

Board Committees: A Window into Shifting Governance Practices

A Special Commentary by

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FROM

Dynamic Governance

AN ANALYSIS OF BOARD STRUCTURE AND PRACTICES IN A SHIFTING INDUSTRY

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OF HOSPITALS AND HEALTHCARE SYSTEMS



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Executive Summary



SINCE WE LAST REPORTED ON GOVERNANCE STRUCTURE and practices in 2009, the healthcare industry looks drastically different, due to the passage of the Patient Protection and Affordable Care Act in March 2010, an increase in hospital mergers and consolidations, and the nation's continued struggle to recover from the Great Recession. The Affordable Care Act is in the earliest stages of implementation, with much of the potential benefits yet to be realized. However, the law's future may be at stake as many states are refusing to participate in certain reform programs including insurance exchanges and loss ratios, not to mention the various lawsuits challenging the constitutionality of the individual mandate (and/or the law in its entirety). Adding to this uncertainty is the federal budget crisis and the delicate position of Medicare and Medicaid in Washington budget conversations.

These factors have created a time in history like no other, both for our country as well as for the directors who oversee the nation's non-profit hospitals and health systems. Thus, our list of "recommended practices"—fundamental board activities necessary to fulfill the fiduciary responsibilities and ensure proper oversight of the charitable mission—continues to evolve in order to help boards frame their work more effectively and enhance their ability to respond to a dynamic marketplace. This year's survey included new questions relating to both governance structure and practices, in an effort to reveal subtle shifts connected to how organizations may be beginning to respond to these unprecedented marketplace dynamics.



Governance Structure

Governance structure is an essential component of the effectiveness of a board. Without the proper structure, boards cannot easily or effectively perform the essential practices to fulfill their duties. Thus, the first portion of our survey focuses on how the board structures itself. Board size and composition, committees and committee meeting frequency, board meeting frequency, and allocation of board meeting time all are fundamentally related to overall board performance. And, significantly, the size and composition of the board overall, are important ingredients in accomplishing the board's work. This

year we added governance structure questions specific to the makeup of the quality committee (which is becoming an essential arm of the board), more specific information about who sits on the board, and the use of a board portal or other online tool for communication between board meetings.

Governance structure has remained relatively consistent over the past few surveys, with boards moving towards the optimal size and structure for their needs. A few differences this year are briefly summarized below.

Board composition: Overall board size increased only slightly. Health system board size decreased slightly, while board size for all other organization types increased slightly. The most significant change is an increase in average physician representation on the board (employed physicians and "outside" physician representation increased across all organization types). However, most respondents indicated that there has been no change in physician representation on the board as a result of employing physicians. We asked this year about nurse representation on the board; subsidiary hospitals have the highest average number of nurses on the board (0.51).

Committees: The average number of committees increased significantly (7.6 vs. 5.1 in 2009); it is possible this is due to an increase in board activity in response to market changes. The percentage of organizations reporting audit and compliance committees (separate) increased by 6 percentage points compared to 2009. With the exception of health systems, there has been a significant increase in the number of organizations with a community benefit committee; there is a higher percentage of investment committees this year. And the percentage of organizations with a quality committee has increased again. The makeup for the quality committee for most respondents is primarily non-physician board members, physicians (either board members or medical staff physicians), and nurses.

The executive committee has less authority than it did in 2009. The percentage of respondents indicating that the executive committee has full authority to act on behalf of the board decreased from 51% to 45%. The percentage of respondents noting activities for which the executive committee is responsible has decreased for each activity, with the exception of board member selection. And more respondents noted that all executive committee decisions must be ratified by the full board (28% vs. 23% in 2009).

Board meeting time: Boards continue to devote about half of their meeting time to hearing reports from management and board committees (49%). Meeting time spent for board education increased slightly from 15% to 16%; however, time spent discussing strategy and setting policy remained the same at 32% (well below recommendations from governance experts). This year's analysis shows a positive correlation between the amount of meeting time spent on strategy and overall board performance (the more time spent on strategy, the higher the performance).

Board member compensation: This year marks the first significant increase in the overall percentage of organizations that compensate their board chair and other board members. Twelve percent (12%) of respondents said their board chair is compensated (up from 10% in 2009), and 15% said all or some other board members are compensated (up from 10% in 2009). For most respondents, the amount of compensation is less than \$5,000.

Use of board portal or similar online tool: Fifty-four percent (54%) of respondents either use a board portal or are in the process of implementing a board portal or similar online tool for board members to access board materials and for board member communication. Forty-four percent (44%) said the most important benefit of using a board portal is the reduction of paper waste and duplication costs.



Governance Practices

This year, we increased the number of recommended practices to 95. This list has slowly been growing from a list of 50 practices in 2003. Some practices have been updated; others were added—most notably practices related to compliance (duty of obedience) and new provisions within the Affordable Care Act. As the list of practices grows and becomes more complete, we are careful to maintain consistency over reporting years for the sake of comparison, while still having the ability to reflect market changes and new governance responsibilities. Thus, the list includes both fundamental governance practices that are not likely to change, as well as leading-edge practices that reflect priorities for boards given the current environment.

This year's results show that adoption of our list of recommended practices is, for the most part, widespread. However, this is the first year that we do not see a significant increase in adoption of most practices compared to our last reporting

year (2009), nor have we seen an increase in boards' ratings of overall performance in most of the oversight areas covered in the survey. The leap in adoption and performance from years 2007 to 2009 was significant, and in 2011 we see a slight leveling-off, which could be related to two major factors: 1) trend lines often grow in a linear fashion for only so long before there is a natural stasis and, 2) it is possible that this year survey respondents are expressing some degree of doubt or uncertainty as to how their organizations will be able to respond to the many changes soon to come.

Health systems and subsidiary hospitals again show a stronger consistency of adoption compared to independent hospitals and government-sponsored hospitals.

Financial oversight continues to be rated first in board performance and the practices in this area are most widely adopted. The duties of care and loyalty also rated high in performance. Quality oversight performance was rated higher this year than in 2009 (the performance score itself remained the same, but its ranking compared with other oversight areas was slightly higher this year), although adoption of practices did not increase significantly. Board self-assessment/development and advocacy remain the two weakest areas in both performance and adoption of practices.

Thus, the survey data reveal opportunities for hospitals and health systems to enhance their performance in ways that support all other board responsibilities. Board self-assessment/development activities include a regular performance assessment of the board, which boards can use to develop an action plan for performance improvement, and ongoing education programs on industry trends and governance information that can be tailored to the board's areas of weakness identified in the self-assessment. There has been increased attention in the industry on the importance of conducting individual board member assessments both to improve overall board performance and also to provide data to assist in the board member reappointment process; this is not reflected in the adoption scores this year. More focus on board self-assessment and development can help boards perform better in all areas, helping them to better anticipate obstacles to achieving board goals and identifying gaps in oversight responsibilities and practices.

Advocacy has long been an area of low performance, and with the current uncertainty in the industry regarding reimbursement levels and new payment models, advocacy efforts and fundraising should be top of mind for boards in helping their organizations have the financial means to continue to provide quality healthcare for the community.

Board Committees: A Window into Shifting Governance Practices

Special Commentary

PAMELA R. KNECHT, PRESIDENT, ACCORD LIMITED

AS IN PREVIOUS YEARS, THE GOVERNANCE INSTITUTE'S 2011 survey results include an enormous amount of detailed information about the structures and practices of not-for-profit hospital and system boards and their committees. This year's results regarding board committees provide a unique window into many of the key trends in governance effectiveness efforts. Those trends include, but are not limited to, the increased use of committees in general; the creation of committees to ensure focus on key issues (e.g., executive compensation, audit and compliance, quality and safety); and the refinement of the type of committees used in systems with multiple boards.



Increased Use of Committees

The number of board committees has increased significantly over the last two years. In 2009, the average number of committees was 5.09, and by 2011, that number has jumped to 7.57. This data most likely reflects a number of key governance trends.

Given the increased scrutiny of not-for-profit boards, many boards have decided to become more engaged in overseeing their organizations. They are requiring deeper analysis of issues and more complete consideration of options. An efficient and effective way to achieve that end is to task committees with bringing their well-considered recommendations to the full board. This way of working often requires additional committees. For instance, many boards have created investment committees. In 2011, 36% of all boards (vs. 31% in 2009 and 25% in 2007) and 70% of system boards (vs. 57% in 2009 and 50% in 2007) reported that they now have investment committees.

In addition, many boards have restructured their committees so that they parallel their governance responsibilities (strategy, finance, quality/safety, management oversight, advocacy, and governance) vs. management's responsibilities. For example, this year only 22% of boards reported having human resources committees and more than half of the survey respondents stated that they have an executive compensation committee (60% in 2011 vs. 54% in 2009 and 48% in 2007). This trend is consistent with boards' increased understanding that their primary contact should be the CEO, and that the majority of human resources-related issues in hospitals are the responsibility of the CEO, not the board. The board's role in management/executive oversight is

to set policy (e.g., ranges for executive compensation) and goals (e.g., ensure a written CEO succession plan), and an executive compensation committee is more likely to be functioning at that level than a more broadly defined committee on human resources.



Ensuring Focus on Hot Topics

However, the increased use of both investment and executive compensation committees may also be a reflection of another governance trend: heightened concern regarding institutional integrity. A hot topic in not-for-profit governance continues to be whether boards are appropriately overseeing the assets that belong to the public trust/community. The Senate Finance Committee, state attorneys general, and other regulatory bodies have been aggressively pursuing boards that they believe have approved excessive executive compensation. Therefore, proactive boards are using executive compensation committees to ensure their oversight of this important area is beyond reproach. Some of these committees have expanded their scope to include oversight of physician compensation, since more hospitals now have highly compensated, employed physicians.

The survey also shows a slight increase in the prevalence of community benefit committees (20% in 2011 vs. 14% in 2007). This trend may also be related to boards' increased desire (and in some cases, need) to prove that they deserve their tax-exempt status. Since *Provena Covenant* lost its property tax-exemption in 2002,¹ there has been a marked

¹ See *Provena Covenant Medical Center vs. the (Illinois) Department of Revenue*, Illinois Supreme Court judgment, March 18, 2010.

increase in investigations of the percentage of total revenues that hospitals and systems are devoting to community benefit. A committee that is focused on setting goals and monitoring achievement toward those targets can ensure that the board protects and communicates its tax-exempt status.

Another key issue for the regulators and legislators is whether the audit and compliance functions are receiving appropriate attention by the board. Clearly, boards have responded to this challenge, because the greatest increases in committee prevalence since 2007 were in these areas: audit/finance (23% to 39%); compliance (19% to 31%); audit (29% to 32%); and audit/compliance (24% to 30%).

As the 2011 data indicates, boards are taking different approaches to handling these issues. Some have created committees that combine audit with finance (48% of independent hospitals); others combine audit with compliance (49% of system boards); and still others create different committees for each. Those that have chosen to separate out the audit function from the finance committee have usually done so to ensure the audit is be overseen only by “independent” directors (as defined by the IRS), while allowing a broader range of individuals to serve on the finance committee. This technique can increase the perception (and reality) of institutional integrity.

One more “hot topic” for hospital and system boards has been oversight of quality, patient safety, and patient satisfaction. Because of the efforts of organizations like The Governance Institute and the Institute for Healthcare Improvement, board members seem to finally understand the important role they play in ensuring high quality/safety/service at lower cost. One piece of evidence to support this assertion is that the number of hospitals that report a board-level quality/safety committee (vs. just a hospital or medical staff committee on quality) continues to increase. Since 2007, government-sponsored hospitals have shown the biggest increase (46% to 62%); independent hospitals’ usage jumped 10 points (64% to 74%); and more subsidiary hospitals (77% vs. 70%) are reporting these committees. Now that they have the structure in place to govern this critical function, the challenge that many boards face is learning exactly what their role should be in overseeing an area in which they may not be experts. To deal with this issue, boards are increasing time spent in educational sessions on this topic and they are adding board and committee members who are physicians and nurses.



Refining System and Subsidiary Committee Structures

The third major “window” that the committee data opened was regarding the efforts by health system boards to refine their own committee structures, and those of their subsidiary boards. Health system boards across the country have been revisiting their governance structures and practices to increase their ability to function as integrated delivery systems.

One of the key levers of change they have used is to more clearly articulate the role and authority of the system board vis-à-vis the subsidiary boards (e.g., hospital boards). The survey data support this trend. Specifically, 83% of system boards have executive compensation committees, whereas only 45% of subsidiary hospital boards have that type of committee. Likewise, 70% of system boards use investment committees, but only 29% of subsidiary hospital boards have created a committee to oversee investments. The other oversight responsibilities that are shifting from subsidiary hospitals to systems are audit and compliance (there is an 11–16 percentage point difference between system and subsidiary boards in the prevalence of both audit and audit/compliance committees, with higher prevalence being found at the system level).

All of these changes are consistent with the system board having more authority for these key areas across all of its entities. On the other hand, subsidiary hospital boards seem to be focused on quality (77% have quality committees) and strategic planning for their entity (61% reported having a strategic planning committee). Interestingly, only 47% of system boards stated that they have a strategic planning committee. One possible explanation for this finding is that system boards may have decided to handle strategic direction-setting as a committee of the whole (i.e., full board), vs. creating a separate committee. That would be understandable, since the challenges facing the healthcare industry have never been greater, and decisions about strategic options now require complete discussion at the full board level.

In summary, the survey data provide clear evidence that all types of boards are using their committee structures (and other advanced governance practices) to enhance their efficiency and effectiveness. It is gratifying to see so many boards implementing advanced governance practices that will be essential to success in addressing the many challenges healthcare organizations face in the coming years. 🌟