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# Board Governance: Reform-Driven Transformation and Reexamination of Fundamentals

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**HEALTHCARE HAS NEVER** been a slow-moving industry, yet it is currently experiencing a transformation unlike any we have ever seen. No doubt we will one day look back on this time as profoundly historic. Healthcare systems, hospitals, and other providers are dismantling current models and redesigning care delivery to manage the health of populations, while also improving quality and safety and controlling costs, even as reimbursements are shrinking.

These are daunting challenges that require not only transformational governance involving new approaches and ways of thinking, but also reevaluation of governance fundamentals and principles to determine whether they still fit.

Texas Health Resources, like Chilton Medical Center in New Jersey and Presbyterian Healthcare Services in New Mexico, has chosen to embrace these challenges, not only in terms of its strategies for healthcare delivery but also in its approach to governance.

In their feature articles, Deborah Zastocki, FACHE, and James Hinton present compelling descriptions of the rapidly changing healthcare environment. Hospitals and health systems are being pushed by reform-driven imperatives to redesign healthcare delivery to provide population health, clinical integration, and accountable care across the continuum of the life span. Consumers and employers are emerging as the purchasers of healthcare services. They assume that quality, patient safety, and value are the price of entry and view competitively lower healthcare costs as their primary driver for healthcare decision making.

The challenge is that health system and hospital competencies are predominantly in acute care delivery in an emerging world that also requires expertise in wellness, chronic disease management, post-acute care, palliative care, and end-of-life care. As providers endeavor to build, buy, or partner for the rest of the continuum, new competitors are emerging in commercial payers,

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employers, physicians, and venture capitalists. As disruptive innovation becomes a driving force, the reimbursement system has not yet evolved to pay for care delivery redesign or innovation, and the transition from volume-based care to value-based care continues to take place.

Most leading healthcare systems and hospitals across the country see the need to transform to meet these challenges. So why is there not a corollary healthcare governance transformation occurring as well? As Deborah Zastocki states, “The challenge is that our toolbox does not contain what is

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needed to build the future healthcare delivery systems required in the post-reform world.” Having built an effective governance structure and infrastructure that have worked well in the past is not enough. Even

the best program requires periodic review and change. Organizations that have not invested the time, resources, and energy in competency-based governance, comprehensive board member orientation and education programs, and carefully structured board discussions that are generative, strategic, and prospective face a major challenge in attempting to catch up.

Why is there such a “governance lag” in healthcare organizations? It seldom is because they do not care or do not want to have good governance. One reason is that, although numerous conferences, articles, books, and forums exist where one can learn about the transformations occurring in healthcare, as well as the components needed for a governance program, few resources are available for evidence-based methodologies that prescribe the steps necessary to actually build a comprehensive and effective governance program.

Governance transformation requires a multifaceted, multiyear approach that is

carefully constructed and executed, as well as continually evolving and advancing with cycles of learning. The approach to governance transformation requires “new skills, expertise, and ways of thinking,” as Zastocki states, but it also requires a return to the fundamentals and reinventing them as necessary.

## TRANSFORMING GOVERNANCE FUNDAMENTALS

Leading governance expert James E. Orlikoff (2015) asserts that effective governance is based on the following explicit principles:

1. *Minimalism*: Fewer governance entities are better.
2. *Consistency*: All governance and leadership structures are consistent throughout the system.
3. *Authority*: Authority should be centralized and decision making should be decentralized; provide constant clarity via an authority matrix.
4. *Intentionality*: Governance structures and functions are based on conscious choices and explicit principles, not on history or happenstance.

Although these governance principles certainly are not new, many organizations in this country have yet to embrace them. In addition to these basic principles, there are other governance fundamentals that most boards have embraced but that need to be reexamined in the current environment.

### Board Size

For more than a decade, governance experts have suggested that the ideal size of a healthcare board is 9 to 17 members (Health Research and Educational Trust 2007; Prybil et al. 2012; Stuart 2011). Certainly, board size should be based on the breadth of the organization, the competency mix needed, and the committee structure, with the

understanding that at a critical-mass point the board will become too large or too small, to the detriment of qualitative discussion and optimal governance effectiveness.

One additional aspect to consider, however, is the number of people who attend board meetings. A board may have an ideal number of directors, but if 36 people are in the room, this defeats the purpose. The number of people in the boardroom needs to be limited, and presenters do not need to attend the entire board meeting.

### Board Composition and Competencies

Zastocki asserts that “Our predominantly cottage industry, with its long-tenured boards that were emotionally attached to the ‘good old days,’ is over.” Is this true, or do we just wish it was over? The good old days included representational governance, and many boards still have it. Boards should have a “clear leadership focus: the purpose of governance is to lead, not to represent constituencies and stakeholders” (Orlikoff 2015). Furthermore, legal fiduciary duties demand that board members place the interests of the organization ahead of their own personal, professional, or constituency interests. In an industry in which virtually nothing will be the same in ten years, a competency-based board has never been more important.

Most boards have, at a minimum, loosely identified competencies. Fewer boards have formally adopted specific core competencies, personal attributes, and knowledge and skills needed. Those that have done so often equate competencies with professional expertise, which is important; however, even more critical competencies are willingness to engage and ask difficult questions. As Hinton’s board concluded, it is increasingly important to recruit “people who [have] experience managing a customer-focused enterprise and people who [manage] large, complex systems.”

Of those boards that have developed competencies, many fail to use the competencies in an effective and ongoing way in board selection and succession planning. Only rarely do boards undertake an ongoing assessment of whether the competencies selected continue to serve the organization well, make adjustments to them as the organization and environment evolve, conduct a concentrated analysis of the board, and achieve a true balance of board members with a mix of competencies.

Considerable information is available to boards about board competencies, including three excellent publications by the American Hospital Association (AHA) Center for Healthcare Governance (2009, 2010a, and 2010b). However, much harder to find are resources and guides that illustrate how to conduct an effective analysis of competencies to determine those that are needed by a particular organization at different levels; how to use competencies systematically in succession planning; and how to balance and advance those competencies over time.

### Job Description

Every board should have one—period. A clear understanding of legal fiduciary duties, roles, responsibilities, and expectations is critical for effective governance and decision making. Failure to develop a job description results in confusion, wasted time, focus on the wrong areas, and potential liability if respective roles and responsibilities among multiple boards and management are not well understood. Further, board job descriptions need to be reevaluated periodically to incorporate and advance transformational governance functions.

### Orientation

For today’s healthcare environment, our traditional orientation and education

programs often are inadequate. Critical to effective decision making in a transformational world is a far more sophisticated approach to orientation than that in the past. Board members need and deserve a timely and well-constructed orientation that, at a minimum, consists of an organizational history and overview, board service fundamentals (e.g., number and length of terms), governance plan and policies, board and committee structure, strategic vision and goals, key performance metrics, ethics and decision-making guides, an understand-

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ing of healthcare financial reports, and credentialing processes. Transformational boards also should provide new directors with a 6- to 18-month multidimensional educational approach to learning about the healthcare industry and its transformational aspects, as well as explain how their organizational culture, market, and strategic vision of the organization fit into the evolving national paradigm.

### **Education**

Board education has never been more important. Terms like “population health,” “clinical integration,” and “accountable care” were not part of our daily healthcare jargon even as recently as five years ago. Board members’ attendance at governance conferences is a useful component to a well-rounded educational plan; however, today’s board education also must include an ongoing systematic approach that involves a number of different modalities to reach different personalities, generations, and learning preferences. These may include a combination of board portals, newsletters, trustee publications, board retreats, shared articles, webinars, and, most important, board meeting time allocated to review and discussion of industry trends

and how they relate to the organization and its strategic direction.

### **TRANSFORMING BOARD MEETINGS**

Having presented on this topic at a number of state and national governance conferences and engaged in dialogue with board members and CEOs, it appears to me that the majority of healthcare boards continue to use the traditional agenda format they have always used, which essentially guarantees the same kind of board meetings they have always had. Typical board meetings largely comprise action items (often without effective use of a consent agenda) and retrospective performance reports that include too many data or too few data, with data interpretation left to each board member. Performance reports often focus on numbers and other facts without an accompanying explanation of how and why the results occurred or action plans to improve or leverage the results. Even more striking is the rarity or complete absence of board discussion on the transformational topics dominating the healthcare horizon, much less how those topics affect the organization and the board.

Board meetings could be transformed by using a consent agenda appropriately, and allowing sufficient time for in-depth discussion stimulated by provocative questions. To make time for discussion of prospective/generative items, routine/retrospective report items should be placed on the agenda *after* the board discussion items, with oral reports focusing on highlights and key variances and being limited in time.

### **IN-DEPTH, PROSPECTIVE, STRATEGIC DISCUSSION TOPICS**

Most boards believe they engage in prospective discussion because directors ask questions and offer thoughts throughout

meetings. When I ask board members around the country about their favorite discussion topics, the offerings typically fall into the realms of quality, finance, conflict of interest, confidentiality, or similar fare. As Zastocki explains, these are fiduciary topics but seldom are generative, transformational, or strategic.

As Zastocki notes, national experts have long recommended that boards allocate at least 25–30 percent of their agenda time to discussion of generative/strategic direction and of challenges in meeting outcomes (Peisert 2011). In my more than 15 years of experience in reviewing and interpreting board self-assessment survey results in comparison with national averages (i.e., the AHA Center for Health Care Governance’s Governance Assessment Process survey), I have observed that one of the lowest-scoring questions nationally pertains to the amount of time a board spends on prospective discussion.

One of the primary reasons boards fail to engage in prospective, generative, and strategic discussion is the challenge in identifying appropriate topics and developing content to guide the discussion. One helpful approach is for the board to have a brainstorming session to plan its discussion topics for the coming year. Another approach is the use of articles, webinars, or external speakers who have developed content on transformational topics geared toward governing boards to lead into a robust discussion facilitated by thought-provoking questions designed to elicit active engagement of board members.

### THE TEXAS HEALTH RESOURCES STORY

Texas Health Resources was formed in 1997 by the joining of Dallas-based Presbyterian Healthcare Resources, Fort Worth-based Harris Methodist Health System, and Arlington Memorial Hospital.

Over the past 18 years, Texas Health has not only established one culture that has become its core competency but also has made great strides to achieve “systemness”—a common approach to governance, leadership, and decision making across the entire organization.

Today, Texas Health is one of the largest nonprofit, faith-based healthcare systems in the country. With more than \$6 billion in assets, it has 22,500 employees and more than 5,500 physicians with active medical staff privileges. It consists of 24 acute care, transitional, rehabilitation, and short-stay hospitals; 65 outpatient facilities, surgery centers, fitness centers, and imaging centers; more than 250 other community access points; and an employed physician group. Texas Health, along with community partners such as other healthcare systems, commercial payers, physicians, and retail outlets, is advancing strategies and programs in population health management, clinical integration, accountable care organizations, chronic disease management, and community clinics. Texas Health is committed to providing value-based and affordable care across the continuum for people in the communities it serves. It is a leading sponsor of the Fort Worth Blue Zones Project®—the largest of its kind in the world—whose objective is to advance healthy lifestyles and well-being on a community-wide basis. As a system, Texas Health provides more than \$685 million annually in charity care and community benefits.

From the outset in 1997, Texas Health was committed to exceptional governance, with the development of a comprehensive governance structure and infrastructure and a multiyear governance plan. I was involved in the development of the first governance plan and decision-making authority matrix. In 2000, I assumed the role of Texas Health’s second systemwide

governance officer, overseeing a staff that is now composed of five professionals.

Since 1997, Texas Health has continually evaluated and advanced its organizational and governance structure, including consolidating and eliminating a number of corporations and boards, as well as invested in innovative structures. In 2012, Texas Health adopted a zone framework—led by a dyad structure at the system and zone levels and a triad structure at the hospital level—through which clinical and administrative leaders share leadership.

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A substantial number of leadership roles system-wide are held by clinical leaders, either physicians or nurses.

Texas Health is currently governed by a system board composed of 18 voting members and a robust committee structure. Each committee has a well-defined charter and structure and is chaired by a system board member. Every system trustee is required to serve on at least one committee, and all committee members are selected on the basis of defined competencies. With the exception of the governance committee and the audit and compliance committee, which are composed entirely of system board members, each board committee’s membership is strengthened and broadened by means of competency-based selection from other boards across the system.

Texas Health hospitals and most other business units are nonprofit corporations, each of which has its own governing board. The system board retains significant reserved powers and decision-making authority, whereas the entity boards have largely oversight roles, with hospitals continuing to be directly responsible for quality of care (consistent with system

guidelines and protocols) and physician/allied health credentialing. The roles, responsibilities, and expectations (i.e., job description) of each board are clearly defined in a “board compact.” Clarity of comparative roles and responsibilities among all boards and employees is provided through a decision-making authority matrix that is continually updated and evolving as organizational and environmental changes occur.

From the outset, Texas Health determined that both its parent and community boards would be competency based. One of its early board-developed competency charts was recognized as a best practice by the American Hospital Association Blue Ribbon Panel on Health Care Governance (Health Research and Educational Trust 2007). Those competencies have been evaluated and have evolved over the years. Texas Health actively uses its competencies in board succession planning, with the aid of an internally developed Board Leadership Continuity and Growth (BLCG) Plan. The BLCG, which was featured as a best practice by the American Hospital Association Blue Ribbon Panel on Health Care Governance (AHA Center for Healthcare Governance 2009), is updated annually by the chief governance officer for each board and serves as a tool to keep each board focused on its competency mix and balance, as well as on board leadership development over a three-year planning horizon.

All Texas Health boards operate under a common, sophisticated, multiyear governance plan that includes the following:

- A comprehensive orientation, education, and communication program that includes a monthly electronic newsletter, conferences, a trustee portal featuring a healthcare industry education section on

transformational topics, and electronic packets and other resources

- Annual board self-assessments
- Standardized organizational documents, as well as standard board agendas, presenter guidelines, and meeting processes designed to drive more prospective/generative discussion and lessen the time spent on retrospective reporting
- A sophisticated governance database and profiling system that tracks competencies, board service information, and data required for regulatory and licensing reporting for all trustees systemwide

## CONCLUSION

Pre-reform governance practices will not be sufficient in the new environment. Boards must reevaluate their governance principles and fundamentals for relevance. They must frequently engage in prospective, generative, and strategic discussion that includes assessment of how population health, accountable care, clinical integration, value-based purchasing, the reimbursement structure, consumerism, exchanges, and other aspects of healthcare reform affect their organization in the context of culture, market, and strategic vision.

Through many cycles of learning, Texas Health Resources has advanced both its leadership and governance structures, as well as developed a sophisticated multiyear governance plan that embraces comprehensive orientation, education, and communication that set the stage for ongoing strategic and generative discussions. These factors, along with its culture and people, carried Texas Health through the recent challenge of treating the country's

first patient diagnosed with Ebola and of being thrust into the global media spotlight. These strengths also have prepared Texas Health for the transformational future, whatever it holds. As James Hinton says in his feature article, "The journey continues."

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