Chapter 3: The Governing Board

Teaching Goals

Effective governance is one of the core problems of all organizations. Of all the links between the patient’s caregiver and the community, governance is the toughest to maintain. Yet evidence from a growing number of healthcare organizations (HCOs) shows that good governance is within reach of real community leaders.

One teaching goal is to get that message across, to convey that the relationship with the stakeholders gets implemented in a very specific way. Certain jobs must get done, and only a group representing stakeholders can do them. Somebody must hire a CEO; reach consensus on the mission, vision, and values; establish short-term goals; resolve the inevitable strategic debates and conflicts; and mind the store.

In HCOs, monitoring must go well beyond a financial report. If the governing board does not manage several dimensions of performance, the organization is in grave danger. Managing the strategic partnership with physicians has traditionally been a board responsibility. In leading organizations, the emphasis has moved from inputs (e.g., credentialing) to outcomes (e.g., CMS and JCAHO “Core Measures,” physician satisfaction). The governing board now has explicit responsibility for quality of care, patient satisfaction, and associate satisfaction, and it discharges that responsibility principally by monitoring objective data.

A second teaching goal is to convey how good governance is achieved. The message is most clearly described in “The Managerial Role” section of the chapter (pp. 99-102). Good governance is always a matter of maintaining a balance among stakeholder voices. Bad governance is either paralysis or an imbalance that is exploited by the powerful at the expense of the disempowered (or, in the most dismal cases, both). Balance is always maintained by checks and balances that are embedded in rules of order. Bryant and Jacobson’s “Ten Measures of Board Effectiveness” (Figure 3.11, pp. 100-101) are a great start. I would add adherence to the schedule (Figure 3.8, p. 93) and to a committee structure (Figure 3.9, p. 96).

Rules like these are embedded by selecting people who “get it,” by carefully orienting newcomers and officers, by providing a reliable stream of hard data, and by using a “governance committee” as an ongoing monitor. The mission/vision/values statements emerge as critical; the board (like everyone else) will use these as a constant reminder of what holds the organization together.

The transition from input management to output management ends the era of the “wobbly three-legged stool.” Combined with service lines, continuous improvement, and benchmarking, output management creates the twenty-first century HCO. Little attention to the three-legged stool is given to that in Chapter 3, because we think it is best not to burden the next generation with history’s errors. Similarly, two competing concepts of
governance are given short shrift. First is resource distribution (pp. 66 and 85). The board
does not exist to divide the spoils. Its first task is to create the spoils, a critical distinction.
(Many HCO failures are attributable to this distinction.) The board will not succeed by
attracting volunteer talent, either (Resource Contribution, p. 67).

**In a Few Words**

The governing board represents the stakeholders and makes a series of decisions in their
behalf. In the process, it resolves conflicting views. The critical decisions are:

1. Selecting and working with the Chief Executive.
2. Establishing the Mission, Vision, and Values.
3. Approving strategies and an annual budget to implement the mission.
4. Maintaining the quality of care.
5. Monitoring results for compliance to goals, laws, and regulation.

Boards succeed at the critical decisions because they follow carefully designed processes
for selecting and educating members, for managing their agenda, and for improving their
own performance. The board’s measures of success are a balanced scorecard of the
organization’s financial, market, operations, and human resources management, and a
checklist of process control.

**Chapter Outline**

*Establishing a culture of respect, honesty, and service*

- Working with the CEO, the medical staff, and senior management
- Maintaining honest and service-oriented governance processes

*Using realistic forecasts to create a plan for meeting community health needs*

- Hearing stakeholder voices, and fairly balancing stakeholder needs
- Translating the mission to a business plan
- Using a long-range financial plan
- Monitoring with a balanced scorecard of organizational performance

*Working with doctors and other caregivers to improve quality and efficiency of care*

- Maintaining the medical staff organization as a real partnership for mutual
  benefit

*Maintaining the board itself as an effective forum for resolving conflicting*
  *stakeholder needs*

- Encouraging, monitoring, and evaluating the performance of the CEO
- Monitoring and improving the board’s own performance

**Powerpoint Slides**

See Learning Tools.
Questions to Debate

Slides of the individual questions are downloadable. We have prepared some summary thoughts on the content of class discussion. Obtain this information by writing (conventional mail) on academic letterhead to:

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(Please include an academic (dot edu) e-mail address.)

1. Should every community have its own HCO, with its own mission, or should hospitals be like Wal-Mart, where the mission is set once for the world? If there is a virtue to individual community missions, what is it, and how should a local governing board establish a mission?

2. How would stakeholders’ lives change if an HCO made no statement of vision or values? If the vision and values were passed by the board, but otherwise ignored?

3. What are the critical skills a CEO brings? What are the professional obligations of the CEO? How does the board know that those skills are present, and those obligations fulfilled? What makes the relationship effective, and what erodes the relationship?

4. Would you add or take away any dimensions of the balanced scorecard? What happens if the board ignores a dimension? Can management prepare plans that improve all dimensions of the scorecard, or are some dimensions permanently in conflict? What should the board do if a dimension is below benchmark and not improving?

5. Why should the governing board evaluate its own performance? How does a board “build in” evaluation so that it is not overlooked? Should a board use both the balanced scorecard and the “Ten Measures” (Figure 3.11) to evaluate its work?

Additional Discussion Questions

1. Review the mission, vision, and values statements of Intermountain Healthcare (see http://intermountainhealthcare.org/xp/public/aboutihc/mission.xml). What changes may be necessary if a large, for-profit, publicly listed corporation like HCA were running it? List the major clauses that would have to be reconsidered, and suggest a for-profit wording. (This question can be reworded for other HCOs, such as rural or specialty organizations.)

2. Review Figure 2.3 (p. 44).
2.1. Should every well-managed HCO provide all of these services? What criterion would you use to decide that some are less important than others, and what priorities would emerge from applying that criterion?

2.2. Other than importance, how might an HCO decide its profile? Traditional hospitals focus narrowly on “acute episode management.” Why should a governing board consider a broader focus?

2.3. Should a well-managed HCO own all of these services? How can an organization provide a service without owning it? Are there any dangers or problems in providing a service that is not owned? How do you avoid these dangers? Are these dangers more serious than those from owning a service and not managing it well? Why?

3. Many important strategic decisions are included in the list in Figure 3.3 (p. 73). Several questions can be asked about examples for each row:

3.1. What factual basis does the board need to decide this question?

3.2. Where does the board get the facts it needs?

3.3. What sorts of risks does the board undertake if it adopts a specific strategy? (e.g., build a new wing, add a doctor’s office across town, add a specialty service like cardiovascular surgery, merge with a competitor) What are the risks if it does not start a specific strategy? What are the risks of not discussing a specific strategy?

3.4. How would a board understand stakeholder viewpoints on a specific strategy? Why would the board ever pursue a strategy that had weak stakeholder support?

3.5. What is the CEO’s role in making sure the board addresses the right questions?

4. About the Annual Budget. See Figure 3.6 (p. 78)

4.1. Why are annual budget guidelines set in advance of the actual preparation? Why are the strategic guidelines set by the governing board? Why are specific unit guidelines not set by the governing board? How does the board know that the specific guidelines add up to the strategic ones?

4.2. Obviously, people setting guidelines should have access to historic data and forecasts from the environmental assessment. What other kind(s) of information is (are) important?

5. What is the board’s role in quality and safety? How does the board ensure that the highest quality of care is being provided? To whom does the board delegate the responsibility of carrying out clinical quality and safety?

6. The board has the responsibility of hiring and evaluating the CEO. What is the potential for CEO evaluation to be superficial and ineffective? What kind of information would the board collect and use for the CEO evaluation? What are potential conflicts in the process?
7. One way to look at the medical staff is as a large set of strategic partnerships. Bylaws are a set of rules and agreements that are incorporated into these partnerships by reference. Why are they important? What kinds of topics would these bylaws cover? Why is approval of the bylaws vested in the board? What might happen if approval were left solely to the medical staff? If the medical staff did not participate in designing the bylaws?

8. Medical staff leadership. What is the role of medical staff leadership, and why should these leaders be appointed by and accountable to the governing board? What might happen if this function was delegated entirely to the medical staff? If the medical staff was ignored in appointing leadership? If the function were delegated to the executive?

9. Medical staff credentialing. All clinical professionals in the well-managed HCO are “credentialed,” in the sense that their preparation and performance are reviewed. Why are physicians (and some other professionals—see Chapter 6) credentialed through peer review and board approval as opposed to through a more common superior/subordinate review? Under what conditions would you consider doing away with board approval? Why might you consider expanding either board approval to other professionals such as nurses?

Questions for Examination

These questions are less ambiguous than the discussion questions. Obtain these questions and the authors’ answers by writing (conventional mail) on letterhead to:

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