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E-Briefings

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Welcome to The Governance Institute's E-Briefings!

This newsletter is designed to inform you about new research and expert opinions in the area of hospital and health system governance, as well as to update you on services and events at The Governance Institute. Please note that you are receiving this newsletter because you are a Governance Institute member or expressed interest at one of our conferences.

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News, Articles, and Updates

Physicians Are Not the Only Ones Losing Their Autonomy in Healthcare Reform

By Jon Burroughs, M.D., M.B.A., FACHE, FACPE, The Burroughs Healthcare Consulting Network, Inc.

The healthcare mandate to optimize quality and reduce cost amidst global competition and payer demands radically alters the role of the physician in society. The staunchly independent and autonomous entrepreneur is replaced by a highly trained interdependent team leader and partner of executive management willing to standardize best practices, customize care to patient preferences, and work with management to drive down operating costs. Medical schools scramble to keep up with these changes and the American Medical Association currently invests $10 million in a grant initiative to attract innovative new ways to redesign medical education so that it is relevant to the altered healthcare landscape of the 21st century.

However, physicians aren't the only professionals who undergo radical transformation in the way in which they must work as increasing numbers of healthcare executives know. With cultural, structural, and inter-professional transformation comes a redefinition of the role of the healthcare executive and how she/he navigates the contemporary healthcare environment.

The following represents some of the key environmental forces that reshape and redefine the roles, responsibilities, and character of the healthcare executive in a time of unprecedented change.

1. Healthcare Industry Consolidation

There are many reasons for the accelerating consolidation of the healthcare industry today, including the drive for economies of scale to reduce cost structure and optimize access to resources and third-party contracts, the climbing cost of capital, physician and labor shortages, the need to build a complex and capital-intensive IT and business analytics infrastructure, and the need to manage actuarial risk. Most small stand-alone healthcare organizations seek larger partners to create varied kinds of economic and clinical integration models through purchase and sale, management services, or affiliation agreements. Many management teams find themselves subordinate to corporate management teams that provide guidance and oversight based upon the strategic corporate goals and objectives. This may result in a local CEO who reports to a system or regional COO instead of directly to a board of directors. Thus, overarching corporate structure and strategy defines the new roles and accountabilities of a healthcare executive, which controls his/her ability to make independent decisions.

2. Evolution of Evidence-Based Management Practices

Physicians increasingly standardize their care through the creation of evidence-based clinical and functional pathways and executive managers

increasingly standardize their approach based upon a heightened accountability to performance metrics. This approach significantly reduces the permissible variation allowed to achieve these goals and requires systemic process standardization and "hard wiring" to ensure success. Like physicians, executive leaders must customize approaches to unique situations and have the wisdom to know how to balance the necessity to customize with the efficiency of standardization in order to achieve both customer loyalty and strategic goals and objectives.

3. Changing Roles of Physicians and Nurses

Many physicians and nurses recognize that they must master both clinical and operational/financial skills to remain relevant. As a result, many physicians and nurses succeed to CEO positions in healthcare organizations. Organizations such as the Cleveland Clinic and Mayo Clinic have always been physician-led, while others like Lehigh Valley Health Network in Allentown, Pennsylvania, or East Jefferson General Hospital in Metairie, Louisiana, have recently appointed physician CEOs to lead their clinical integration efforts. This trend indicates that physicians and nurses increasingly join or replace non-clinical CEOs with the intensified demand for both business and clinical expertise to lead integrated healthcare delivery systems. This interdisciplinary skill set requires unprecedented collaboration between operational and clinical leaders. Physicians can no longer make clinical decisions that have potentially dire financial or operational consequences and management can no longer make operational or financial decisions if they have potentially dire clinical consequences. Thus, both parties must work together to achieve approaches that balance the need for quality outcomes, patient safety, and excellent service with operational and financial efficiencies.

4. Dependence on IT Infrastructure and Business Analytics

The explosion of IT healthcare infrastructure and the creation of the electronic healthcare record (EHR) through the implementation of meaningful use criteria have received abundant coverage. Equally profound is the growth of business analytics and informatics tools that enable managers and executives to finally gain access to real time data with regard to labor, supply chain, revenue cycle, and cost accounting management. These tools enable a level of standardization in management practices that will reduce process and operating expense variation significantly. Currently, there is over 20 percent variance among U.S. healthcare organizations in the percentage of net operating revenue spent on labor costs, over 15 percent variance in supply chain costs, and almost tenfold variation in the amount of direct variable costs spent on individual patients with equivalent medical and surgical conditions. This variance is no longer acceptable and executives will increasingly standardize their practices to achieve nationally benchmarked practices in these key operational areas.

5. Strengthening of Governing Boards

Highly functional boards play an increasingly active role to closely monitor key clinical, service, operational, financial, and market metrics. Transparency and accountability are paramount and boards expect management and physicians to be highly responsive to organizational expectations through the successful execution of board-approved strategic goals and objectives. Increased governance rigor changes the dynamic between the CEO and governing board as increasing numbers of executives turn to the board as a partner in strategic discussions and planning rather than as an entity of well-meaning community leaders to be "managed." Governing boards recruit members based upon specialized expertise in mission-critical areas such as mergers/acquisitions, population health, accountable care organizations, business development, clinical quality, and patient safety so that the board can effectively partner with management, particularly when strategic execution involves areas that few executives have experience leading. Finally, boards accept their ultimate legal and fiduciary responsibility for organizational performance and asserts its "right to know" and hold accountable in more meaningful and effective ways.

6. The Need for Rapid and Unprecedented Innovation

Healthcare reform and the transition from traditional fee-for-service (FFS) to global or bundled payment with incentives for quality, safety, service, and cost dismantles a significant portion of our "focused factory" inpatient ancillary and procedural infrastructure and replaces it by a largely ambulatory population health infrastructure to focus on preventative healthcare and the avoidance of unnecessary or non-cost-effective treatments and services. This radical

transformative infrastructure requires leaders who can innovate and create a strategic vision that ventures into largely unchartered territory. Many leaders were trained and developed in a traditional healthcare system that rewarded incremental change and the protection of vested interests. Some of these individuals successfully transition to a transformational environment whereas others will not. Leading through rapid change requires a tolerance for risk, the unknown, and the unknowable and leaders prepared for a traditional system will need to solicit the input and expertise of those outside of healthcare to succeed. The ability to rapidly adapt, gain new skills, recalibrate vision, and work closely with non-traditional collaborators (including physicians and nurses) within complex systems defines contemporary leadership success.

Conclusion

Healthcare reform is not a passing trend. It is an economic, quality, safety, service problem in the guise of a political conflict that requires widespread change in an increasingly global market. The mandate to achieve world-class quality at half the cost requires wholesale infrastructure change to population health; standardization of clinical, safety, service, and management practices; and the widespread use of business analytics and IT infrastructure throughout the inpatient and ambulatory setting. These changes require leaders willing to sacrifice professional autonomy for interdependence, gain new skills, work in large complex systems, and delegate control and trust so that we can rebuild our healthcare system to work for those we commit to serve.

The Governance Institute thanks Jon Burroughs, M.D., M.B.A., FACHE, FACPE, president and CEO of The Burroughs Healthcare Consulting Network, Inc., for contributing this article. He can be reached at jburroughs@burroughshealthcare.com or (603) 733-8156.

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Toward an Effective Director Evaluation Process

By Michael W. Peregrine, Esq., McDermott Will & Emery, LLP

This is the fourth article in a series examining the role of the board following the wave of industry consolidation.

A regular, robust, and self-implemented director evaluation process will be a critical component of effective governance, as hospitals and health systems evolve to larger and more sophisticated corporate structures. The concept of director self-evaluation is not a new concept in healthcare, and has been accepted by many prominent systems. Yet, the typical process is the governance equivalent of "soft-toss," when the organization may be better served by "hardball." Indeed, the significantly increased fiduciary responsibilities associated with larger systems require a more thoughtful, penetrating evaluative process that incorporates consequences for material underperformance.

It should be noted that director self-evaluation has long been a governance "best practice." The Panel on the Nonprofit Sector recommends that board members should evaluate their performance as a group and as individuals no less frequently than every three years, and should have clear procedures for removing board members who are unable to fulfill their responsibilities.[1]

This core principle is intended by the Panel to apply to all types of non-profit corporations. Note that it specifically contemplates a removal mechanism. But there is no one-size-fits-all approach; what may work for the local social service agency is unlikely to work for a large health system, many of which have hundreds of millions of dollars—or even billions of dollars—of assets under ownership. And the financial costs and liability risks associated with preserving ineffective board members in office is so very high with respect to health systems.

[1] *Principles for Good Governance and Ethical Practice: A Guide for Charities and Foundations,* Panel on the Nonprofit Sector, 2007; The Governance Institute recommends conducting a formal board self-assessment on an annual basis, and individual board member assessments within time for the board member to make appropriate improvements prior to reappointment to another term (frequency based on term limits).

The traditional resistance to vigorous director evaluation is based on three primary concerns: 1) it will upset the culture of the boardroom, 2) it will increase the difficulty in attracting qualified volunteer director candidates, and 3) there are often practical barriers to removing those who "grade out" poorly. These are understandable in each instance.

Still, none of these concerns are sustainable in the context of the governance of highly regulated, organizationally complex non-profit health systems. The primary cultural focus of the board must be on establishing expectations of competency, loyalty, and compliance. In that context, boardroom collegiality is more of an aspirational goal—a byproduct of effectiveness. Thoughtful governance practices commensurate with the size and sophistication of the organization are more likely to attract competent, qualified director candidates than deter their recruitment. Indeed, quality directors are more likely to leave a board that tolerates underperforming members, rather than stay because of a climate of non-confrontation. A broad understanding of the risks associated with maintaining underperforming directors in office will often remove many of the practical barriers associated with removal.

For these reasons, the board (or the appropriate committee) is well advised to review its approach to the director evaluation process and to consider those changes that may be necessary in order to ensure that the evaluation process is supportive of the board's long-term governance goals; i.e., to help ensure that the composition, qualifications, competence, and effectiveness of the board is commensurate with the mission and operations of the organization. Such a review could involve the steps described below.

Step One: Expectations and Goals

Before a comprehensive evaluation process can be identified, it will be important for the board to agree on the goals and expectations for the process. For non-profit hospitals and health systems, a primary goal is usually to establish and supplement evidence of the board's good faith with respect to governance practices (good faith being, of course, a critical element of effective and responsive governance). Courts have historically recognized that the conscientious pursuit of recognized governance best practices is reflective of good faith—and as noted above, director self-evaluation protocols are recognized as "best practice" in the non-profit sector. A related goal is to supplement the director nomination process, by identifying elements of effective and ineffective governance practices by individual directors. A third goal may be to enhance director training and information through the information gathered in the evaluation process. A fourth goal may be to position the organization for a more favorable credit rating, when the credit analysis takes into consideration the quality of corporate governance. A fourth goal is sometimes to respond to the requirements of statute, regulation, accreditation, settlement, or governance reformation agreement with a third party.

Step Two: The Self-Evaluation Process

The question here is not whether an individual director self-evaluation process can be an effective governance tool. It can be, especially when teamed with other measures discussed in step three, below. Rather, the question is whether the existing structure and focus of the self-evaluation process still "works" given emerging board dynamics, policy goals, and regulatory expectations. The traditional hospital self-evaluation form necessarily focuses on the individual's perception of his or her performance in comparison to broad, generous descriptions of expected conduct. It is designed to "touch the bases" of core conduct (e.g., mission comprehension, fiduciary duties, CEO evaluation, strategic awareness, financial model) in an inoffensive and non-threatening manner. Am I committed to the mission of the organization? Is my meeting attendance record satisfactory? Do I read the board materials sufficiently in advance so that I am prepared for the meeting? Do I pay attention during meetings and ask questions? Do I appreciate my basic fiduciary duties? Am I comfortable with the way leadership responsibilities are allocated between the board and executive leadership? Do I have a respectful relationship with the CEO and other members of senior management? Do I generally understand the healthcare sector and its financing mechanism? Am I aware of and support the strategic plan? Those kind of questions are perhaps well suited to a community hospital board circa 1980, but decidedly unsuited in the context of the more complex healthcare provider/system in the post healthcare reform environment.

The answers to the traditional self-evaluation questions simply will not provide any clue as to whether board members believe that they understand, and are operating consistent with, the standard of fiduciary conduct applicable to the current environment. Especially if it is a check-the-

box type of form that allows a tiny space for a handwritten supplement. The board's governance committee should review the current self-evaluation form in a manner that emphasizes the currency of the question and the completeness of the response, as opposed to the ease and speed with which the questions can be answered. This may mean adding an "edge" to specific questions—focusing on prompting responses that will generate meaningful data for governance committee evaluation—such as adding questions relating to the level of individual director commitment; a true understanding of the role of the board as providing a set of "checks and balances" over management; a comfortable appreciation for the changes created by the Affordable Care Act; an appreciation of the strategic risks, and opportunities, of the system; an accurate description of the boardroom culture; a willingness to challenge the CEO when necessary and to push back against management assumptions and proposals; and a recognition of when a relationship might constitute a conflict, and the willingness to make disclosure—and an acknowledgement of the areas in which the director sees room for personal improvement.

"Kicking the tires" of the self-evaluation process every two years or so is thus almost a governance prerequisite in the context of seismic health industry change.

Step Three: The External Evaluation

Perhaps the more serious discussion is whether the hospital or health system should incorporate an external component to its evaluation; i.e., engaging an external consultant once every several (e.g., three) years to conduct a more penetrating evaluation of the board and its practices, intended to raise sensitive and important issues that individual directors may be unwilling to raise directly in the context of self-evaluation. The "template" that some larger health systems are beginning to implement is based on the use of an independent, highly qualified facilitator whose goal is to draw out from confidential interviews with individual board members perspectives that might not arise from the self-evaluative process. These might include comments and views on such important topics as:

- The quality and timeliness of management's information flow to the board
- The extent to which management decision making is within the board's risk profile comfort zone
- The extent to which board decision making and oversight are consistent with expected standards
- Concerns with respect to the attentiveness and commitment of individual board members
- Concerns with respect to the ability of individual board members to comprehend and respond to key issues
- Whether the board lacks particular areas of expertise
- Concerns with respect to possible self-interest and conflicts within the board
- Whether the board is adequately focusing on strategic considerations
- The relationship between senior management and the board
- Whether governance control is concentrated in a few, rather than the whole

A qualified facilitator will be well-positioned not only to summarize the results of those interviews, but also to make related observations and recommendations. Typically, that facilitator will not be a practicing lawyer and will not be qualified to comment on the legal implications of the interview results. For that reason, the facilitator should work in conjunction with the corporate counsel to make sure that appropriate legal input and comments are included in the final report. This is particularly the case where the facilitator's engagement covers operational items such as board size and structure, board policies, committee charters, minute taking, and agenda preparation—all of which are primarily legal matters. Indeed, where the work product protection afforded by the attorney client privilege may be important it may be valuable for the corporate counsel to directly engage the facilitator.

Step Four: Responsive Measures

This is where the "rubber meets the road" in terms of the net result of the evaluation process cycle—the extent to which the board effects meaningful responses to the observations gleaned from both self-evaluation and external evaluation processes. For in many respects, the results of a properly conducted evaluation cycle is like a "live grenade," it possesses great destructive power if not swiftly and accurately disposed of.
Traditionally, the end of the evaluation cycle has several recognized stages along an escalating chain:

1. Dissemination to the board of a confidential report summarizing the results of the evaluation and, where it was conducted by

an external advisor, the recommendations of that advisor.
2. The identification of specific board education measures intended to correct broad-based questions or concerns with respect to the board's understanding of operational or strategic matters or of fiduciary standards.
3. The pursuit of structural/procedural changes to the manner in which the board is organized and operates (e.g., size, scope, duties, use of committees; receipt of information from management) intended to correct identified deficiencies.
4. Revisions to the director nomination matrix intended to identify specific qualifications and characteristics that should be more prominently represented on the board.
5. The process of either not renominating, or actually removing, those directors whom the process has clearly identified as non-performing.

The larger the non-profit health system, and the greater the assets under its control and management, the more comprehensive a response regulators will expect once the evaluation cycle has been completed. Board leadership will not have the luxury of sharing evaluation results only within the governance or executive committees; if the full board is empowered to exercise fiduciary responsibilities, then the full board must have the benefit of those results. Neither will the board have the luxury of deferring painful or politically difficult challenges with respect to board restructuring (changing the size and composition of the board and of key committees).

If something or somebody is not working out in terms of effective corporate governance, regulators will expect board leadership to take prompt and effective action, even if it means removing a board member before his or her term has ended. In the current healthcare environment, there is far too much at stake in terms of effective governance to allow sentiment or a desire to avoid confrontation serve as a barrier to decisions that an evaluation process makes painstakingly clear. The liability profile of the board would be significantly expanded if in the context of financial or operational crisis, or regulatory challenge, it was determined that the board failed to implement specific recommendations identified in the evaluation cycle. Governance charters and philosophy statements should be revised to more directly speak to a culture of boardroom accountability, in which sustained substandard fiduciary conduct will not be tolerated. The adoption of such policy revisions, and other steps arising out of the evaluation reports, lend a self-executing mechanism to the evaluation process. There arises a clear expectation of substantive board-level action in response to the recommendations of the evaluation cycle.

Summary

The rapid consolidation of the non-profit healthcare sector from independent, stand-alone hospitals to the proliferation of regional, statewide, and national systems changes dramatically the circumstances through which board conduct will be evaluated. System governance will be expected to operate at a standard of conduct that is commensurate with the size and scope of its operations and the value of the assets under its control and ownership. In that context, traditional perspectives on director evaluation may be insufficient to respond to legitimate concerns re: director and board effectiveness. For that reason, healthcare boards are well-advised to revisit the manner and intensity with which they pursue director evaluation processes.

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Committees: Your Board's Backbone or Achilles Heel?: A Case Study

By Paul J. Taylor

White glove inspections by building committee members were routine at a Connecticut hospital for decades. Committee reports noted findings like dust spots. Usually, the directors simply commented, "All else was found to be in good order."

Are your governing board committees still searching for dust? Do committees help achieve your board's strategic goals, or add value to your governing systems, management, and the medical staff?

What would an objective assessment conclude about your board members' performance? Would they be ranked as engaged and informed as should be expected? Or is your governing board stuck in a rut of seemingly endless meetings? Is management on a treadmill preparing for and following up on meetings? Does the inscription on one of my favorite coffee mugs ring true: "Meetings: The Perfect Alternative to Real Work"?

If your answer to any of these questions is "yes," then now is the time to reassess the ability of your committee structure to effectively support the work of the board. One regional medical center experimented with a governance cultural reform: all standing board committees were eliminated, substituting a "committee of the whole" concept at regular board meetings. Sub-groups of directors were created only when the dynamics of a smaller group might be helpful. Even then, they were always short-term and temporary. More than 12 years later, the experiment proved a big success and was a major building block in the hospital's success.

This article describes a unique case example of a functional governance structure, including some of the key reasons why streamlining the committee structure significantly helped one board. It allowed the full board to focus and work directly on issues and challenges it considered its top priorities, rather than delegating priorities to smaller groups. This structure may not work for all boards. As such, the article provides discussion points for your board to determine a committee structure that is most beneficial for the unique circumstances of your board and organization's mission.

Why Upset the Apple Cart?

How governing boards are organized and whether they are high performing defies one-size-fits-all models or solutions. Prescription before diagnosis is as much malpractice in governance as in medicine. But one certainty is that systems and structures created decades ago deserve scrutiny and possible updating.

More importantly, the apple cart has already been upset. Accelerating federal, state, and other external factors are creating new challenges in boardrooms. No matter what hand is being dealt to healthcare organizations in general, or to yours in particular, success or failure of any organization begins in the boardroom. Business as usual shouldn't be an option today. The key to high-performing governing boards begins with engaged and involved directors. The pace of today's healthcare world demands governance insight and nimble leadership.

The following are two examples of why the functions of seemingly sacrosanct committees should be transformed:

- **Quality/safety:** Quality and safety are the highest priorities of every healthcare board. The board's duty isn't to become healthcare experts, but to set goals based on the best information available, demand frequent results and benchmarks, and then hold management and the medical staff's feet to the fire for results. Assuring that all board members understand and are effectively engaged in quality and patient safety issues is critical to fulfilling these most important of all healthcare governance responsibilities. A strong quality committee is a best practice approach recommended by many, including The Governance Institute. However, this level of communication and delegation of decision making between a committee and the board can be difficult to manage and to ensure that every director is involved. To create proper emphasis on the importance of quality, the board members in this example wanted to find a way to engage all directors. They created a non-board "Quality Council," whose membership included a broad representation from all clinical departments and the medical staff in general. The Quality Council provided

high-level summaries and recommendations to the full board, allowing directors to see the proverbial forest through the trees.

- **Audit:** Many boards fulfill the audit responsibility by recruiting a few directors with financial acumen for the audit committee. But should independent directors who are not on the committee be involved at a deeper level? Is it enough for them to receive a summary of observations by the committee and the auditor? Or should every independent board member participate in questioning, probing, hearing explanations, and meeting face-to-face with the external auditor?

The same concept can apply to other committees common to most boards: executive, strategic planning, community benefit, finance/investment, executive compensation, nominating, and so forth. The primary question is, if it is an organizational or board priority, shouldn't the full board be involved to the greatest extent possible? In some cases (e.g., audit and compensation), non-independent directors may need to be excluded from deliberations, just as they are required to be within a traditional committee system.

To determine whether your board's committees are serving their purpose effectively, or whether your board should consider adjusting its committee structure, consider the following questions:

- Do committee reports (even if provided in advance and then reviewed at a board meeting) sufficiently inform all directors and fulfill their responsibility to that priority?
- How can committee reports (and their delivery method) be improved to better facilitate full-board discussion and decision making where appropriate?
- Is the issue for which the committee is responsible an organizational or board priority? (If not, why was this committee created?)

But How Would It Really Work?

Simplifying committee structure (or, in this case example, eliminating committees all together) streamlines the dynamics of how the board spends it time, how directors are informed, how they meet their oversight responsibilities, and how they prioritize meeting agendas. Streamlining strengthens both the collective and individual satisfaction of directors, as well as making their intellectual contributions more effective. Streamlining should strengthen, not diminish, director prerogatives and responsibilities.

Six Myths about Board Committees

1. Committees are required by external accreditation or regulatory bodies.
2. If almost all governing boards have committees, they must be effective.
3. Directors can rest assured that they are fulfilling their responsibilities if a subset of board members experienced in a specialty handle those matters they know best.
4. Dividing responsibility for specialized topics with reports at full board meetings makes board meetings more efficient.
5. Prospective directors will be put off by a system that differs from what they may have experienced on other boards.
6. A robust committee structure with reports at board meetings is an efficient use of director and management resources.

The streamlining process begins with board leaders who decide to champion the streamlining concept to the full board. Next, the board should lead an assessment of the business conducted by existing committees. Discussion should focus on whether each committee's purpose is still relevant. Could the work be handled by management/governance support staff, the medical staff, or consultants, with the board receiving periodic updates?

Streamlining deserves deep consideration. The board in this case example found that the best venue for this consideration was to hold a few board sessions dedicated exclusively to governance matters after the regular meeting agenda items. These sessions evolved into annual one-day, off-site "retreats" that resulted in an already strong board moving to new and even more effective levels.

A common question will be, "Won't regular board meetings turn into marathons if most matters considered previously in committees are now on

one agenda?" The good news for the example board was this structure eliminated committee meetings (and their preparation) and reduced repetitive information, which significantly offset the increased length of board meetings. Monthly board meetings averaged only about an hour longer.

> Flexibility should be the byword. Mandating a committee-less governing board is no more practical than rigidly adhering to a standing committee system created when carbon paper was the best practice in office efficiency.

This structure created time savings for the management team and governance support staff as well. The administrative team had more to do to ensure that directors were even better prepared for board meetings but, overall, much less work was involved without also having to prepare paperwork for numerous committee meetings.

The directors found that, over time, they were exploring more substantive and strategic matters than the traditional report and meeting structures had allowed. In this case, a good board became a great board.

Greater involvement of all directors represents a cultural enhancement to governance dynamics. One important building block helped empower all of the directors in this example: no subgroups could take final action on behalf of the whole board. This board felt so strongly that every director should be involved in each decision—especially those that required immediate action—that it eliminated an executive committee that could act on behalf of the board between meetings.

The directors were certain that they could be available for a special meeting in person or through teleconferencing or similar electronic communication. They were right. Many special meetings were called but none were affected by lack of a quorum or suffered from full board involvement.

Years later, the board collectively agreed the committee-less system resulted in the best governance experience they had anywhere. But they also concluded that other governance systems needed to be even more dynamic—this, despite ranking itself as high performing on the annual board self-assessment survey.

A two-year plan was created to incrementally enact systemic improvements in governance organization. Areas of interest by the board for priority consideration were assigned to *ad hoc* subsets of three directors (the board had 12 members at the time) and staffed by one or two senior managers. Each work group (the board preferred that they not be called "committees") made recommendations to the full board. Once each set of recommendations was acted upon, the group was disbanded. Then, a new one was created to focus of the next priority on the list.

Six Prerequisites for Boards without Committees

1. A boardroom culture that respects full and open discussion.
2. An open-minded board chair and CEO who balance their roles as leaders and facilitators, encourage director opinions, and are non-judgmental about input.
3. Directors willing to accept that governance structures need to be openly and regularly reviewed for relevance and effectiveness.
4. Board membership no larger than 15 to allow each director to ask questions, make comments, or otherwise participate.
5. Directors willing to devote the time and energy to increase their knowledge and express their views in the boardroom rather than in the parking lot afterward.
6. Mutual respect for each other and the need for confidentiality of every matter in the boardroom.

The "work group" concept is an example of flexibility: the concept was not to "never have committees," but rather, to form groups to address specific opportunities or challenges, and then move on. These sub-groups never lived forever.

This structure produced a governing board that—both as a group and as individual directors—is high performing by any measure. Its dynamics of involvement and global understanding of its own organization and healthcare in general helped to leapfrog strategic goal achievement.

The evolution of this board took more than a decade. The improvements took admirable self-reflection and leadership, but the board's diligence ultimately enabled its organization to develop into one the most successful hospitals in the region.

Abandoning committees entirely may not be for every board, but assessing and streamlining surely should be. Boards should demand the same self-assessment and performance improvement of itself that it expects from the organizations they lead.

The Governance Institute thanks Paul J. Taylor for contributing this article. Taylor is a 40-year veteran of working with hospital boards and CEOs on governance affairs. He also has served as a director of foundations, trusts, business, and community boards. Mr. Taylor retired in 2012 as senior vice president of South Shore Hospital, Weymouth, Massachusetts. He can be reached at pjtaylor7X@gmail.com.

New Publications and Resources

Quality Reporting Expands beyond Hospital Walls (Case Study, June 2013)

Physician Compensation Oversight: An Emerging Governance Best Practice (Webinar, June 2013)

Governance Notes (Governance Support, June 2013)

Board Recruitment and Retention: Building Better Boards, Now…and for Our Future (*White Paper,* Spring 2013)

***BoardRoom Press*, Volume 24, No. 23** (*BoardRoom Press,* June 2013)

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The Governance Institute Conferences

Governance Support Conference in Washington, D.C.

Join us for this year's **Governance Support Conference** at the **Fairmont Washington, D.C., Georgetown** from **August 4–6**. This conference is designed especially for governance support professionals. It provides governance support professionals from around the world the opportunity to hear expert speakers, learn about new resources, and gain knowledge on current healthcare trends so they can better support their boards. This conference also presents the opportunity to network with peers and gain insights from those with a similar commitment to elevating board performance.

Presenters at this conference include:

- **Thomas A. Atchison, Ed.D.:** Healthcare through the Eyes of Governance Support Professionals

- **Brian J. Silverstein, M.D.:** The Change Paradox: Early Indicators of the Next Generation Model
- **Michael W. Peregrine, Esq.:** The Digital Information Exchange & Its Impact on Governance Support
- **Marian C. Jennings, M.B.A.:** Strategic Planning in a Time of Turmoil: Impact on Board Roles & Processes

September Leadership Conference at The Broadmoor

Our **September Leadership Conference** is at **The Broadmoor** in **Colorado Springs**. From **September 15–18**, healthcare leaders will gather to hear leading industry experts discuss current trends in healthcare and give their predictions for the future. This conference will offer healthcare leaders the opportunity to gain new perspective on the current healthcare landscape and walk away with fresh insight on ways to better prepare for the governance challenges and industry changes ahead.

Presenters at this conference include:

- **Robert M. Wachter, M.D.:** The Quality, Safety, & Value Revolutions: The New Era Begins
- **Todd Sagin, M.D., J.D.:** Hospital Employment of Physicians: Common Mistakes & Best Practices
- **Don Seymour:** Between a Rock & a Hard Place: Three Challenges for the Next Five Years
- **Ryan Donohue:** Considering the Consumer: Building & Positioning Value with Healthcare's Newest Change Agent

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