Quality of Board Governance in Nonprofit Healthcare Organizations

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Abstract

According to Pointer and Orlikoff's 1999 book, in response to the revolutionary change in providing and financing healthcare services, healthcare organizations are undertaking radical transformations to survive. The quality of board governance has become a life-saving necessity to healthcare organizations. This article raises a number of issues regarding the quality of board governance in nonprofit healthcare organizations. These include effectiveness of board governance linked to organizational performance, board accountability to communities served, how to be an effective chairman, how board self-assessment changes the governance process, developing effective information systems in ways that respect the governance roles and responsibilities, policy formulation regarding finance matters and quality of care, and the red flags of poor governance. Finally, this article discusses the essential factor contributing to the board: executive relationship.

INTRODUCTION

To understand the complexities of governance in healthcare organizations, one needs to be aware of the changes that are currently taking place in the healthcare industry. Pointer and Orlikoff ($_1$), in their book Board Work: Governing Health Care Organizations, wrote that providing and financing healthcare services are going through a revolutionary change driven by healthcare customers and purchasers—who they are, how they want to pay, and what they are demanding. Managed care has become a central philosophy for the healthcare services delivery in the United States ($_2$). In response, healthcare organizations are undertaking proportionate transformations to survive. The organizations are beginning to shift focus from process to outcome and significantly redesign the services they provide. Vertically and horizontally integrated healthcare organizations, capable of providing a full range of services, are being created. The transformation processes affect the organizations' vision, missions, goals, strategies, structure, and key competencies and capacities. Regardless of the exact design healthcare organizations assume to address these revolutionary changes, the quality of their governance has become a necessity to them ($_1$).

Numerous practitioner-oriented publications have expressed concern that the contributions and performance of many healthcare boards are less than optimal. According to

Anthony and Young ($_3$), in many nonprofit organizations the line of leadership responsibility is f unclear. Unlike for-profit organizations, nonprofit groups have no shareholders, trustees are seldom paid for their services, and trustees often are appointed for financial or political reasons rather than their capability to exercise sound judgment regarding the organization's management. In some institutions, a widely quoted maxim states that the purpose of a board is only to hire a president and then support him or her. Furthermore, performance of some healthcare boards has been under severe strain; disputes over the quality of governance are increasingly overflowing from board rooms into courtrooms. Peregrine and Schwartz ($_4$) noted that allegations of breach of fiduciary duty were at the core of the state attorney general challenges to proposed closures of several hospitals in New York City and West Palm Beach. "Board negligence is frequently alleged in 'imprudent investment' actions brought by attorney generals against failed nonprofit investment practices" (p. 23). Kazemek, Knecht, and Westfall ($_5$) stated that in many of the cases where high-profile health systems and hospitals have been on the verge of financial collapse or declared bankruptcy, their boards were major contributors to their problems.

The most shocking example was the failure of the Allegheny Health Education and Research Foundation (AHERF) in Pennsylvania. Burns, Cacciamani, Clement, and Aquino ($_6$) described how the leadership problems brought AHERF to

bankruptcy with $1.3 billion debt and 65,000 creditors in July 1998. One of the many governance problems of AHERF was its weak governance structure: an enormous parent board with membership that varied from 25–35 persons and a network of 10 individual boards accountable for its various entities. The directors on one board were never sure what was going on elsewhere in the AHERF empire; thus, effective oversight was impossible. AHERF also suffered from several inherent conflicts of interest in the board composition. Five board members were directors or executives of Mellon Bank. In April 1998, 3 months before filing for bankruptcy, AHERF's CEO directed an order to repay an $89 million loan to Mellon Bank without board discussion or approval. In some instances, the CEO conveyed key decisions to the board after they were already made or never announced them at all. Another reported problem was the CEO's domination of all board meetings and decisions and his protection by the board chairman. Former board members described board meetings as scripted affairs, intentionally staged to limit participation and oversight. For example, board members received packages of 1,000 pages to be discussed at brief board meetings. Some former members explained that they did not even open the book because they did not have the time and, as a result, relied on the CEO's and chairman's judgment. Moreover, AHERF's CEO actively presented himself as the only decision maker and consequently shielded the board from responsibility. For instance, during the negotiations with Vanguard Health Care System regarding the purchase of eastern hospitals, AHERF's CEO negotiated directly with Vanguard's CEO, who expressed a concern that he could not access AHERF's board. AHERF's CEO reportedly told him ([6]), "When you are talking to me, you are talking to the board. I have the authority to make this happen" (Problems with Governance sec., ¶ 7). Lastly, AHERF's corporate bylaws and enforcement were severely flawed: AHERF management could make cash transfers without explicit rationale and without knowledge of the board. The lack of board control and oversight led to the bankruptcy of AHERF and subsequent legal action. On June 22, 1999, the Committee of Unsecured Creditors sued 10 AHERF officers and directors "for $1 billion in damages on three counts of breech of fiduciary duty, gross negligence and management, and corporate waste" ([6], Problems with Governance sec., ¶ 10).

Every board has a vital responsibility to make sure that the organization is maintaining public trust and goodwill by demonstrating efficient and responsible use of all its resources. Federal Reserve Board Chairman Alan Greenspan ([7]) stated, "Governance quality is the single best measure of an organization's character" (p. 28). Some believe that boards must become more accountable for their performance, more responsible, and more transparent. It may be time to rethink, redevelop, redesign, and reinvigorate the way board governance is practiced in healthcare organizations ([7]). To illustrate some of the unique challenges that boards of directors experience in nonprofit healthcare organizations, this article reviews current literature regarding the quality of board governance, attributes of effective boards, board accountability to communities served, and red flags of poor governance. In addition, this article discusses the essential factor contributing to the board: executive relationship.

BOARD GOVERNANCE LINKED TO ORGANIZATIONAL PERFORMANCE

Pointer and Jennings ([8]) stated that a board bears ultimate authority, responsibility, and accountability for an organization's performance. "Consider this, your board is convened and given an assignment: In 15 minutes, make a decision that could cause severe damage to the organization. Could the board do it? Most CEOs and board members respond, 'Yes, and in half the time'" (p. 22). Therefore, the quality of the governance matters. Orlikoff and Totten ([9]) pointed out that turnarounds in healthcare organizations, are preceded by years of declining performance indicators that are repeatedly explained away or unheeded by the organization's leaders. The underlying cause of the need for the majority of healthcare organization turnarounds is weak leadership, and the ultimate accountability for their failure rests with the governing boards. Michael Rindler is president of a Chicago-based company that provides turnaround management services to financially challenged hospitals and advisory services to underperforming hospitals. Rindler ([9]) said,

While a variety of external reasons are usually given for why a hospital needs a turnaround, often the real reasons are internal. The most common and pervasive reason is failed leadership from executives, medical staff and the governing board. Typically, the organization's top leaders have failed to take action over a period of months or years to address declining performance trends in a number of areas, such as finance, quality of care and services, or payer relationships. Distressed healthcare organizations often suffer from having little vision or no strategic focus, concentrating instead on year-to-year performance. (¶ 5)

The effectiveness of the board of trustees and the quality of governance are critical to an organization's success ([10, 11]). Jaklevic ([12]) cited results of the Governance Institute's survey of 234 hospital trustees who attended educational conferences in January and February 2003. The following percentages represented the factors that the survey participants believed to be affected by good governance: overall success of the organization, 99%; ability to recruit new trustees, 95%; and organization's credit rating, 86%. Because quality is so important, researchers have sought to identify attributes of effective boards.

ATTRIBUTES OF EFFECTIVE BOARDS

Alexander, Lee, and Bazzoli ([13]) noted that the act of governance involves the process of formulating the organization mission and vision, setting and monitoring the goals, and developing strategies. Roberts and Connors ([14]) stated that the main responsibilities of governing boards of nonprofit healthcare delivery organizations encompass five basic elements: (a) setting the direction, (b) assuring effective management, (c) enhancing the assets, (d) achieving quality goals, and (e) acting as stakeholders on behalf of the communities served (p. 111). The results of the Governance Institute's survey, reported by Jaklevic ([12]), indicated the following top five factors that were rated by participating trustees as "very important" to effective governance: (a) board endorsement of additional education for trustees (92%), (b) conducting a formal CEO performance review (91%), (c) board composition of mostly outside independent directors (81%), (d) chairman of the board is an outside director (80%), and (e) regular board and trustee performance evaluation (76%).

Overall, the literature pointed to 13 attributes of effective boards that are described in detail in the following sections. Effective boards have dedicated trustees, an effective chairman, and an organized and disciplined operation. They use their power as a group, engage in strategic planning, and monitor ethical performance. Effective healthcare boards formulate specific financial policies, make decisions regarding quality of care, and educate their trustees. These successful boards also implement a governance information system, crisis prevention and management procedures, self-assessments, and regular audits.

MEMBERSHIP

Kazemek and Peregrine ([15]) wrote a hypothetical advertisement for a vacant position of a trustee needed for a healthcare organization:

Looking for someone willing to assume a position of tremendous responsibility overseeing an organization in one of the most complex industries in America. Significant time demands preparing for and participating in numerous board and committee meetings. Ongoing education on multiple subjects required, including attendance at weekend retreats. Subject to intense scrutiny by the public, physicians and, possibly, the state attorney general's office. Little to no pay. Advancement opportunities comprise becoming a board officer and doing more of the same. (¶ 1)

Such a notice fairly represents the public expectations of healthcare system or hospital board members. In the fee-for-service days, serving on a hospital board did not require this much effort. It was more an honorary or social post because management basically ran everything. Although such a relaxed approach was not what the law intended, no one seemed to care. Those days are a distant memory now. The literature has reported that, currently, the majority of healthcare board members spend an average of 120–200 hours annually preparing for and participating in board meetings, committees, and self-evaluation activities. The increased time demands, liability concerns, and legal pressures have made it increasingly difficult to recruit and retain experienced and qualified individuals for board service ([15]).

Community leaders are busy people with substantial demands on their time, frequently stemming from job and family responsibilities as well as other forms of community service. For some, the learning curve is steep and the healthcare issues are complex. Each trustee should be encouraged to decide realistically whether board service is reasonable from a time point of view and whether he or she can sustain the commitment for the appointment term ([16]).

Kazemek et al. ([5]) provided an exemplar of a large nonprofit healthcare system that instituted term limits for its board members: three 3-year terms. Looking continually for new trustees, the system board insists that new members be clear on their motives for participating. People who are seeking a social experience or personal gain are screened out. Members are actively sought who will add to the diversity of board perspectives. The board has set targets for the proportion of board and committee members that should be female or physicians. Potential trustees are given their job descriptions and the board's expectations, including a commitment to attend at least 40 hours of educational sessions a year and an agreement to participate in annual

individual and board self-evaluations.

Pointer and Orlikoff ([17]) recommended four criteria for screening and selection of new board members: (a) foundational qualifications, (b) demographic qualifications, (c) general competencies, and (d) special competencies and required frequency. The authors defined foundational qualifications criteria as "willingness to serve on the board; commitment to and interest in the organization (its vision, mission, and key goals); ability to meet projected time and effort requirements; and high level of personal and professional integrity" (p. 101).

With regard to board composition, Kazemek et al. ([5]) noted that the proportion of female board and committee members serving healthcare organizations is inadequately small, even though national studies have revealed that women make a majority of decisions about healthcare in their families. A 1999 survey conducted by the Governance Institute, La Jolla, California, showed that only 23% of healthcare board members were female. Moreover, although physicians are major stakeholders in healthcare organizations, many hospitals and healthcare systems do not have enough physicians on their board. Of the system boards surveyed by the Governance Institute, 24% reported having no physician trustees, and only 35% had 1–3. Additionally, Conger, Lawler, and Finegold ([18]) reported that limiting the percentage of inside directors on the board is an important board power factor that leads to more effective governance. Directors on boards with 10% or less inside directors rated their performance as more effective on both their success in developing external relationships for their organizations and on their internal strategic roles than did directors on boards that with a higher percentage of insiders.

HOW TO BE AN EFFECTIVE CHAIRMAN

Carver and Carver ([10]), well-known authorities on board governance, stated that because, by definition, the board is a group of peers, no trustee has authority over another trustee. The group of peers creates a position of chairman—first among equals—to facilitate the board work. Although it is important that each trustee continues to take responsibility for the overall board behavior, the chair is granted extra authority necessary to make decisions that keep the board on track.

Matheson ([19]) stated that effective and successful chairmen demonstrate a high degree of integrity in word and action, have good personal relationships, are open and relaxed, and are equal rather than superior. The personal attributes that distinguish outstanding chairmen vary in degree among individuals, but usually include the following attributes: (a) has the time to devote to the duties and role of chairman; (b) demonstrates leadership skills such as motivation, persuasion, good interpersonal relationships; and (c) effectively guides the board processes and demonstrates independence and objectivity. The key functions of a chairman are to create an effective board and to act as the spokesperson on behalf of the organization. Therefore, the chairman must not only have the necessary communication skills, but also be well informed and briefed. A consummate chairman continually maintains awareness of the external trends and environment, the happenings, and the issues important to the organization. Being an active networker and attending relevant presentations and seminars are some means to stay informed and up to date. In addition, effective chairmen also have the experience in dealing with people and the ability to resolve issues and personal conflicts ([19]).

BOARD OPERATIONS AND DISCIPLINE

The most common complaint about board governance is a lack of adequate time. However, in many cases, meeting time is not used efficiently, and too much time is spent on operational rather than strategic issues ([5]). According to Carver and Carver ([10]), effective boards govern in an organized and highly disciplined manner. Not everything is appropriate for board agendas, even if the management wants the board to discuss an issue and to make a decision or if the topic is interesting. The board or board committees should not decide on matters that have been delegated previously to the CEO, because in making such decisions, the trustees render themselves unable to hold management accountable. Board meetings do not exist to assist staff, be entertained by staff, or perform formal approvals of staff plans. Board meetings occur so that board members can contemplate and deliberate together, learn together, and decide together. Effective board meetings resemble learning and studying sessions. The CEO is always present at the meetings but is not the central figure. Also, other staff might be invited when they have valuable input on issues the board is to decide. The board does not merely confirm board committee decisions; it is the body that makes the decisions. The committees should be used to increase the board's knowledge of factors and options, but by no means to assume board prerogatives or take away difficult choices from the board table.

POWER

The boards of trustees exercise considerable power. They

can audit the performance of an organization, hire and fire executives, and make major strategic decisions. If the potential power of the board is misused or not used at all, the trustees do not contribute to organizational effectiveness and, therefore, do not serve the stakeholders. The board's membership composition is a critical determinant of the types of power a board will have and how the board will exercise that power. Research has suggested three types of power that are particularly pertinent with respect to boards: personal, expert, and position. Personal power is based on the personality of the individual; it is independent of an individual's formal position or authority. Expert power is based on the individual's knowledge and information. Position power is based on the individual's formal position and is usually spelled out in the organization's bylaws and operating procedures [18].

A number of studies have indicated that trustees' power, particularly the readiness to use that power, is strongly associated with the positions held beyond their board participation. Specifically, outside directors with no business ties to the organization or its executives are more willing to exercise their power than inside directors, particularly discussing matters that involve questioning the performance and challenging the decisions of senior management. Therefore, at present, boards prefer to appoint outsiders independent of the CEO and other senior management [18].

Carver and Carver [10] stated that the board speaks authoritatively only when it passes a formal motion at a properly constituted meeting. Any other statements by individual board members have no authority. The board speaks exclusively with one voice. In other words, the one voice principle helps to distinguish what the board has said from what it has not said. This principle requires all board members to respect board decisions. Furthermore, board decisions can be changed only by the board and never by individual board members. Hence, board practices must demonstrate that the board, not individual trustees, has authority.

RESPONSIBILITY FOR STRATEGIC PLANNING

As governance scholar Howe [20] suggested, the board of a nonprofit organization is responsible for the effectiveness and welfare of the whole organization; therefore, the board must ensure strategic planning. It is advantageous for boards to create a standing or ad hoc committee to make plans for planning. In other words, this committee is to make recommendations on how, when, and where planning should

take place. The executive staff members often play a pivotal role making sure that the planning team has all necessary information and ultimately implementing the plan. As the result of the strategic planning process, the planning team devises a modification or reaffirmation of the mission statement and the vision that will drive the system or hospital. Kazemek et al. [5] stated that this type of strategic thinking involves a complete analysis of the current state of affairs as well as understanding of all the available options and the likely ramifications of various strategies.

MONITORING THE ETHICAL PERFORMANCE OF THE ORGANIZATION

Conger et al. [18] defined the ethical responsibility of boards as "ability to identify and raise key ethical issues concerning the activities of the company and of senior management as they affect the business community and society" (p. 41). According to the American Hospital Association's [21] advisory publication Ethical Conduct of Health Care Institutions, the governing board of the healthcare institution is responsible for establishing and evaluating the ethical standards that serve as guides for institutional policies and practices. Also, the governing board must assure that its policies, members, and practices comply with both ethical and legal standards of behavior. The CEO is ultimately responsible for ensuring that hospital employees, medical staff, and volunteers understand and adhere to these principles. The CEO is also responsible for promoting an organizational environment sensitive to differing values and encouraging ethical behavior [21].

Larson [22] cited Dr. Robert Potter of the Midwest Bioethics Center, Kansas City:

Organizational ethics in health care is a managerial strategy to intentionally use corporate values to guide system decisions for patients' good... It doesn't happen by accident or as you always wish it would. The real activity of ethics is compromise...and the culture you create from the top determines how those decisions are made. (¶ 3)

That responsibility falls directly on the board. Therefore, accepting that responsibility means asking (a) what the hospital has done to bring ethics into its clinical and management decisions, (b) whether trustees have considered inviting ethics consultants into board meetings or naming an ethics officer, and (c) whether an ethics audit is used regularly through the quality assurance committee. If a hospital has appointed an ethics committee, the trustees should receive ongoing reports about its work from the

committee chair or CEO.

According to Conger et al. ([18]), the key determinant of how effectively trustees monitor the ethical performance of an organization is their access to information. Boards need means to probe deeply into the organization to detect potential ethical issues. They need information from customers, employees, suppliers, communities, and government agencies that are familiar with the performance of the organization. Power is an important issue if trustees need to react to ethical problems. At times, the only resolution to an ethical dilemma is to dismiss employees, even members of senior management. If the trustees feel a problem warrants investigation, they also need to be able to collect data independently of information offered by senior management. A CEO who does not want the trustees to uncover ethical problems can possibly keep the board from gathering information and discussing such issues by regulating the meeting agenda and by rejecting the resources necessary for gathering data. In such an event, a key concern is the power to control data gathering and to direct discussions and boardroom time. Boards need the power to perform as independent auditors and data gatherers when investigating issues of unethical behavior.

POLICY FORMULATION REGARDING FINANCE MATTERS

Pointer and Orlikoff ([1]) stated that nowadays the financial challenges facing healthcare delivery organizations are of far greater magnitude than in the past. As fiduciaries, in order to fulfill their accountability for the organization's financial health, boards must do the following:

1. Specify financial objectives.

2. Make sure plans and budgets developed by management are aligned with and promote achievement of financial objectives, key goals, and the board's vision.

3. Monitor and assess financial performance and, when problems are detected, ensure management takes corrective actions.

4. Ensure that necessary financial controls are in place (1, p. 68).

The shift from fee-for-service reimbursement to managed care adds to the challenges facing boards. Even experienced administrators have difficulty figuring out capitation and risk

contracting. Trustees might be hindered further because financial information presented by management is often filled with accounting terms and too detailed. Many boards invite outside auditors to assist with the financial reports ([5]).

When it comes to ensuring a healthcare system's or a hospital's financial health, the first step of a board, taken with assistance of the CEO, should be to determine key performance indicators for the market and business strategy, revenue, and costs ([23]). A board has to make sure that accounting systems supply accurate and timely financial information; that transactions are properly authorized, recorded, and executed; and that financial statements accurately present the organization's financial status. To accomplish this, the board should conduct an annual audit performed by an independent certified public accounting firm. This audit (a) examines the organization's financial statements; (b) assesses the adequacy of accounting, financial, and control systems; (c) ascertains whether practices and procedures are in agreement with generally accepted accounting principles; and (d) presents recommendations regarding improvements and modifications to the board and management ([17]).

DECISION MAKING REGARDING QUALITY OF CARE

Kazemek et al. ([5]) pointed to the Institute of Medicine report that revealed that approximately 98,000 people die annually from medical errors. These statistics have intensified the need for boards to oversee the quality of medical care. Because trustees are rarely familiar with patient care, they depend on the medical professionals to interpret clinical data and medical terminology used in quality reports. Pointer and Orlikoff ([1]) noted that responsibility for quality of service is unique to the boards of organizations. Other nonprofit organizations can hand over this responsibility to management. This aspect of governance typically causes healthcare board members their greatest concern. To fulfill this responsibility, a board must (a) define quality to reflect the aspects of specific practice, (b) credential the medical staff, and (c) monitor data to assess the quality of care provided. "Credentialing is the process that appoints, reappoints, and determines the clinical privileges of physicians" ([1], p. 57). The purpose of this process is to ensure that only qualified doctors are hired and remain on the organization's medical staff, and that they provide services within their scope of competence.

Roberts and Connors ([14]) reported that achieving the quality

goals encompasses such activities as rendering clinically appropriate care, meeting contemporary standards, achieving high levels of patient satisfaction, and maintaining an environment of continuous quality improvement. Trustees, therefore, must establish the indicators needed to provide necessary oversight. Reinbold ([24]) offered that 43% of the current Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards is directly related to patient safety and 35% is indirectly related to patient safety. The greater portion of these standards is located in the leadership chapter of the JCAHO's Accreditation Standards Manual. The key features of these standards are the following:

1. A proactive approach to risk identification and prevention,

2. A culture that reflects staff willingness to report and participate in risk-reduction activities as well as measure their own and patients' perceptions of possible risks in the organization,

3. A systematic approach to integrating all safety activities to ensure coordination and eliminate duplication,

4. Selection of one high-risk process each year for assessment and risk mitigation, and

5. A medical errors report given to the board at least once a year (24)

JOINT EDUCATIONAL EVENTS

According to the Governance Institute survey, despite heightened concern about accountability, 83% of hospitals do not require trustees to receive a defined amount of appropriate board education. Only about 35% of trustees attended an off-site healthcare leadership or governance conference during 2002 ([12]). Many governance scholars pointed out that as a decision-making body with fiduciary duty, the healthcare organization's governing board has a responsibility to gain sufficient knowledge about the areas of healthcare delivery operations, finance, and market issues facing organizations. Further, it is extremely important to develop continuously trustees' competencies and capacities ([8], [16], [25]). For instance, the board should have the means to act promptly to remedy emerging managed care contract problems before they become catastrophic. To illustrate, if a contract is being underpaid as a result of the managed care plan payment policies, the trustees may be asked to give

approval either to sue for a recovery of underpayment or to cancel the contract. In this example, the board would be better equipped to make knowledgeable decisions aimed at the financial success of the managed care contract if it had been educated and kept informed during the contract negotiation process, when less drastic measures could have been taken to resolve the issue ([25]).

Roberts and Connors ([16]) looked at factors that contribute to achieving effective trusteeship. They concluded that, given the complexities of the healthcare field, an ongoing educational program for trustees is necessary. The board educational programs should include educational updates at every meeting, workshops and seminars, retreats, outside speakers, and selected subscriptions. Most nonprofit healthcare organizations' mission is to provide quality healthcare services to improve the health of their communities and to meet the needs of those who do not have the ability to pay. Areas of building knowledge that deserve particular attention in this area include (a) managing financial risk, (b) ethical decision making, (c) strategic planning and positioning, (d) quality assessment and improvement, and (e) achieving healthy communities.

Parson ([26]) stated that for any healthcare delivery organization, potential can be gained or lost based simply on its approach to trustees' education. As a remedy, Parson suggested the following: (a) In addition to annual retreats, every meeting of the board should include a 30-minute educational session, (b) a policy needs to be established that each board member attends at least one conference or seminar each year, and (c) a policy must require an annual survey on educational needs of the trustees. Kazemek et al. ([5]) provided an example at St. Joseph Health System in Bryan, Texas, where weekend retreats and dinner meetings are used to bring its trustees, physicians, and senior managers together for educational sessions. Once a year, the board invites an external speaker to describe national trends and facilitate action planning addressing the most critical issues. President and CEO Sister Gretchen Kunz and Board Chair Bill Magee agreed that these educational sessions have significantly improved board members' ability to contribute to strategic discussions and to make better decisions.

DEVELOPING EFFECTIVE GOVERNANCE INFORMATION SYSTEMS

Conger et al. ([18]) defined the term information as it relates to boards, as "information about the operations and management of the organization, the business environment,

and the performance and activities of competitors" (p. 21). Those boards that have better information sources appear to be more effective. Boards that have established a broad range of indicators for organizational performance and benchmarking the organization against top performers in the industry perform their functions far more effectively than boards that lack this information.

Most boards do not experience a lack of information; rather, they are often overwhelmed by it. Unfortunately, the wrong type of information is frequently presented in the wrong way. Trustees typically receive products of the management and clinical information systems that have been designed to assist management and medical staff [1]. Raw data are presented rather than information from data analysis trended over time. Often, the data available to trustees are primarily operational in content, dominated by historical financial data, and soft on measurement of services and clinical indicators [16]. However, boards have different roles and responsibilities from those of executives and physicians; therefore, they need governance, not operational, information. They need strategic data by intent [1]. Benchmarking with mature healthcare systems is a valuable methodology [16]. For each dashboard, appropriate indicators must be constructed. The specific aspects of the organization's performance to be monitored should be determined based on the board's policies that convey expectations regarding its responsibilities. The principle suggested by Pointer and Orlikoff [1] for selection of indicator gauges, states, "If something is important enough for a board to express and expectation about, it is important enough to monitor" (p. 103).

Bitoun [27] provided as an exemplar the Sisters of Charity of Leavenworth Health System, a nine-hospital system spanning four states, where the board established a 30-indicator report, beginning in 2001. The indicators reflected the system's four areas: (a) mission and culture, (b) healthcare delivery transformation (e.g., new service lines), (c) physician relations, and (d) consumer value. Within each area, the board tracked indicators delineated by white dots (indicating that the target had been met), red dots (the target had not been met), or green dots (the target had been exceeded). Some indicators came out of the strategic plan, whereas some were actually the measures used for executive performance-based compensation. The indicators covered traditional financial markers, employee vacancy rates and turnover, community service, free care, physician and patient satisfaction, and medication errors that cause patients harm.

The targets, plus or minus 3%, indicated either internal system-wide goals or industry norms. The board chair stated that dashboard indicators had reduced confusion and streamlined board meetings. This approach was key to improving the trustees' efficiency, setting incentive compensation, setting agendas, making strategic moves in local markets, and bringing in speakers to address trouble spots. The board chair also commented [27],

It's amazing how much time you save and how much it helps you focus your interest... You don't have to spend 40 minutes going over 60 pages of financials. Literally, within two minutes, you can figure out where your problems are, then go to that part of the financial statement or the feasibility report, or whatever it is. (¶ 16)

PREVENTING AND MANAGING CRISES

In discussing effective governance strategies, Conger et al. [18] stated that when organizations face crisis situations, securing the opportunity to meet and problem solve promptly is one of the biggest challenges for a board. Because trustees are typically very busy, it can be problematic to assemble a meeting on short notice. The board needs a rapid-response potential that includes both time to discuss as well as means for gathering information that is pertinent to the crisis issue. This means can be hiring outside experts to gather data and conduct research or having some of the trustees spend their own time assessing the situation. Further, Conger et al. suggested that any board can enhance its rapid-response potential by regularly performing scans of the environment in an effort to anticipate possible threats and by conducting exercises to imitate how the board would act in response to such situations. Such exercises serve to build trustees' knowledge of the issues they could face as well as to identify the information they will require. Ideally, undertaking crisis response exercises helps prevent or reduce the severity of a crisis. To illustrate, simulating a situation with a lawsuit for fraud may reveal weaknesses in existing audit measures, which in turn can lead to enhanced financial monitoring. Similarly, simulating the need to change a suddenly incapacitated CEO may make trustees aware that their succession planning method is providing them with inadequate information about possible replacements.

As Peregrine and Schwartz [4] observed in their analysis of the board needs for its own legal counsel, the boards of nonprofit organizations always have the discretion and authority to retain separate counsel. Boards can seek the

assistance of separate counsel in connection with issues that are controversial or crucial to the organization's mission. Examples include

advice on how to apply the corporate conflict-of-interest policy to specific "duty of loyalty" problems; developing suitable board policies on investment practices; limiting board authority to act under its corporate charter; accessing restricted gifts; avoiding the "Intermediate Sanctions" IRS excise tax; and exercising "reserved rights" or similar powers over a corporate subsidiary. (p. 23)

BOARD ACCOUNTABILITY TO COMMUNITIES SERVED

Simply put, boards exist to be accountable that their organizations work [10]. Roberts and Connors [16], however, that it is easier to announce sincere intentions to be answerable to communities than to demonstrate particular mechanisms where accountability is in place. This is especially difficult for boards working in communities where extreme competition seems to stifle community planning, collaboration, and accessible performance information. Roberts and Connors provided the following examples of forms that accountability initiatives might take: town meeting forums, focus groups, use of the media, and full disclosure to the communities of the operational, financial, and quality performance of the organization. The board composition should reflect a representative perspective (social, political, gender, age, and economic) so that a balanced community-wide perspective is considered during the decision-making process.

Roberts and Connors [14] stated that trustees must gain an understanding of the true expectations and needs of the organization's key stakeholders so that the board strategies can be both practical and responsive. Sometimes, the true needs of the community are not in harmony with the priorities of the organization. The board of trustees' responsibility is to recognize and balance any competing needs in resource allocation decisions. For instance, trustees can focus on providing access to needed care for all through moderating costs to the payment source, the individual, and the community.

BOARD SELF-ASSESSMENT

Although JCAHO has required board self-evaluations since 1986, many nonprofit healthcare boards began performing self-examinations in 1999 or 2000, in the wake of the industry's economic downturn and concern about widespread clinical errors [12]. Fifty-four percent of health system boards responded to the 1999 Governance Institute survey, indicating that they had conducted a comprehensive evaluation of their governance structures, including subsidiary and regional boards. Some of the changes generally made based upon these assessments were decreasing the number of committees and boards and clarifying their responsibilities, roles, and authority among governing entities [5].

Self-evaluation provides trustees with the measure to review existing practices and to plan future approaches, answering such questions as "What are we doing well? What could we be doing better? To what extent did we achieve our goals and objectives?" [1, p. 202]. The self-assessment survey generally consists of two distinct parts: one that measures the board's performance overall and one that helps each trustee define how well she or he is performing on the leadership team [28]. Most board self-assessment processes are based on the use of questionnaires anonymously completed by each trustee. The aggregate responses are analyzed and used to facilitate board discussion [1]. Hacker [28] noted the importance of establishing the expectation that the assessment process will take place regularly: twice each year if the board meets at least four times a year, or once a year if the board meets less frequently.

Boards are highly recommended to hire an outside facilitator to perform the assessment. Someone with independent objectivity can look at the board practices with fresh eyes and uncover issues that might be too sensitive or politically charged for insiders to raise. The facilitator's role is to collect and compile the survey responses, present the findings, help the board evaluate the results, and identify measures that would enhance the board's future performance [28].

Perrine [29] provided an example at St. Joseph Hospital, Orange, California, where improving board meetings brought tangible benefits to the organization. Throughout the 1990s, managed care penetration made St. Joseph Hospital's board's job increasingly difficult, and as a result, the complexion of board meetings changed. Agendas became more educational. Tough discussions regarding contracting and acquisitions usually occurred only in small committees, because physician trustees had an expressed conflict of interest. A turning point came in January 2000, when the CEO, chief of medical staff, and the board chair decided to hold a special retreat to evaluate the board's performance.

The retreat was facilitated by a governance consultant. Through dialogue, board members acknowledged their own perspectives and realized they must support the final board decisions regardless of personal conflicts. They spoke frankly about their frustrations with governance processes, decided to make a number of changes, and created 10 new board meeting practices to adopt. The following board meeting practices were named as the top five ([29]):

1. Organize every agenda around a limited number of board goals, and limit or eliminate items that aren't pertinent.

2. Target 80 percent of board dialogue to forward-looking issues, with only 20 percent focused on the past, and ask one trustee to measure/report the percentages of how time is spent at each meeting.

3. Minimize staff presentations by providing background information in the board packet, sent at least seven days in advance. Use board meetings for questions or clarification only.

4. Move board education topics to quarterly study sessions, allowing trustees to avoid repetitious topics, and preserving meeting time for dialogue.

5. Present issues requiring a vote only after trustees have been briefed and had time to discuss the issue. (¶ 7)

This retreat has become an annual event where board members and hospital executives discuss those goals most important to the organization's stakeholders and identify where trustees can have the greatest impact. The nine board meetings following the original retreat showed immediate results. Dialogue between board members became more open, and trust has been increased. Perspectives of different trustees (physician leaders, administrators, Sisters of the sponsoring congregation, and community members) have been expressed openly and respectfully. Outside the boardroom, all trustees present decisions with one voice. Employee, physician, and trustee satisfaction have increased dramatically, while the medical foundation bottom line has improved ([29]).

THE ROLE OF THE AUDIT COMMITTEE

Totten and Orlikoff ([30]) stated that the audit committee should have a written charter that addresses (a) committee membership policy, (b) terms of office, (c) relationships with internal and external auditors and with management, and (d) when and how often the committee should meet as well as its key responsibilities. The audit process is one of the principal ways an organization fulfills its duty for reliably reporting its financial and operational performance and for monitoring whether performance goals are being met. Hospital boards need to be aware of the wide-ranging risks facing their organizations. For instance, these can include major payer risks, insufficient internal financial controls, the impact of a new local specialty hospital, inadequate performance oversight, the lack of a succession plan for the CEO, and the lack of a medical staff development strategy to ensure a sufficient supply of both specialty and primary care physicians. To evaluate the organization, the board-appointed audit committee needs to gain detailed knowledge about the organization's services, geographic scope, revenue sources, suppliers and contractual commitments, competition and market needs, industry risks and trends, regulatory requirements, industry as well as organizational accounting issues, and any possible performance issues that could have an effect on the organization's future success and viability. In addition, the audit committee should ensure that management uses a process to oversee how well the organization's staff complies with the ethical code. Such a code delineates the organization's principles for ethical behavior and is intended to promote conflict resolution and ethical decision making ([30]).

The audit committee also should review the organization's business, financial, and information systems; how effectively these systems function; the extent to which external and internal auditors have tested the organization's in-house controls for financial reporting; and the past reliability of the financial reporting processes ([30]). Wilson ([31]) suggested that the audit committee test the extent to which financial statements could have been affected by management's accounting judgments and estimates, and where those judgments and estimates fall on a scale from aggressive to conservative. While reviewing the quality of monthly and annual financial reports, the auditors should focus on the nature and magnitude of year-end adjustments. Large year-end adjustments may suggest that monthly financial reports provided to the board are unreliable. Special attention should be given to one-time or unusual transactions. Overall, the board's existence, purpose, parties, terms, risks, duration, and rewards should be examined.

BOARD–EXECUTIVE RELATIONSHIP

Carver ([32]) wrote that in every organization no other

relationship is as important as the relationship between the board and its CEO. In all probability, no single relationship has such dire potential consequences or is as easily misconstrued. If well conceived, that relationship can set the stage for effective leadership and governance. The most important obligation of a board may be the right choice of the CEO. Even though choice is surely important, establishing a respectful and effective working relationship is even more compelling.

The board and its CEO contributions are formally distinguishable, and once clearly differentiated, their roles can be respectful and supportive of each other. The foremost expectation of mutual cooperation is that each position remains true to its peculiar responsibility. The CEO should be able to rely on the trustees to confront and resolve governance issues while respectfully staying out of management. Correspondingly, the board should be able to trust the executive to confront and resolve management issues while respectfully staying out of governance. Trustees have the right to expect honesty, straightforwardness, and dedicated performance from their CEO. Sometimes, boards can be understanding about performance; however, they should never compromise integrity. The CEO should be able to rely on the board to be clear about the rules and to play by them, to speak with one voice, and to meet its own responsibilities ($_{32}$).

Roberts and Connors ($_{33}$) reported from experience that healthcare executives sometimes do not believe in proactive, strong, community-based boards and exhibit such beliefs by the following behavior examples: (a) failing to keep trustees fully informed, (b) expecting unqualified support, (c) putting a low priority on board members' development efforts, and (d) failing to involve the board in crucial strategic plans early enough to enable effective input. Reversing such behavior requires both immediate and long-term strategies. Governing board self-evaluations can uncover such perceived management behaviors. Straightforward feedback and adjusted behavioral expectations of management by trustees can alter the behavior of executives. Explicit priorities and expectations must be mutually established, monitored, and evaluated by board and management. Kazemek et al. ($_5$) pointed out that sometimes the problem arises if some board members have been selected by the CEO. Those members may feel they are being unreliable if they challenge the CEO during board meetings or during the executive performance review. "I've seen boards wrapped around the finger of the CEO far too many times in my career," said Jordan Hadelman, chairman of a national healthcare executive search firm in Oak Brook, Illinois ($_5$). "It's never a healthy situation for one person to have that much power in any organization. Just look at what happened at AHERF" (p. 19).

Because the board is ultimately accountable for the performance of the organization, and because the management actually runs the organization, it is essential to trustees that management be successful. The board must be very clear about its expectations of management and must monitor whether those expectations have been met. In this way, everyone concerned can be clear about what constitutes the expected success ($_{10}$). Barbara Runyen of Executive Coaching Partners, LLC, Chicago ($_5$), said,

In my career as a healthcare executive and now as a partner in an executive coaching firm, I have found that CEOs who are abruptly removed from their positions often complain that there was a lack of clarity from the board about expectations and lack of open and honest dialogue around key business performance issues. (p. 21)

Carver and Carver ($_{10}$) noted that through the CEO, trustees can express their expectations for the entire organization. In other words, all the authority granted by trustees to the organization is in fact granted personally to the executive. The board, actually, has one employee. In his earlier work that is frequently cited in the literature, Carver ($_{32}$) pointed out that if the CEO must report to one voice only, no individual trustee can have authority over the CEO. Conversely, the CEO must report to the board as a whole. If any board officer or board member assumes personal authority over the CEO, the board–executive relationship is seriously disrupted.

CHAIRMAN AND EXECUTIVE CONFLICT OF INTEREST

As noted by Carver and Carver ($_{10}$), only the board has authority over the CEO, and it exercises that authority through thoroughly crafted policies and procedures. For the board chairman to supervise the CEO and to tell the CEO the wishes of the board is needless and harmful; the board speaks for itself. Therefore, both the CEO and the chairman work for the board as a group, but their roles do not overlap, for they are given authority in different areas. The chairman's job is to see that the trustees get their job done. The CEO's job is to see that the organization's staff get their job done.

EXECUTIVE COMPENSATION

With respect to the executive compensation, Pointer and Orlikoff ([1]) suggested that many health system and hospital board members do not have any idea how much their CEO is paid. In such cases, those boards' executive and compensation committees suppose this to be such a sensitive matter they refuse to notify the board as a whole. According to Pointer and Orlikoff's perspective, this approach, to say least, is unreasonable. As in any nonprofit organization, by law, the salaries of certain staff members are a matter of public record. Moreover, the CEO is the employee of the board as a unit. Therefore, every trustee should be aware of the amount of the executive's compensation and the method by which it is determined. Pointer and Orlikoff offered a set of guidelines for boards managing their CEO's compensation.

1. This is an issue fraught with sensitivities, technicalities, complexities, and legalities. Accordingly, Pointer and Orlikoff recommended that the board hire and retain a compensation consultant.

2. The board should regard CEO compensation not as an expense, but as an important investment in the organization's future. Some proportion of the CEO's compensation should be linked directly to performance—the organization's and the CEO's—and benefits provided to the community.

3. Boards must have a rationale for the amount of CEO pay and how it is determined. Compensation judged to be unjustified or unreasonable may jeopardize an organization's nonprofit status and can result in civil penalties.

4. Boards must recognize that CEO compensation decisions are inherently sensitive and problematic. Some board members may make only a fraction of the executive's base salary and never collect a bonus. Compensation seeming reasonable to one board member may be considered unjustifiable to another.

5. Specific terms of the compensation agreement must be codified in an executive contract. The board should formalize its requirements of the executive and what it provides if its expectations are met.

RED FLAGS OF POOR GOVERNANCE

As Duffy ([11]) observed in the Journal of Accountancy, the following features reflect the signs of poor board governance: (a) an insider-dominated board of directors; (b) questionable board composition, including members who appear to be appointed due to political or other influence; (c) the presence of a "celebrity" CEO; (d) risky pay schemes for the CEO that could encourage short-term actions damaging to the organization's creditors; (e) lack of attendance at important meetings, particularly the audit committee; (f) high director absenteeism; and (g) an incoherent ethics policy or policy without a clear implementation plan. Babcock ([34]), in his analysis in Directors and Boards, pointed out warnings signs such as (a) directors approve and sign documents without adequate review, (b) committee charters are boilerplate, and (c) board meetings are sporadic. Additionally, Walker ([35]), in his Trustee publication, identified the following red flags of poor governance: (a) too little formal director education, (b) regular delegation of decisions personally to the chairman and CEO, (c) overreliance on the executive committee, (d) governance emphasizing civic honor and fundraising more than fiduciary responsibility, and (e) too few internal audit functions.

CONCLUSION

Given the pivotal role that healthcare organizations play in our communities, the quality of board governance in these organizations is uniquely important ([31]). To be effective, boards should establish measures to ensure that they perform in a highly organized and disciplined manner. Trustees must take the initiative in identifying the type of information necessary for execution of their oversight role in a way that ensures accountability ([1]). A board's power is maximized when the trustees emphasize board education and gain knowledge of the many issues facing healthcare organizations. This power is strengthened further when the trustees focus on developing an effective relationship with the CEO and long-term strategies that are rooted in the foundational vision of the organization. The current healthcare industry climate necessitates that every nonprofit healthcare board evaluate its rightful roles and duties, performance, and preparedness in meeting the challenges of today and tomorrow. As Pointer and Jennings ([8]) wrote, "Feedback is the 'breakfast of champions'" (p. 23). Self-assessment enables board members to uncover particular areas of under-performance and to identify best solutions.

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