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Article published March 2, 2009

Raising the bar for boards

The days of adding people to healthcare boards 'sight unseen' are coming to an end as trustees' skills, makeup now being scrutinized

By Melanie Evans

Posted: March 2, 2009 - 5:59 am EDT

Demand for better-run and safer hospitals has heightened oversight of a group more used to watching over others than being watched: hospital trustees.

The latest to step in is an American Hospital Association affiliate, the Center for Healthcare Governance, which last month released a report detailing essential qualities, skills and education for hospital board members. The makeup of an ideal board member goes beyond a working grasp of complex subjects such as finance and healthcare quality into more gray areas of personal attributes and behavior, the report found.



Becker



Ellis-Williams

Such an extensive report follows efforts by one major insurer and hospital trade groups in more than a half-dozen states to define good governance and prod the largely volunteer governing boards at U.S. hospitals to be better educated and more assertive.

Since 2006, hospital associations in Georgia, Minnesota and Tennessee have adopted voluntary certification for hospital trustees. In New Jersey, where a deadline for state-mandated board education looms, the hospital association is tweaking its planned certification. Hospital trade groups in Nebraska and West Virginia added certification within the past year. And in Texas, officials at the Texas Healthcare Trustees expect to convert an existing distinction for trustees to a voluntary certification by summer.

Healthcare's escalating cost, an aging population and more public quality information have raised expectations, said Peggy Allison, who joined the then-Southwest Texas Methodist Hospital board in 1985 and remained a trustee until she stepped down from the board of three-hospital Methodist Health System in 2007. "I don't know if people knew or cared what went on in hospitals," Allison said. "Now they do."

Indeed, behind the movement are calls from policymakers and regulators in recent years to improve not-for-profit healthcare's transparency and, more broadly, faltering public confidence in corporate

oversight, said observers and industry insiders. The push to improve quality has also fueled scrutiny of boards, they said. Trustees have an obligation to push for safe, high-quality healthcare and hold executives accountable to deliver. In the Bay State, Blue Cross and Blue Shield of Massachusetts has tied financial incentives to boards that improve quality oversight.

The activity suggests an emerging, more extensive standard for governance for not-for-profit healthcare, said Sean Murphy, senior vice president and general counsel for Solaris Health System, who has tracked the efforts to certify hospital trustees and written on the subject for the Governance Institute. Policies that address how the board operates, such as recruiting new members or evaluating board performance, that may have been previously overlooked may be “more of a duty and obligation, and not just an option anymore,” he said.

Not-for-profit healthcare relies heavily on voluntary efforts to bolster governance. Despite increased demands on not-for-profit healthcare governance, regulation of tax-exempt boards falls short of oversight among for-profit companies, said Kathleen Boozang, a health law professor at Seton Hall University. Not-for-profits cite as a standard the 2002 Sarbanes-Oxley Act designed to bolster corporate accountability, but they don't have to adhere to the law's governance rules. “It's optional,” she said.

Who belongs on boards?

Boozang praised the Center for Healthcare Governance report released in February and said that it may serve as a guide to drafting a plan for governance.

The report, jointly developed with the Health Research & Educational Trust and financed by drugmaker Hospira, outlines what makes a good board member, not how a good board functions.

Richard de Filippi, chairman-elect of the AHA, a trustee with the Cambridge Health Alliance and chairman of the panel that drafted the Center for Healthcare Governance report, said hospital performance has been linked to how well boards govern.

Any effective board members should be competent in at least 14 areas, according to the report: accountability, achievement orientation, change leadership (defined as: “maintains an eye on strategic goals and values during the chaos of change”), collaboration, community orientation, information seeking, innovative thinking, complexity management, organizational awareness, professionalism, relationship building, strategic orientation, talent development and team leadership. In a 10-page form, the report gives examples of how to interview and evaluate candidates for each attribute.

The report lists additional skills and knowledge in healthcare delivery and performance, finance and business and human resources that at least some trustees should demonstrate.

State certification and education efforts have also sought to define the essential knowledge and obligation for board members.

Craig Becker, president and chief executive officer of the Tennessee Hospital Association, said the trade group's certification, launched in 2006, gives trustees the education to be effective lobbyists on behalf of their hospitals. Becker said legislators listen more closely to trustees than executives. “Their credibility is a whole lot higher.”

In April 2007, New Jersey enacted a law that required all newly appointed hospital trustees to undergo education. The mandate was expanded to all board members in late 2008 after the Commission on Rationalizing Health Care Resources cited the need for improved governance among the reasons for the state's struggling hospitals (Aug. 18, 2008, p. 12).

Antoinette Ellis-Williams, an associate professor of women and gender studies at the New Jersey City University and board chairwoman of 211-bed East Orange (N.J.) General Hospital, finished her

mandatory seven hours of continuing education last week at a daylong event hosted by the New Jersey Hospital Association. Seven of the hospital's 12 current board members joined her for the education, which she described as necessary for an effective board. "I'm a believer that you're always learning," she said. Continuing education by the board also sets an example for executives and medical staff who are also expected to continue their education.

Ellis-Williams, who holds a doctorate in public policy with concentrations in program evaluation and city planning, was recruited to join East Orange General's board six years ago when the hospital faced significant financial and governance problems. She was named vice chairwoman "sight unseen," she said, and arrived to find a board without critical policies, including those for conflicts of interest or recruiting members. Since then, the entire board has turned over, and Ellis-Williams said recruits are vetted and evaluated as they serve on board committees for their knowledge and commitment. "The worst thing to do is have someone on the board who is taking up space," she said.

Sooner or later

In Georgia, Martha Harrell, vice president of educational services at the state hospital association, took note of New Jersey's mandate and decided Georgia's hospitals should move on their own "so that if we followed suit, we could go to legislators and say we've been doing it for years," she said.

The trade group's certification launched in January 2008 and 150 trustees from 19 hospitals have earned the qualification. Given the state's large number of rural hospitals—more than 40% of Georgia's community hospitals operate outside of major metropolitan areas—the association offers online training. Georgia's certification requires, among other items, that trustees receive 12 hours of education, sign a conflict-of-interest policy; undergo evaluation once a year; and guarantee certain board standards, such as a standing place on agendas for quality and safety.

Harrell said that she expects to see initiatives spread from state to state, including the pay-for-good-governance effort under way in Massachusetts. "Whatever happens there, it will probably come to all of us sooner or later," she said.

In Moultrie, Ga., veteran trustee Durwood Dominy is pushing for trustees to quickly seek certification. "Trustee education is nowhere where it needs to be," he said. Dominy joined the board of 73-bed Colquitt Regional Medical Center 18 years ago and said education to keep up with such a complex industry is necessary and "just good business." The medical center's nine board members finished the trustee certification, but are in the minority statewide, he said.

New board members need an introduction to healthcare's technical and medical jargon, Dominy said. All trustees need to keep abreast of changing regulations, labor shortages and issues such as the uninsured. "When you go in, you don't know what fully to expect," he said. "It took me about two years to understand the language. There's a learning curve all along. As I got into it, I said, 'This learning curve is not going to end.'"

Low public confidence in corporate oversight has made it increasingly important for boards to welcome improvement when the opportunities arise, Dominy said. "The public needs to know we're interested in the same things they are," he said: the best possible care at the lowest possible cost. Well-educated board members can help with Georgia's push to become one of the top 10 states on certain quality measures, he added. "They'll have walking-around sense and know what questions to ask."

In Massachusetts, one major insurer has pushed quality education for boards in a bid to boost hospital



Watch an interview with Marie Sinioris, president and chief executive officer of the National Center for Healthcare Leadership

performance. Blue Cross and Blue Shield of Massachusetts targeted trustees as part of a broad plan to improve quality and eliminate waste and errors that harm patients and drive up costs, said Fredi Shonkoff, senior vice president of corporate relations. The insurer backed a course on quality tailored for boards, jointly developed by the Massachusetts Hospital Association and the AHA.

Nine Massachusetts hospitals in late 2007 tested the course, and the results prompted the insurer to launch a speaker series on quality and two governance initiatives. One used the insurer's leverage as a payer: the Blues plan is adding pay-for-performance measures for quality oversight by boards. The second created a one-year grant program to further trustee quality oversight. Five hospitals received \$50,000 grants to bring in quality consultants for six months to draft a goal that will dramatically improve the hospital's quality and safety.

The pay-for-performance plan offers bonuses tied to governance, staggered over three years, Shonkoff said. Hospitals receive a bonus in year one if at least 75% of board members attend classes on quality improvement. Twenty-five hospitals have finished the course, she said. The number is expected to climb to about 50 by the end of the year and as the insurer negotiates new contracts with hospitals.

To earn a bonus in the second year, governing boards must create a quality improvement plan that identifies three quality or safety gaps. In the final year, the incentive is tied to a governance plan to eliminate five quality or safety gaps and the board must link the CEO's performance evaluation to quality improvement.

John Lowe, a healthcare management associate professor at Simmons College, Boston, and a trustee at 166-bed Emerson Hospital, Concord, Mass., said that expectations for board savvy has increased with insurers' heightened focus on quality, citing the state Blues plan and Medicare's move to halt pay for preventable illness or harm. "When the people paying the money make it their business to get involved in this, then the people taking the money better pay attention," said Lowe, who joined Emerson's board 13 years ago when he moved from Chicago to Boston to join Simmons College's faculty.

Emerson received one of the Blues' five grants, which require hospitals to provide \$25,000 in matching funds. The hospital was also among those to test the quality training for trustees, which prompted Emerson's board to create a quality committee nine months ago.

"Doctors and management can only take you so far," Emerson said. Trustees chose not to pick a doctor as chair of the newly created quality committee to increase its accountability to the hospital's patients, he said. "You want the face of the effort to come from the community."

Seth Medalie became the chairman at Beth Israel Deaconess Hospital-Needham (Mass.) a little more than a year after joining the board and just as the community hospital decided to try to eliminate all preventable harm by January 1, 2012. Medalie said that trustees at the 33-bed hospital felt inspired by the aggressive goal and driven to succeed, but even as management pressed on, the board needed more education to understand its role.

"I don't think we knew what we were getting into," Medalie said. The board, already grappling with the hospital's largest construction project, also had new members from outside healthcare who needed training and exposure to hospital operations to become more familiar with quality and safety issues. Without education, trustees struggle to hold executives accountable or know where to invest to best improve quality, he said.

Medalie, founder and president of financial firm the Bulfinch Group, was "fully prepared" to rebuff trustees who had approached him to take over as chairman, given the requirements of the job. His experience with healthcare is as an outsider. He agreed only after the outgoing chairman pledged to meet two hours each week before the transition.

The Needham hospital, an affiliate of 585-bed Beth Israel Deaconess Medical Center, Boston, also

scored one of the Blues' quality and governance grants. Medalie said working with a consultant will help the board establish its process for quality oversight. "Our heart is in the right place," he said. "We're totally committed to this. Now we need help with the steps."

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