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Prescriptions for Excellence in HEALTH CARE

A COLLABORATION BETWEEN JEFFERSON SCHOOL OF POPULATION HEALTH AND LILLY USA, LLC

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Editorial

Wrap-Up...and Regroup!

By David B. Nash, MD, MBA

Editor-In-Chief

This issue marks 2 important transitions in the 6-year history of *Prescriptions for Excellence*. The first is that our 3-part series on health care organization governance has come to an end. Collectively, the articles in the series validate my initial editorial comment¹ that “governance is risky business” and provide an up-to-date tutorial on this multidimensional topic. Judging from the feedback I’ve received, including requests for additional copies, many readers agree.

As those who know me can attest, I am a huge proponent of disseminating print material via hard copy. For me, referring someone to a Web site doesn’t have the same cachet as handing him or her a tangible item. So it is with mixed feelings that I announce the second transition. Beginning with the Fall 2013 issue, *Prescriptions for Excellence* will transition into a digital publication. Readers can rest assured that the timeliness, applicability, and quality of the content will continue at the same high level.

Before wrapping up the topic of governance, I’d like to touch on an aspect that may be an uncomfortable topic for physician leaders — specifically,

the governance risks associated with confidentiality, conflicts of interest, and related fiduciary issues. As hospital and health system boards respond to the Affordable Care Act’s (ACA) call for integrated strategies, boards must be particularly sensitive to these areas. Consider the following scenario:

Acting in response to the ACA, a medical center’s governing board meets to formulate a plan for incorporating an accountable care organization (ACO) and a patient-centered medical home (PCMH). Sitting on the board are 6 physician members of the center’s medical staff, 2 of whom have relationships with competing provider organizations (eg, imaging laboratory). One discloses the relationship and recuses herself from confidential discussions pertaining to the particular service. The other secretly

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transmits confidential information to the competing organization, thereby undermining the medical center's integration efforts.

Although hypothetical, the scenario isn't as far-fetched as it sounds. In fact, the authors who created it reported disturbingly similar events that had occurred, one of which led to a 1995 California jury award of nearly \$14 million in damages to a hospital in a lawsuit against 2 former physicians who were alleged to have similarly exploited their governing board positions to build their own competing facilities and steer patients to them.²

Physician directors make vitally important governance contributions to health care organizations. However, when governing boards consider new proprietary strategic integration models, a physician director is in a potentially difficult position if discussions involve his or her medical practice and/or business.

Boards that anticipate such risks and take a proactive approach can minimize the potentially adverse effects of such biases or other conflicts of interest. The authors suggest a formal plan that includes: general board education on applicable state law regarding the director's duty of loyalty, targeted briefing of the board's conflicts committee and of physician directors on the potential issues arising from consideration of integration-based strategies, careful monitoring of board and committee agendas to identify sensitive discussion items in advance, making the hospital's legal counsel available to physician directors for consultation on specific issues, and assisting the board's conflicts committee to resolve disclosed potential issues (eg, adopting specific conflicts management plans).

I'll close with kudos to the authors in this issue who shared their keen insights into governance in 4 key areas:

the continuing impact of the ACA on governance (*"Governance Implications of the Affordable Care Act and Other Health Care Trends"*), governance in large health systems (*"Using Quality and Safety Data for Board Engagement That Makes a Difference in Patients' Lives"*), the impact of external forces on governance (*"The Future of Governance: Health Care Boards Change with Challenging Times"*), and an enlightening study of governing boards (*"Board Size and Composition in Large Nonprofit Health Systems"*) that reveals both how far we've come and how far we have yet to go.

As always, I welcome feedback from our readers at david.nash@jefferson.edu.

References

1. Nash DB. Governance is risky business. *Prescriptions for Excellence in Health Care*. 2013 Winter;18:1-2.
2. Peregrine MW, Rich JP. The potential risk to successful hospital integration strategies under the PPACA posed by physician board members' conflicts of interest. <http://www.governanceinstitute.com/ResearchPublications/ResourceLibrary/tabid/185/List/1/ProductID/1057/default.aspx?SortField=DateCreated+DESC>. Accessed May 8, 2013.

A Message from Lilly Sustaining Medical Innovation in a Time of Rapid Reform

By Alex M. Azar II

Among the insightful perspectives in this issue of *Prescriptions for Excellence*, perhaps none is more important than the need for governance boards to look forward — particularly as the hospitals and health systems they oversee drive significant shifts in our national health care landscape. In surveying the future, we must not lose sight of one of the vital drivers of improving long-term patient outcomes: the pursuit of medical innovation.

While much of this discussion lies at the federal policy level, much also rests in the hands of the growing number of state health insurance exchanges (HIE), integrated health systems, and accountable care organizations across the United States. Washington's reforms may have accelerated the pace of change, but it will be up to individual systems — and, by nature, their governing boards — to bring them to life for the advancement of quality patient care.

As Barry Bader writes in an article that follows, "Success under the incentives of reform will be determined by how hospitals and health systems redesign care delivery in order to drive down spending and improve outcomes." In doing so, we must not harm the health care ecosystem that has so crucially fostered innovation — and with it, improved outcomes — over the long term.

In my former role as Deputy Secretary of Health and Human

Services, I often met with my counterparts in the health ministries of other countries, and I found my position unique. Like the others, I was responsible for the financing and delivery of health care. But my portfolio also included innovation — most notably, oversight of the National Institutes of Health and the Food and Drug Administration (FDA).

Unlike my colleagues, I had to balance the goals of reducing costs *and* sustaining innovation. This broader perspective also helped me appreciate the potential for innovation to reduce costs, improve quality, and allay suffering. As we struggle with the challenges of health care, a narrow focus on costs to the exclusion of innovation would be self-defeating.

What we need is a different perspective on the value of medical innovation and an understanding of what it will take to increase that value in the years ahead to improve our collective “ROI” — Return on Innovation.

Medical innovation over the past century transformed the basic expectations of human life that had prevailed since the dawn of civilization. Tens of millions of death sentences were lifted, and once-dreaded diseases became manageable chronic conditions. Consider our progress against 2 leading killers:

- **Coronary heart disease (CHD):** The death rate from CHD in the United States has declined by about two thirds since it

peaked in 1968.¹ There were 1.7 *million* more Americans alive last year who would have died at the 1960s' rate.²

- **Cancer:** The American Cancer Society states that, from 1991 to 2009, the death rate for all cancers dropped 20%. That's 1.2 million people who did not die from cancer.³

The cumulative impact of the medical innovation of the past century is nothing short of mind-boggling. In 1900, the average American life expectancy was age 47, and in 2000, it was age 78 — an unprecedented increase of 66% in 1 century!

The biopharmaceutical industry is a big reason we've gained these extra decades. An analysis by Columbia University Professor Frank Lichtenberg found that launches of new medicines accounted for 40% of the increase in life expectancy during the 1980s and 1990s alone.⁴

We all know people in their 70s — and even 80s — who have left behind rocking chairs for sea kayaks and cross-country skis and, while we're all frustrated with the rise in overall health care spending, a big chunk of it is due to the fact that these folks are now healthy enough to get knee replacements or coronary artery bypasses or cancer treatments and continue their active lifestyles, which sounds a lot better than the alternative to me.

But we must ask: As we reform our health care system, are we building a new foundation that will make the breakthroughs of tomorrow possible?

The pursuit of innovation in any field is a difficult, high-risk venture. If innovation is to take root and grow, it requires a combination of elements we describe as an “ecosystem.” The health of the ecosystem starts with open access to health care markets with market-based pricing. For example, we believe that doctors and patients must remain the ones to choose, in an informed way, from all available treatment alternatives.

My message is simple: A myopic focus on cost control impacts prices, prices affect investment, investment affects innovation, and innovation affects quality of health outcomes. Innovation and freedom of competition play a critical role in our health care economies, and misguided — albeit well-intentioned — government and institutional policies can greatly stunt its growth.

Without question, the tension between meeting rising costs and investing in innovations for tomorrow is one of the most intractable questions political leaders face. Consider the European experience. Often, in trying to strike this balance, European policy makers lean too much toward short-term savings and succumb to the temptation to control expenditures through direct price controls, cuts in reimbursement rates, delayed market access, and other subtle and not-so-subtle practices that either restrict the amounts paid for innovative products or reduce consumption of innovative medicines and devices.

Unfortunately, these trends have recently spread across the Atlantic and are rearing their heads in

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our commercial and government systems here in the United States with disturbing frequency.

Why does this matter? Because there is a direct relationship between these types of cost containment measures and innovation. A study by the US Commerce Department evaluated cost controls in a number of industrialized countries and found that lifting cost controls could increase revenues for patented medicines by as much as \$18 billion to \$27 billion annually — something that would greatly foster innovation.⁵ This translates into as much as \$5-\$8 billion of lost global research and development as a result of cost controls.

Rather than looking at cost as the only driver of value, we must implement market-based solutions to sustain innovation in the future. Consumers are served best by free, strong competition that creates choices, better prices, and broader benefits while encouraging sustainable innovation.

Contrast the European experience with our own great American experiment with Medicare Part D — the only part of our government-sponsored health care system that does not have the distortion of price controls. Part D has been a bigger win than even those of us who helped launch it imagined. Costs have been 40% below the original Congressional Budget Office estimate, and beneficiaries report a 90% satisfaction rate.⁶

As HIEs resulting from the Affordable Care Act launch later

this year, we should be looking to Part D for learnings to foster maximum competition. When you have a competitive health insurance market, with a well-informed beneficiary in the driver's seat making choices rather than bureaucrats, the value of the medicine — and innovation — is preserved.

If the sole impact of biopharmaceutical innovation was additional decades of life and health, we'd be hard-pressed to find its equal. There's also compelling evidence that innovative medicines are the most cost-effective part of health care. A couple years ago, former Medco CEO David Snow visited Lilly and reported that it costs half as much to treat patients with diabetes who adhered to their prescribed course of medicine compared to those who didn't.

Medicines are not cost drivers, they're cost savers. In 2011, the *Journal of the American Medical Association* reported that when seniors who didn't have comprehensive prescription drug coverage received coverage through Medicare Part D, they saved an average of \$1200 per year in hospital, nursing home, and other medical costs.⁷ That translates into \$12 billion per year in savings across Medicare.⁸ David Snow summed it up well: "Drugs used properly are part of the solution, not part of the problem."

Some people will still say that we have all the innovation we need or that, in this difficult economic climate, we just can't afford it. But we must build upon — not rest upon — the contributions of the past. For all our tremendous progress, much more remains to be done.

With 10,000 American baby boomers turning 65 every day, it's not surprising that we're seeing a sharp increase in the incidence of diseases associated with aging (eg, cancer, type 2 diabetes, osteoporosis, neurodegenerative diseases). The Alzheimer's Association estimates that by 2050 — absent effective treatments — the number of Americans over age 65 who develop Alzheimer's will triple to 13.8 million, and costs in the United States alone could rise to \$1.2 trillion a year.⁹

Let's face it: The only way to make further inroads against these and other conditions is to sustain medical innovation. The good news is that advances in the life sciences are bringing treatments, once beyond our reach, finally into view. One need look no further than the 35 new molecular entities approved by FDA in 2012.

But we can't stop the revolution cold in its steps as our health care system continues down the path of rapid reform. Clearly, when it comes to sustaining innovation, the burden remains on research-based companies like Lilly — as it should. Businesses that live or die by health care innovation ask only that we be allowed to continue doing just that: Proving the value of what we've developed ... and succeeding or failing in the marketplace.

It is impossible to predict the full range of benefits that future generations could enjoy from today's innovation, but when I think of the incredible advances in medicine over the past century, I'm convinced

that what might seem unimaginable today will be commonplace tomorrow. For example:

- treatments that transform cancer into a chronic disease, with survival times measured in decades rather than months,
- effective treatments for malaria, tuberculosis, and other diseases affecting tens of millions in the developing world,
- breakthroughs that will save millions from the devastation of Alzheimer's disease,
- cardiovascular repair and prevention of heart disease,
- replacement organs, and, ultimately,

- additional healthy, productive years for people to enjoy life with enhanced vitality.

As members of health care governance boards grapple with cost and quality questions, I hope they too will conclude that innovation is not the problem. Innovation is the solution — the essential key to ensuring that our ecosystem remains healthy and viable to deliver improved patient outcomes for years to come.

Alex M. Azar II is the President of Lilly USA, LLC, the U.S. affiliate of Eli Lilly and Company, and is a former Deputy Secretary of Health and Human Services.

References

1. National Institutes of Health. Morbidity and Mortality: 2012 Chart Book on Cardiovascular, Lung and Blood Diseases. Chart 3-6. http://www.nhlbi.nih.gov/resources/docs/2012_ChartBook_508.pdf. Accessed June 18, 2013.
2. National Institutes of Health. NIH Fact Sheets, Heart Disease. <http://report.nih.gov/NIHfactsheets/>

[ViewFactsheet.aspx?csid=96](#). Accessed June 18, 2013.

3. Centers for Disease Control. Cancer Statistics 2013. <http://www.cancer.gov/news/facts-and-figures-report-declines-in-cancer-deaths-reach-milestone>. Accessed June 18, 2013.
4. Lichtenberg FR. The impact of new drug launches on longevity: evidence from longitudinal, disease-level data from 52 countries, 1982–2001. www.rand.org/content/dam/rand/www/external/labor/seminars/adp/pdfs/adp_lichtenberg.pdf. Accessed June 18, 2013.
5. U.S. Department of Commerce, International Trade Administration. Pharmaceutical price controls in OECD countries: implications for U.S. consumers, pricing, research and development, and innovation. December 2004. <http://ita.doc.gov/td/health/DrugPricingStudy.pdf>. Accessed June 18, 2013.
6. Medicare Today, KRC Research. Seniors' opinions about Medicare Rx: 7th year update. December 2012. <http://www.medicaretoday.org/MT2012/KRC%20Survey%20Seniors%20for%20Medicare%20Today%2010%2002%202012.pdf>. Accessed June 18, 2013.
7. McWilliams JM, Zaslavsky AM, Huskamp HA. Implementation of Medicare Part D and nondrug medical spending for elderly adults with limited prior drug coverage. *JAMA*. 2011;306(4):402–409.
8. PhRMA.org. New JAMA study highlights continued success of Medicare Part D. <http://www.phrma.org/media/releases/new-JAMA-study-highlights-continued-success-medicare-part-d>. Accessed June 18, 2013.
9. Alzheimer's Association. 2013 Alzheimer's Disease Facts and Figures. http://www.alz.org/downloads/facts_figures_2013.pdf. Accessed June 18, 2013.

Governance Implications of the Affordable Care Act and Other Health Care Trends

By Barry S. Bader

As much as hospitals and health systems have grown and changed over the past several decades, their governance has tended to retain many traits from their roots. These often include recruiting trustees from the local community's business and finance elite, limiting what is expected from volunteers, measuring performance mainly in the acute care setting, and allocating "representation" to a semiautonomous medical staff.

In recent years, however, several powerful forces have necessitated significant

changes in the governance of not-for-profit hospitals and health systems:

- Higher expectations for corporate accountability and director professionalism are requiring boards to be more accountable, independent, and transparent, and to follow "best practices" such as competency-based selection to optimize their effectiveness.
- Recognition that, in this era of industry aggregation (ie, spread

of multihospital systems, and increasing economic alignment of hospitals and physicians), boards are governing large, complex, diversified organizations that require optimization of system-wide rather than silo performance to be successful.

- Heightened scrutiny of tax exempt organizations by Congress, the Internal Revenue Service (IRS), state governments, and the courts means not-for-profit boards can no longer take their tax status for

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granted. They must be prepared to demonstrate their organizations' community benefit, responsible stewardship, and ethical conduct to "earn" their tax breaks.

Looking ahead, the reduced reimbursements, value-based payment methods and quality incentives embodied in the Affordable Care Act and embraced by private payers are expected to drive further industry aggregation and performance improvement. Success under the incentives of reform will be determined by how hospitals and health systems redesign care delivery in order to drive down spending and improve outcomes. These organizations must transform into high-performing, integrated delivery systems that are accountable for their costs and quality across the full continuum of care.

Three Structural Models of Future Care System Governance

Each hospital and health system must undertake a candid self-examination of its governance. Are there certain hospital-rooted roles, structures, and practices that once were strengths but that could be impediments to high-performing care system governance? Are current structures and practices sufficiently robust to evolve as the delivery system transforms or does the governance model require a complete overhaul?

It may be useful for boards to think about 3 emerging governance models, described in a recent survey of health system leaders by the American Society for Healthcare Strategic Planning and Marketing and the American College of Healthcare Executives. The models reflect different core properties of various care systems (Figure 1).

Professional Governance Model: Organizations that see themselves as

Figure 1. Three Emerging Care System Governance Models



Source: American Society for Healthcare Strategic Planning and Marketing and the American College of Healthcare Executives.

a "health company" (ie, not-for-profit in motive but possessing the culture of a customer-focused, high-performing corporate enterprise) may adopt this model wherein governance is viewed as a "professional commitment" of the highest order by hard-working directors as in the best corporate boards. Whether compensated or not, such boards impose higher expectations on directors' performance than the typical volunteer board.

Directors are recruited wherever the best talent resides — locally or outside the communities served. Board composition is based on *exceptional* competence in needed skills and independence (ie, no material conflicts of interest).

Organizationally, such boards have a lean approach to size, committee structure, and meeting frequency — all intended to drive a collaborative team culture of high-performing, independent, and accountable governance. A single parent board has unquestioned authority; local subsidiary boards, if retained, serve in advisory roles although large, multistate care systems may retain regional governing bodies with delegated authority and responsibility.

Clinical Enterprise Governance: This model is designed for organizations that view themselves as primarily clinical enterprises that are physician-driven, professionally managed, and patient-centered. Medical and professional staff are employed or under contract, and clinical services are comanaged by "dyads" of physician and nonphysician leaders such as nurse executives.

Governance often involves 2 boards that have clearly delineated authority and roles. A corporate parent or foundation board has ultimate decision-making authority and focuses on high-level strategy, goal setting, and independent oversight. An empowered and active clinical enterprise board of senior executives and senior physician and nursing leaders is the engine for delivery system leadership that is fully accountable to the parent board for the patient experience, clinical quality, financial results, and clinical operations.

In addition to the chief executive officer (CEO) and chief medical officer, the parent board includes predominantly, or all, independent directors. As in the Professional Governance Model, local and outside parent board directors are selected mainly on the basis of needed competencies.

Enhanced, Community-based Governance: Organizations that see themselves primarily as integrally connected to and serving mainly their local communities retain a community flavor in their board composition and its scope of work; however, they tend to adopt sensible enhancements to assure director professionalism and to facilitate transformation to an accountable care system.

This model likely has a parent board with broad-based composition

drawn from the communities served. Competency-based succession planning for the board is more rigorous and ongoing than it is on most boards today, but most trustees still come from the community served. Diversity is a higher priority, and at least a majority of board members meet the IRS independence test. The board may include several staff physicians who are selected using the same competency-based criteria and selection process as any other trustee rather than as medical staff representatives.

An active working committee structure engages trustees and other leaders; committees do the heavy lifting for the board's core responsibilities (eg, finance, audit, compliance, quality, community benefit, governance). Subsidiary boards may be eliminated or retained in advisory and/or community connectedness roles.

As each board envisions its ideal governance model for the future, it is likely to adopt a hybrid of the 3 prototypes, drawing relevant attributes from each model to construct its desired "board of the future." Professional boards, for example, select trustees based on particular competencies but still may look to their service areas for trustees with connections or philanthropic ability. Like professional boards, community-based boards will expect more from their trustees and focus more time on strategy, and clinical enterprise boards will draw elements from both models.

Best Practices Will Be Widely Adopted

Structural reform alone is not enough. The literature on effective governance has grown exponentially in recent years. As evidence mounts regarding which practices are truly connected with better performance for the organization and board, boards must move from

viewing best practices as aspirational to making them standard governance procedure. Some practices are particularly important to care system transformation and will apply across multiple models of future governance. These include:

- **CEO support:** Recognizing that a CEO who wants an informed and engaged board and actively supports its work is essential to high-performing governance, boards will explicitly select and evaluate CEOs for this attribute.
- **Expert competency:** Board composition will include at least 1 independent expert in *each* of the board's core responsibilities; notably, finance, quality, executive leadership, and audit. Boards also will include new backgrounds and skills consistent with being an accountable care system (eg, expert knowledge and leadership experience in population health and enterprise risk management). Lacking sufficient expertise locally, smaller community boards may need to broaden their outreach.
- **Quality:** Boards will elevate quality to strategic priority status that requires planning as well as oversight. They will expand their purview to embrace the Triple Aim: improving the patient experience, the per capita cost of care, and the health of communities or populations. They will adopt the board practices that evidence indicates are connected with higher performance by the board, the organization, or both. These include spending at least 20% of the board meeting time substantively discussing quality performance, using a board quality subcommittee to perform more in-depth oversight

than the full board can, reviewing a dashboard of quality indicators regularly, setting quality objectives for the CEO's performance evaluation, and participating with medical staff leaders in establishing quality and patient safety goals.¹⁻³

- **Transformational leadership:** Boards will draw on a range of leadership tools that are suited to leading change and transforming organizations in an uncertain economic environment. These include:
 - devoting 75% or more of board meeting times to substantive interaction on strategic issues rather than passively listening to reports
 - embracing "generative governance concepts" to identify and explore questions that unearth new thinking in board discussions⁴
 - adopting scenario-based and "what if" strategic planning methods
 - employing bifocal metrics, focusing on 2 sets of metrics simultaneously: (1) keeping tabs on current performance, and (2) tracking progress toward long-term goals
 - using enterprise risk management techniques to assess the many types of risk that exist in a changing environment (ie, financial, strategic, regulatory, reputational).
- **Community benefit:** As a matter of both mission and economics, boards will devote increased attention to community benefit, community health improvement, and elimination of health disparities as strategic priorities.
- **Capacity for collaboration:** Boards must strengthen their capacity

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for trust and collaboration as care systems pursue their aims in cooperation with organizations outside of their control (eg, accountable care organizations, medical homes, public health agencies, private insurance plans.)

- **Board self-evaluation:** Boards will link board evaluation with specific board improvement plans. They also will adopt an individual director assessment process to reinforce performance expectations by providing directors with constructive feedback and by

using evaluations to make reelection decisions.

Capacity for Self-Assessment and Improvement

Boards that have established a culture characterized by accountability, trust, collaboration, candor, engagement, continuous learning, and self-assessment will be well equipped to consider their need to enhance or overhaul their structure and practices. For boards that have not reached this point, the journey to a new governance model will be more challenging.

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References

1. Ashish J, Epstein A. Hospital governance and the quality of care. <http://content.healthaffairs.org/content/29/1/182.abstract>. Accessed June 3, 2012.
2. Jiang HJ, Lockee C, Bass K, Fraser I. Board engagement in quality: findings of a survey of hospital and system leaders. *J Healthc Manag*. 2008;2(1):2-9.
3. Vaughn T, Koepke M, Kroch E, Lehrman, et al. Engagement of leadership in quality improvement initiatives: executive quality improvement survey results. *J Patient Saf*. 2006;2(1):2-9.
4. Chait RP, Ryan WP, Taylor BE. *Governance as Leadership: Reframing the Work on Nonprofit Boards*. Hoboken, NJ: John Wiley & Sons, Inc; 2005.

Using Quality and Safety Data for Board Engagement That Makes a Difference in Patients' Lives

By Stephen R. Grossbart, PhD

Currently the largest health system and the fourth largest employer in Ohio, Catholic Health Partners (CHP) is one of the largest nonprofit health systems in the United States, with more than 100 provider organizations that meet the health care needs of people in Ohio, Kentucky, and contiguous states. Operating under a decentralized model, CHP's approach to governance and management balances decisions made at the local level with those made at the combined system level. Although each of CHP's 7 regional health systems has its own board of trustees, all are ultimately accountable to the CHP board of trustees.

In 1999, CHP was part of a small but growing number of health systems that recognized the need to elevate quality to the same level of governance as other aspects of health system operations.¹ CHP's board of trustees decided to create a board quality and patient safety (QPS) committee 5 years before the National Quality Forum (NQF)

published *Hospital Governing Boards and Quality of Care: A Call to Responsibility*, encouraging hospital governing boards to become actively engaged in quality improvement and focusing attention on the relationship between governance and quality of care.²

Though CHP was an early adopter of health care governance, initially QPS committee meetings dealt primarily with performance improvement project updates, crude performance dashboard reviews, and issues such as Joint Commission readiness. It was not until 2002 that quality objectives were added to the system-wide annual plan.

Today, all members of the CHP executive management team, including regional chief executive officers (CEOs) for the hospital system, are held accountable for meeting the quality performance goals of the annual plan. In retrospect, "top quartile" targets such as use of angiotensin-converting enzyme

inhibitors for heart failure patients and timely use of antibiotics for pneumonia patients started CHP on a journey toward elevating the importance of QPS for the organization's largely nonclinical administrative leadership.

Quality Measurement

After becoming a member of the NQF in 2002, CHP made a policy decision to use measures endorsed through NQF's consensus development process whenever possible. In addition, the system formally embraced the Institute of Medicine's *Quality Chasm* report as its framework for quality improvement,³ linking objectives and associated measures to the report's 6 aims. Consistent with the work of Berwick et al,⁴ CHP embedded a clear distinction between "measurement for accountability" and "measurement for process improvement" in its board-approved policy on quality reporting and oversight. CHP adopted NQF's *Safe Practices*⁵ at about the same time.

Measurement System

Originally, CHP's decentralized model did not provide corporate staff with direct access to quality data. This changed with the gradual implementation of a system-wide decision-support system, computerized physician order entry, and an electronic health record at all ambulatory and hospital sites. This centralized information system is critical to providing timely information to the board and giving staff the data analytic ability to understand variances. Today, the board views information that typically is harvested through the month prior to meeting.

Executive Accountability

CHP has set incrementally higher expectations for its senior team to meet QPS objectives. In 2002, only 10% of the total number of system objectives focused on quality and safety. Today, over half of the system goals are directly tied to QPS. Each objective has equal weight in determining executive compensation. The board also requires the system to meet 3 threshold targets in the areas of finance, community benefit, and quality. Today, hospitals must meet a minimum performance threshold for patient experience to be eligible for any incentive compensation. Seven of CHP's 22 hospitals did not meet this target in 2012 and their leadership teams did not receive bonuses.

The board QPS committee regularly reviews data to ensure that performance levels meet minimum expectations and patients are not at risk of imminent harm. If data analysis reveals an issue or if significant patient events occur, the QPS committee may place any hospital or entity on "oversight," an action that requires the regional CEO to attend a QPS committee meeting to outline an action plan to achieve minimum performance levels or eliminate the risk

of patient harm. In addition, the regional board of trustees is updated on the reasons for the oversight. Three hospitals have been placed under the oversight of the CHP board QPS committee since 2009.

Boards on Board Campaign

A significant change for CHP came about as a result of the Institute for Healthcare Improvement's (IHI) 5 Million Lives Campaign, at which time CHP embraced the IHI's Boards on Board campaign (ie, began to provide educational sessions to members of the system board of trustees and regional boards, and encouraged all regional boards to adopt the campaign planks).^{6,7}

The IHI campaign called upon boards to understand 6 key steps to improving governance: (1) setting aims, (2) getting data and hearing stories, (3) establishing and monitoring system-level measures, (4) changing the environment, policies, and culture, (5) learning...starting with the board, and (6) establishing executive accountability. At that time, the board QPS committee had already set aims, established a monitoring system, and held senior system leaders accountable for quality performance, though many in the organization still believed finance trumped quality. In response to IHI's emphasis on the need for culture change, the committee's priorities shifted toward stories of patient harm and changing the environment, policies, and culture of the organization.

CHP's culture transformation began with tracking and reporting the rate of serious reportable events (SREs) based on the NQF definition.⁸ Hospital presidents were trained to make patient safety walk rounds, and the system CEO began to join individual hospital presidents on their walk rounds. The system adopted "just culture" principles and conducted its first Agency for

Healthcare Research and Quality Patient Safety Culture Survey in 2005.

A dramatic step toward changing culture was storytelling around tragic events involving patient harm. After hearing a story of patient harm at its April 2008 meeting, storytelling by a regional CEO or hospital president became a required agenda item at virtually every board QPS committee meeting.

Presentation of Data and Information

CHP has developed increasingly sophisticated mechanisms for sharing information with its board and QPS committee at multiple levels. Reviewed at every meeting, a high-level dashboard identifies performance at system, regional, and facility levels, and provides information on multiple goals. For 2012, the dashboard tracked year-to-date performance on system-level goals: (1) eliminate preventable harm, (2) reduce mortality, (3) improve patient experience, (4) reduce length of stay, (5) reduce readmissions, (6) improve emergency department median admit time, (7) patient-centered medical home recognition, and (8) achieve CMS Partnerships for Patients goal to reduce hospital-acquired conditions.

The board QPS committee also is provided with a detailed drill down on each goal as well as a control chart (Figure 1). Eliminating preventable harm has been a system objective since 2010. Of the 5 harm measures tracked by CHP, reducing hospital-acquired falls and trauma with harm has proven most difficult to achieve. Quantitative data can be presented in many ways, enabling clinical staff to inform the QPS committee that:

- CHP's rate of patient falls with injury, an NQF SRE, has decreased

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2.5-fold since 2008, from a rate of 0.637 falls per 1000 to 0.261 falls per 1000.

- This is substantially below the national average of 0.564 falls per 1000 reported in the CMS Hospital Compare database.
- Fall rates have dropped below the historical average for 9 consecutive months beginning in September 2011, representing a statistically significant improvement.

One might ask, does the board need to know anything else about falls or should the staff be congratulated? If the staff was content, they would be failing to fully inform the board. In addition to reporting *rates* of falls, CHP shares the *number* of injuries that occur in our hospitals:

- Falls are an NQF SRE defined as “largely, if not entirely, preventable and serious.”
- In 2008, a total of 104 patients fell and injured themselves in our hospitals, an average of 9 patients a month.
- If trends during the first 8 months of 2012 hold, then 53 patients will suffer a fall with injury, about 4.4 per month.
- Over 25% of the hospitals in the United States report no falls.
- Nine of CHP’s 22 acute care facilities have had zero falls through August 2012.
- Evidence-based practices have been shown to reduce or eliminate the risk of falls; not all our hospitals adhere to these practices.

This additional information helps the board place what initially appears to be robust performance in the appropriate

Figure 1. Proportion of Patients with Falls or Trauma

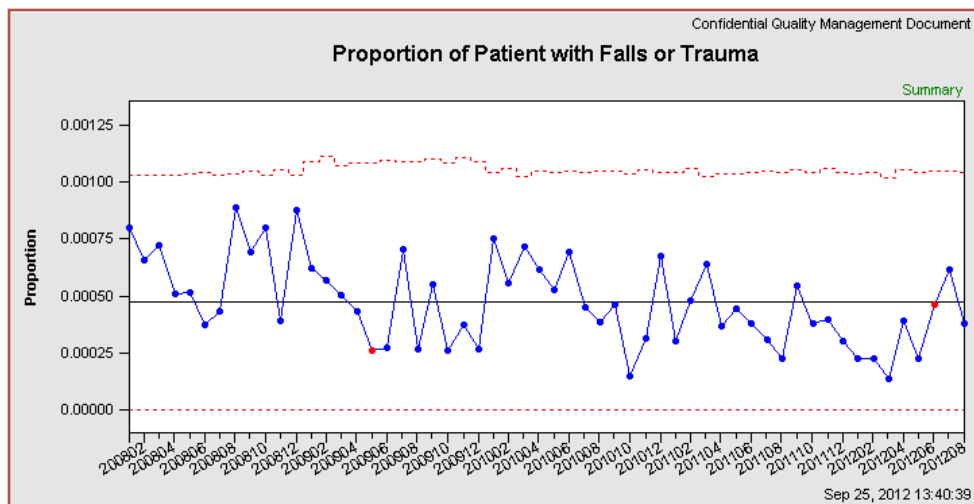
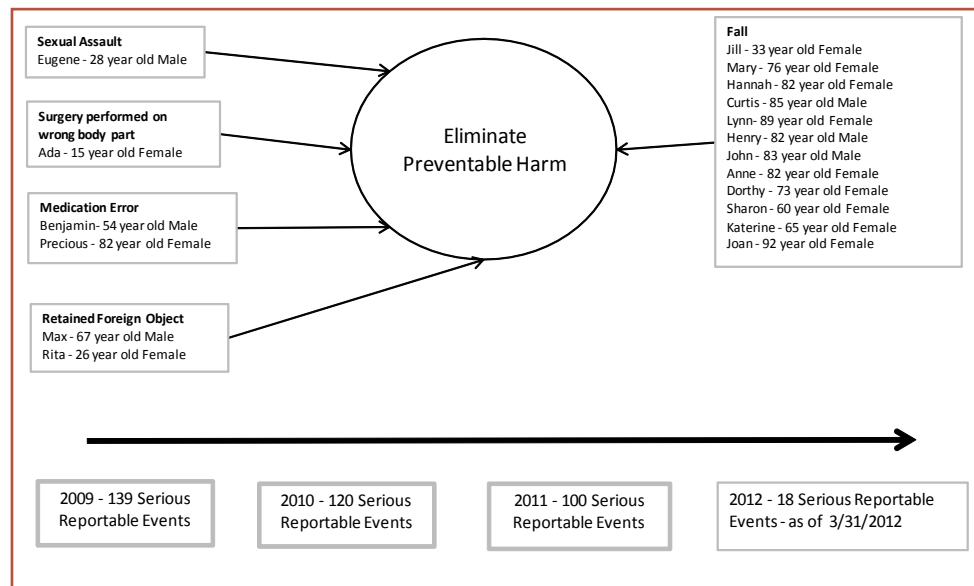


Figure 2. Failures of Care Report



context. To put a human face on these data, CHP developed a quarterly “Failures of Care” report that highlights the impact of harm at a human level (Figure 2).

System-wide Adoption of Best Practices

In 2012, CHP corporate QPS staff requested that each region share its Failures of Care report with local boards of trustees. Noting that best practices adopted at the system level had not been adopted consistently among the regional boards, the system’s executive management team requested that all regional CEOs begin to share stories consistently as outlined in the Boards on

Board campaign and to share the Failures of Care report quarterly.

Inconsistency in adoption of best practices across a system is not unique. As demonstrated by Jha and Epstein, “fewer than half of the boards rated quality of care as one of their 2 top priorities, and only a minority reported receiving training in quality.”⁹ This is little changed from Joshi and Hines’ finding in 2006.¹⁰

Conclusion

Six years since the launch of the Boards on Board campaign, many hospitals have yet to implement the necessary

cultural changes, measurement systems, and governance changes to achieve the goals of the 5 Million Lives Campaign.

Ultimately, the ability of staff to support good governance depends primarily on the senior team's commitment to leadership practices focused on providing data and information with a high level of transparency.^{11,12}

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References

1. Bader BS. Best practices for board quality committees. http://www.greatboards.org/newsletter/reprints/Board_quality_committees_best_practices.pdf. Accessed September 23, 2012.
2. National Quality Forum. *Hospital Governing Boards and Quality of Care: A Call to Responsibility*. Washington, DC: National Quality Forum; 2004.
3. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.
4. Berwick DM, James B, Coye MJ. Connections between quality measurement and improvement. *Med Care*. 2003;41(1 suppl):I30-I38.
5. National Quality Forum. *Safe Practices for Better Healthcare—2010 Update: A Consensus Report*. Washington, DC: National Quality Forum; 2010.
6. Institute for Healthcare Improvement. *Getting Started Kit: Governance Leadership "Boards on Board" How-to Guide*. Cambridge, MA: Institute for Healthcare Improvement; 2008.
7. Conway J. Getting boards on board: engaging governing boards in quality and safety. *Jt Comm J Qual Patient Saf*. 2008;34(4):214-220.
8. National Quality Forum. *Serious Reportable Events In Healthcare — 2011 Update: A Consensus Report*. Washington, DC: National Quality Forum; 2011.
9. Jha A, Epstein A. Hospital governance and the quality of care. *Health Aff (Millwood)*. 2010;29(1):182-187.
10. Joshi MS, Hines SC. Getting the board on board: engaging hospital boards in quality and patient safety. *Jt Comm J Qual Patient Saf*. 2006;32(4):179-187.
11. Institute for Healthcare Improvement. *A Framework for Leadership of Improvement*. Cambridge, MA: Institute for Healthcare Improvement; 2006.
12. Reinertsen JL, Bisognano M, Pugh MD. *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care*. 2nd ed. Cambridge, MA: Institute for Healthcare Improvement; 2008.

The Future of Governance: Health Care Boards Change with Challenging Times

By F. Kenneth Ackerman, FACHE, FACMPE

Health care is arguably the most rapidly changing industry in America. These are turbulent times for boards and chief executive officers (CEOs) who face difficult issues and mounting uncertainty. Unless the health care enterprise is a sustainable business model, even the best governance cannot assure success. The crucial question facing boards today is whether the health care enterprise can transform itself fast enough to succeed in the face of all this turbulence.

In preparing for this article, 25 health care industry leaders with over 1000 years of collective governance experience were interviewed. Ten themes emerged from these interviews.

1. Health care boards will continue to become smaller

An important change in governance of nonprofit hospitals and health systems will be in the size of boards. According to the American Hospital Association, most boards today have between 15 and 18 board members, and some of the

largest ones have 30 or more directors. Many of these boards are still too big to assure effective governance.

Smaller boards lead to a greater sense of ownership and accountability. Members come to meetings better prepared and feel more satisfaction in their board service. Smaller boards are less cumbersome decision makers and take action more promptly when it is needed.

2. Boards will govern larger and more complex clinical enterprises

Consolidation in the industry will continue to accelerate for one simple reason: *scale matters*. In addition to economic pressures, there are other compelling forces requiring hospitals and health systems to manage the entire continuum of care. The visionary health care enterprise is already focusing on managing the health of entire defined populations.

We are witnessing a transformation in the way health care is delivered in this country, one that is driven by the simple reality that health care costs are growing at a rate that is unsustainable. This transformation will be a catalyst that ultimately requires boards to significantly upgrade their own performance.

3. Boards will need to understand and manage risk

With the growing complexity of health care systems comes increased risk in several areas — strategic, operational, financial, and compliance. In addition to regulatory risk more risk will arise from the growth and complexity of the enterprise, the challenge of physician-hospital integration, quality issues, the expanded use of electronic health records while meeting Health Insurance Portability and Accountability Act privacy and security requirements, increasing reliance on outsourcing, and other factors. Environmental, economic, political, regulatory, and

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social landscapes are in a state of flux. At any given moment an unexpected crisis can demand an immediate response.

The responsibility for risk oversight lies with the full board of directors. Boards will need to develop a clear understanding of the risks they face and avoid, mitigate, or monitor them. Risk scenario planning will become commonplace on good boards.

Because many risks can be “value killers,” or “reputation killers,” they require constant vigilance. Board members must continually ask themselves, “What don’t we know that we should know?”

4. Board composition will change

Hospitals and health systems will focus more on the clinical enterprise, becoming obsessed with outcomes, quality, and safety. More of these organizations will be led by physician CEOs. Good governance requires independent directors with the right skill sets and expertise to make difficult decisions. More boards will look outside their communities to find directors with the requisite backgrounds, including industry experts (eg, physician executives, nurse executives, marketing executives, chief information officers, health insurance executives).

The right board composition for any organization is driven by the vision and strategy of the enterprise.

5. Boards will become more diverse

It is important to have a mix of perspectives on any issue. Racial, gender, and ethnic diversity helps to assure robust boardroom discussions when dealing with the strategic imperatives of the enterprise. If diversity doesn’t start with the board, it is often difficult to assure adequate diversity throughout the organization. However, finding

directors with the appropriate skills and experience will remain the top priority.

6. Boards will become more transparent

Outside pressures, including the new Internal Revenue Service form 990 and its schedule H, state and federal governments, and aggressive states’ attorneys general — all in an environment with Internet and 24/7 media attention — will drive organizations toward greater transparency. The public demand for higher quality, safety, and customer service create a need to demonstrate the “value proposition” for community wellness, disease prevention, better health outcomes, and lower costs. Also, transparency builds trust both inside and outside the organization.

7. CEO succession will become a priority

Despite the fact that CEO turnover has remained alarmingly high for the past decade, fewer than 20% of boards have a good succession plan in place. The lack of a formal succession plan heightens the possibility that the organization will need to recruit the next CEO from the outside, an option fraught with risk of a costly failure.

Succession planning is a fundamental responsibility of the board. Successful transitions require careful planning by the board and the CEO.

8. Best practices will become the norm

The current health care environment — with changing regulations, pressure from ratings agencies and payers, liability risks, rising public expectations, and the potential for public embarrassment if something goes wrong — is best dealt with by adhering to best practices.

Sophisticated boards will constantly measure everything, including their own performance. They will conduct annual CEO appraisals, annual appraisals of

board and committee chairs, reviews of board and committee performance, and peer- and self-evaluations of directors. Intentional self-examination over a sustained period will help improve board performance.

9. Highly qualified directors will be difficult to find

Board work today requires significantly more time than it did 10 years ago. Although there are rewards for board service there are drawbacks as well, including the rigors and risks of board membership, the travel and preparation time required, and concerns about personal liability and reputational risk. Other factors (eg, retirement of baby boomers, scarcity of CEOs willing and able to sit on outside boards) are reducing the pool of candidates for board membership.

The best boards are already thinking outside the box, expanding their search parameters, and looking outside their own communities to find well-qualified candidates to fill board positions. The use of professional search firms to identify qualified board members will become common practice.

10. More large health system boards will compensate directors

The importance of finding the right candidate, an acknowledgement of the time requirements placed on board members, and the growing recognition that highly-qualified candidates have many opportunities to serve on other boards are among the primary reasons why many large health systems will consider compensating board members.

Although director compensation is controversial, real value lies in the social contract that such pay establishes between the board and the organization. Boards must

weigh the decision to compensate directors carefully to determine whether it is the right decision for their particular situation.

Summary

The next 10 years will be a difficult time to serve on the board of a health care provider organization. Boards will need wisdom and courage to keep their organizations on the right course. They will need to follow governance best practices to demonstrate to a wary public that they are acting in the best interests of the patients and the communities they serve. They will need to deal with issues such as CEO turnover, physician integration, revenue and capital constraints, quality and safety issues, and mounting risks in governing bigger and more complicated enterprises — all in the face of changes in the environmental, economic, political, regulatory, and social landscapes.

To meet the challenges of the future, boards must begin to operate differently

than they did in the past by adopting best practices, recruiting directors carefully, being proactive and transparent, and making decisions quickly. Good governance will be essential to assure a high-performing health care enterprise in these challenging times.

Recommended Reading

1. Ackerman FK. The compensation committee. In: Nash DB, Oetgen WJ, Pracilio VP, eds. *Governance for Healthcare Providers*. Boca Raton, FL: CRC Press; 2008: 204-206.
2. Alliance for Advancing Nonprofit Health Care. Compensation for nonprofit health care board members: the right path or a minefield? *Inquiry*. 2012;49(1):9-14.
3. Bader BS. Conflict Manager: The board chair's unsung role. www.greatboards.org/newsletter/2012/conflict-manager-summer12.pdf. Accessed April 22, 2013.
4. Bjork DA. *Healthcare Executive Compensation: A Guide for Leaders and Trustees*. Chicago, IL: Health Administration Press; 2012.
5. Bjork DA, Fairley DJ. *Leadership Continuity: The Board's Role in Maintaining Seamless Management and Governance Transitions*. 2nd ed. San Diego, CA: The Governance Institute; 2012.
6. Bowen WG. *The Board Book: An Insider's Guide for Directors and Trustees*. New York: W.W. Norton and Company; 2008.
7. Brown D, Murphy S, Prybil L. *Great Governance: A Practical Guide for Busy Board Leaders and Executives on Nonprofit Health Care Organizations*. <http://www.nonprofithealthcare.org/resources/Alliance-GreatGovernanceGuide.pdf>. Accessed April 22, 2013.
8. Crowe K. *The Path Toward a Paperless Board Room*. https://www.boardmember.com/MagazineArticle_Details.aspx?id=7401. Accessed April 22, 2013.
9. George W. Board governance depends on where you sit. In: Lorsch JW. *The Future of Boards*. Boston, MA: Harvard Business Review Press; 2012: 97-112.
10. Gillespie J, Zweig D. *Money For Nothing: How the Failure of Corporate Boards Is Ruining American Business and Costing Us Trillions*. New York: Free Press, a division of Simon & Schuster, Inc.; 2010.
11. Keenan C. The invisible threat. <https://www.boardmember.com/The-Invisible-Threat.aspx>. Accessed April 24, 2013.
12. Lublin SJ. Board rooms remain old school. <http://online.wsj.com/article/SB10001424052748703905404576164791847168546.html>. Accessed April 22, 2013.
13. McGinn P. *Partnership of Equals. Practical Strategies for Healthcare CEOs and Their Boards*. Chicago, IL: Health Administration Press; 2009.
14. Nadler D, Behan B, Nadler B. *Building Better Boards: A Blueprint for Effective Governance*. San Francisco, CA: Jossey-Bass; 1999.
15. Orlikoff EJ. Cultural transformation: the buck starts with the board. <http://www.nhha.org/files/whatsnew/Trustee%20Cultural%20Transformation.pdf>. Accessed April 22, 2013.
16. Pointer D, Orlikoff EJ. *Board Work: Governing Health Care Organizations*. San Francisco, CA: Jossey-Bass; 1999.
17. Scally D. The new frontier. https://www.boardmember.com/MagazineArticle_Details.aspx?id=7422. Accessed April 22, 2013.
18. Snyder SL, Reif D. *Answering the Call: Understanding the Dilemmas, Risks and Rewards of Corporate Governance*. Washington, DC: Women Business Leaders, US Healthcare Industry Foundation; 2011.
19. Walker L. Dangerous board diseases. http://www.htnys.org/training/boardroom-basics/docs/2011-11-18_dangerous_board_diseases.pdf. Accessed April 24, 2013.

Board Size and Composition in Large Nonprofit Health Systems

By Lawrence Prybil, PhD, LFACHE

A recent study examined board structures, processes, and cultures in a set of the country's largest nonprofit systems and compared them to benchmarks of effective governance.¹ The 4 phases of the methodology employed to gather and analyze information have been published previously.²

Summary of Findings Regarding Board Size and Composition

Board Size

Neither in the health care field nor other sectors is there an exact answer to

the question, "How large should a board of directors be?" The 2007 report of the Center for Healthcare Governance Blue Ribbon Panel on Healthcare Governance advocated a range of 9 to 17 voting members for hospital and health system boards.³ Several other authorities have offered similar recommendations.

For 10 of the 14 systems, board size is consistent with the Blue Ribbon Panel's recommendation. Three boards have between 18 and 28 voting members; 1 board has 60 members. The median

size is 15 members, excluding the outlier with 60 voting members.

The boards of these systems are somewhat larger than the boards of our country's hospitals and health systems as a whole (whose average size consistently has been between 12 and 14 since 2005) and the boards of our country's public companies (whose average size has remained in the 8 to 9 range for many years).¹

Board Composition

Independence. The Sarbanes-Oxley Act of 2002 made the definition

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of “independence” more stringent and increased the requirements for independent board members on the boards of public companies. The impact on the composition of public company boards has been striking. The proportion of independent directors on the boards of Fortune 500 companies increased from 22% in 1987 to 84% in 2011.⁴ Although the Sarbanes-Oxley Act applies only to public companies, many of its key provisions have been adopted voluntarily by nonprofit hospitals and health systems. Several authorities, including the Internal Revenue Service, have called for a *majority* of board members in nonprofit organizations to be independent.

For the purpose of this study, the term “independent board member” was defined as persons who are “not a member of a sponsoring body such as a religious congregation, not a full- or part-time system employee, and not directly affiliated with the system in any way except serving as a voting board member.” Table 1 shows that, in total, 60% of the members of the 14 system boards in this study population meet these criteria. However, 82% of board members in the 5 *secular* health systems meet the criteria for independence — virtually identical to the current composition of America’s public companies — while only 49% of *faith-based* system board members meet those criteria. Clearly, the composition of most faith-based system boards still includes a substantial proportion of persons who are affiliated with the previous or current religious sponsors. The range of *independent* member composition varies from 18% for 1 faith-based system to 100% for 1 secular system, the single system in which the CEO is not a voting member of the board.

Diversity. In the health care field and other sectors, there is agreement that governing boards must include persons with a strong *blend* of pertinent

experience and skills in order to perform their fiduciary duties effectively. It is increasingly recognized that the boards of nonprofit organizations also should include members with diverse backgrounds and perspectives.

Table 2 shows the proportion of nonwhites serving on the boards of the 14 large systems in this study population. In total, 17% of the systems’ board members are nonwhite; the proportion of those serving on faith-based vs. secular boards is virtually identical. This is somewhat higher than the comparable figure (10%) for hospitals that participated in a 2011 survey conducted by the American Hospital Association (AHA).⁵

Table 3 shows the gender mix of the 14 systems’ boards. Although there is some variation from board to board, the overall proportion of women serving on the boards of the 9 faith-based systems (40%) is significantly higher than the corresponding figure for the secular systems (21%). Collectively, hospitals

and health systems that participated in a nationwide survey by the Governance Institute in 2011 reported that 26% of their board members were women.⁶

As compared to America’s Fortune 500 companies, the boards of these 14 large, nonprofit health systems are more diverse, both in racial and gender composition. In 2011, only 14% of Fortune 500 board members were nonwhite and only 16% were women.⁴ It appears that our nation’s largest nonprofit health systems are responding to what is, on balance, a compelling case for diversity in board composition.

Clinical Engagement. The National Quality Forum and other prominent health care organizations have urged hospital and health system boards to engage clinical leaders in developing strategies to improve patient care quality and safety. Involving highly qualified physicians who are committed to the organization’s mission has become a standard governance practice. The findings of several national studies in

Table 1. Independent vs. Non-Independent Board Members

	Board Composition in Faith-Based Systems (n = 179)	Board Composition in Secular Systems (n = 95)	Board Composition in All Systems (n = 274)
Independent	49%	82%	60%
Non-Independent	51%	18%	40%
<i>P</i> < .01*	100%	100%	100%

*The chi-square test demonstrates significantly different proportions of independent board members in faith-based systems.

Table 2. Racial Composition of Large System Boards

	Board Composition in Faith-Based Systems (n = 179)	Board Composition in Secular Systems (n = 95)	Board Composition in All Systems (n = 274)
Nonwhite Members	17%	18%	17%
White Members	83%	82%	83%
N/S*	100%	100%	100%

*The observed differences were not statistically significant

recent years show physicians generally constitute approximately 20% of hospital and health system board membership.

In contrast, engaging nursing profession leaders in the governance of health care organizations traditionally has not been a common practice. Studies completed in 2005 and 2009 found that nurses comprised only about 2% of nonprofit hospital and community health system boards.^{7,8} Recognizing the vital role of nursing in determining the quality and cost of care, a growing number of respected organizations including the Robert Wood Johnson Foundation have urged hospital and health system officials to consider the appointment of highly qualified nurse leaders to their boards.

Table 4 shows that, in combination, 14% of the study populations' board members are physicians and 6% are nurses. Physicians are somewhat more prominent on the boards of secular systems (18%) as compared to faith-based systems (11%); nurses comprise a larger proportion of the faith-based system boards (9%) than the secular system boards (2%). In both groups, clinicians collectively constitute 20% of the systems' voting board membership.

The finding that 6% of large system board members are nurses is exactly consistent with the results of the AHA's 2011 survey of American hospitals.⁵ These findings appear to represent a shift in the direction that Hassmiller and Combes, and others believe is "... long overdue."⁹

Table 3. Gender Composition of Large System Boards

	Board Composition in Faith-Based Systems (n = 179)	Board Composition in Secular Systems (n = 95)	Board Composition in All Systems (n = 274)
Women	40%	21%	33%
Men	60%	79%	67%
<i>P</i> < .01*	100%	100%	100%

*The chi-square test demonstrates significantly different proportions of women board members in faith-based vs. secular systems.

Table 4. Clinician Composition of Large System Boards

	Board Composition in Faith-Based Systems (n = 179)	Board Composition in Secular Systems (n = 95)	Board Composition in All Systems (n = 274)
Nurses	9%	2%	6%
Physicians	11%	18%	14%
Other	80%	80%	80%
<i>P</i> < .05*	100%	100%	100%

*The chi-square test demonstrates significantly different proportions of nurses in the board compositions of faith-based vs. secular systems.

Conclusion

With respect to board size and composition, the boards of these large systems are somewhat more consistent with current benchmarks of effective governance than the country's hospitals and health systems as a whole. The board leaders and CEOs of these systems are encouraged to continue their efforts to identify opportunities to improve their governance model and performance.

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References

1. Prybil L, Levey S, Killian R, et al. *Governance in Large Nonprofit Health Systems: Current Profile and Emerging Patterns*. Lexington, KY: Commonwealth Center for Governance Studies, Inc.; 2012.
2. Prybil LD, Bardach DR, Fardo DW. Board oversight of patient care in large nonprofit health systems. <http://ajm.sagepub.com/content/early/2013/04/22/1062860613485407.full.pdf+html>. Accessed May 20, 2013.
3. Wegmiller DC, Alexander J, Altman H, et al. *Building an Exceptional Board: Effective Practices for Healthcare Governance*. Chicago, IL: Center for Healthcare Governance; 2007:13.
4. Corporate boards: now and then. *Harvard Business Review*. 2011;89:39.
5. American Hospital Association. *2011 AHA Health Care Governance Survey Report*. Chicago, IL: Center for Healthcare Governance; 2011:3.
6. *Dynamic Governance: An Analysis of Board Structure and Practice in a Shifting Industry*. San Diego, CA: The Governance Institute; 2011:5.
7. Prybil L. Size, composition, and culture of high-performing hospital boards. *Am J Med Qual*. 2006;21:224-229.
8. Prybil L. Engaging nurses in governing hospitals and health systems. *J Nurs Care Qual*. 2009;24:5-9.
9. Hassmiller S, Combes J. Nurse leaders in the boardroom. *J Healthc Manag*. 2012;57:8.

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