by the CEO and the directors simply affirmed his or her decision-making. Now boards are much more engaged in setting strategic vision for the organization and holding management accountable for achieving that through operations, he says.

"But they're saying, 'Don't just do it, show us how you're achieving that vision,' " he says. "There are some CEOs who are not as excited about having board members in their business as they should be, but thank goodness it's happening."

In an anecdotal example, CHC and Williams were called in to assist a hospital in an urban marketplace that he prefers not to name for obvious reasons. "They have a history of success. You would know them," he says.

On the day Williams arrived to meet the board and attend his first meeting, the board chairman opened the meeting by reminding his colleagues to get their continuing education trips scheduled, and that hospital administration would make arrangements for them. He suggested many East and West Coast opportunities for board education at tony resorts.

"The irony of that is that he was encouraging them to spend money when they had three days cash on hand. Their heads were stuck in the sand, and that's because the CEO had not kept them informed about the hospital's need to change. They were on the brink of failure and they didn't know it."

Williams and CHC eventually led a multimillion-dollar turnaround there, he says, "through basic blocking and tackling."

But they were lucky. If a hospital is too far gone financially or has not retooled to better respond to the fact that it is being judged on other factors, board members may be in for a rude awakening, he says.

"There will be hospitals that will close. Many board members have never thought about living in a community where there was not a hospital, but for first time, they're being challenged by demographic and economic factors they have never faced before," he says. "I love to tell boards that the more control you desire to keep, the less access to capital you'll have."

Many times that is reflective of how an organization has been managed in the past, and there's only so much that can be done to change the pecking order now that so much time has passed and so many healthcare organizations are so far ahead of them.

Right mix and size

As a longtime Bay Area venture capitalist who has served on various for-profit boards over his career and on John Muir Health's for seven, David Goldsmith may be better prepared than most to help lead his board and advise senior management. But in light of the changes facing his board at the Walnut Creek, Calif.–based system that includes a 572-licensed-bed trauma center, another

313-bed medical center, and a 73-bed psychiatric hospital, he remains humble.

"I've been in healthcare for 40 years, but I'm still learning," he says.

John Muir Health's board, at 19 members currently, has a wide mix of backgrounds and expertise. Eight are physicians who are nominated by the medical staff and by their medical groups at each of the system's two hospitals and whose terms are limited to nine years.

The rest of the board is made up of community members of all stripes. As it serves a culturally and racially diverse population, Goldsmith says the board is careful to look at racial and gender diversity in addition to seeking out particular skills and perspectives the organization may lack.

But it may be too big. It can be tough to manage board composition when the somewhat competitive goals of community representation and range of expertise conflict.

"The literature on boards says you should be in the single digits," he says. "Seven or nine is the ideal number. We're in the high teens, which does put a lot of people in the room at the same time."

There is disagreement on ideal board size, though.

"We have 23 or 24 board members," says David Atchison, board chairman for 259-bed Elmhurst (Ill.) Memorial Healthcare. "Good governance would suggest we should have a 13- or 15-member board."

Regardless, both board bosses would prefer a smaller group than they have.

Balancing size and levels of expertise can give healthcare board chairs headaches.

Given the size of the John Muir Health board, Goldsmith says they have not as yet used executive recruiters to help find board members with certain skill sets, but that he has used them in the for-profit realm and would not rule it out.

"The risk in not doing it is that we tend to hear only about potential board members who look a lot like ourselves," he says. "We have talked about it, but I think in order to get a more diverse board, we may at some point turn to one of the recruiting firms."

The board at CaroMont Health, parent of 435-bed CaroMont Regional Medical Center just outside of Charlotte, has a more reasonable board size, according to the experts, but maintaining a board of only 14, 13 of whom are appointed by county commissioners, leaves little space for recruiting some of the expertise that Board Chair H. Spurgeon Mackie Jr. feels will be necessary to meet the goals of healthcare reform, among other strategic imperatives.

"We've given some thought to maybe expanding the board by maybe a couple more spots," says Mackie, an executive vice president with IberiaBank. "We've thought about allowing a couple of them to be from outside the county, partly because we have minor operations outside the county," and partly to find expertise that might not be available so close to home , he says.

Filling holes in expertise and skill

Especially in a community hospital environment, qualifications for membership on healthcare boards have traditionally been minimal. The most important aspect was always that the board reflected the community and had diversity of background and skills. That's no longer enough, say experts. By necessity, healthcare boards are becoming more thoughtful about how they recruit new members.

For example, recruitment for the board at Elmhurst had always been through word of mouth, with an emphasis on geographic representation in the service area, says Atchison, whose day job is president and CEO of Ponder & Co., an independent healthcare-focused financial services provider based in Chicago. Recruitment there has now become "more refined and thoughtful," he says.

"Now, we're looking for certain skill sets to complement the existing trustees, and it's important that we have physicians and other allied health representatives on the board," he says. "That said, we are more or less a typical community hospital board with people who have participated for a number of years, are civic leaders, and are interested in healthcare."

Though not speaking specifically about the Elmhurst board, that lack of specialization could be a problem for any community hospital, says Carol Geffner, PhD, president of Newpoint Healthcare Advisors, whose area of expertise is board governance strategy and change.

"One of the things I've seen firsthand is board members who do not understand, in depth, the linkages between transformation, culture, and physician alignment to performance and hospital reimbursement," Geffner says. That can show up in different ways. But having that expertise is critical because executive leaders will be expected to execute the strategy the board articulates. "Issues such as transformation and culture are now business issues, whereas in the past they might have been viewed as soft. Today they are directly tied to performance and reimbursement," she says.

Atchison, for one, seems to understand that. Whether the board has those capabilities or can attract them is less certain.

"As we move forward with consolidations in healthcare, we'll end up with multibillion dollar–revenue organizations," he says. "Those will seek to attract a higher caliber of trustees, if you will, that reflect a number of different skill sets or may not be in the service areas of the hospitals that they operate."

Elmhurst's board is not standing still on that front. It's created a governance committee to review its current structure and has engaged an expert to advise directors on how to integrate those skills into the board. Some of the ideas were implemented and others were deferred, but the whole process started with an education on best practices "and how we lined up against those, and then we started a work plan to, over time, implement them," Atchison says.

He says Elmhurst's board is deficient in several areas, but good to very good in others. For example, for reasons of history, he says, there are no limitations on tenure. Rather than implement term limits, as many other systems do, Elmhurst does an in-depth assessment each year of all the trustees.

Atchison says locating the high-level skill sets Elmhurst may need is not easy, even drawing from Chicago, the nation's third-largest city, which presumably would have experts geographically close by who could serve on the board.

"Very few nonprofit organizations have a specific plan to recruit specialists in certain areas," Atchison says. "They may be lucky in finding a great HR person in corporate America who lives in the community, for example, but I think that's the next step for community hospitals—to put in place a recruitment process and work plan that attempts to do that."

Technology and social media also are becoming important in governance, says Newpoint's Geffner. "Because of the trend and need for transparency, social media also now plays a major role relative to a hospital's public reputation, community impact, and brand. At the governance level in the post-reform environment, it is helpful for boards to factor in the impact of social media on strategic decision-making."

Goldsmith, of John Muir Health, identifies managed care expertise as one skill set that is on his board's recruitment matrix, and they are trying to fill that gap because he says that expertise might be the biggest deficiency for community hospitals accustomed to the fee-for-service world.

"Historically a relatively small percentage of patients have been at risk. But as we look to 2020, the majority of patients might be at risk," he says. "That turns everything 180 degrees from what we and other hospitals have been doing for 40 years."

Similarly, fresh ideas are needed. Goldsmith says his board, for example, would consider bringing in as a board member what he calls a "No. 2 or No. 3 individual" in a noncompetitive health system in a separate geographical area.

"I know of a number of nonprofits that have done that or are in the process of doing it," he says. "We have not, but I think it would give us some additional viewpoints—a pretty exciting win-win."

Mackie, of North Carolina's CaroMont Health, says his board and CEO identified a need for expertise on quality.

"As we were moving into quality, we wanted more of a scientific background," he says, so they recruited Sheila Reilly, PhD, a professor of biology at local liberal arts college Belmont Abbey. "She brought to the board a higher level of scientific background."

Focusing on strategy

Especially during this time of transition, boards should make sure they're focusing on strategy, not operations, says Goldsmith. That advice should be obvious, he says, but only relatively recently has his board really embraced that role.

"Historically, a lot of board meetings were taken up with committee reports and repetition of what's in the board package distributed before the meeting," he says. "But now we operate under the assumption they've read all that."

He says he makes sure to maintain that focus by stressing seven strategic objectives for the year on the first page of the board package distributed prior to meetings, and credits his predecessor, the outgoing board chair, for moving discussions more toward strategy.

"My expectation will be that if you come, I assume you've read it, and if you have questions, you'll pick up the phone and call the relevant executive before the meeting, get your questions answered, and be prepared to discuss strategy. Having said all that, it's always a battle. If the board is to be of any value, we have to focus on strategy."

Failing the ability to attract certain individuals to the board, Atchison seeks input from a wide variety of sources. Some experts, he envisions, could be guest speakers at part of the board meeting.

Such presentations could help board members understand the constituencies Elmhurst serves or the perspectives it could take advantage of, from managed care to strategic consulting to business development, nursing and marketing and brand management, and corporate leaders, like CEOs and CFO of large companies.

"Volunteer boards often largely take direction of the executive management team," Goldsmith says. "Increasingly, boards need to be more strategic and proactive in orientation and spend less time in oversight of operations."

Ahlquist says historically, this focus on strategy has come and gone in healthcare, especially at the board level. "In past years, changes in our industry tended to be focused on one aspect. Not to say they were small, but when HMOs came in, we saw disruption but not a lot of change at the Medicaid and Medicare level. Now everything is changing," he says.

Now, boards increasingly have to make participation decisions with other providers. They have to make strategic decisions on tech spending or the level of consolidation they're comfortable with. Ultimately, Ahlquist says, boards have to make the "big" decision: "Can or should we stay independent? Can we handle the level of change coming upon us or do we need a partner?"

CaroMont's Mackie says board members sometimes have difficulty recognizing the difference between being in leadership and governance, but CaroMont's board has evolved with what he calls stronger committees, adding that members do a lot of work through the committees rather than the whole board.

Quality gets more agenda time, and so do readmissions, "which we know will impact reimbursements," he says. "We actually do a lot of the standard reporting in the consent agenda so we have more time left to dedicate to strategy."

What about former execs?

Despite all the focus on strategy, however, Newpoint's Geffner says she has seen a lot of interest from boards in recruiting former, perhaps retired, healthcare executives, because they "can assume both a governance and operational perspective."

If a board has an appreciation of the competencies it needs, and if a former hospital exec possesses those, she says, it's a really good idea to have that voice at the table. "Having an understanding of operations is of value in the boardroom," she says.

Many retired healthcare executives serve on hospital boards. Dan Wilford, who retired as CEO of Houston's Memorial Hermann Health System in 2002, is a past director on the board of the Mobile Infirmary Association, parent of the Mobile (Ala.) Infirmary Medical Center, and is currently on the board of St. Joseph Health, an integrated delivery system with hospitals in California, New Mexico, and Texas. Many other former healthcare executives do this, but they are in high demand, says Williams of CHC.

But there's a dilemma. At the same time, Geffner says, if board members defer to the former executive too often, it may cause challenges to meeting their fiduciary responsibilities—not to mention possible conflicts with the CEO and executive team. They should be extra careful, in such circumstances, to encourage diversity of opinion and different points of view.

"If you have former hospital leadership in the boardroom, if practiced well, that point of view can also understand the CEO and executive team's perspective."

But ultimately, she says, it all comes down to developing a culture of openness, transparency, strong leadership, and an investment in being what she calls a "learning board."

"If those practices and points of view are in the boardroom, you will optimize the talents in that room," she says. "But you could take the same people and a culture that doesn't look like that and you're suboptimizing the talent in the room."

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