Governance at a Crossroads
Trustees' role in the future of health care
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Health care governance is clearly at a crossroads. The changes being brought by delivery system transformation and health care reform have handed boards huge responsibilities to reposition their organizations for the future. Health care boards will need new skills and competencies to guide organizations toward success. These include sophisticated strategic planning skills, team building, change management and the ability to think outside traditional health care norms. Boards also must be prepared for greater transparency and engagement with hospital leadership, physicians and the community.

To assess the evolution of health care governance and the role of governance in the future, Health Forum convened a panel of trustees and hospital executives July 18 in San Diego for a roundtable discussion. Health Forum would like to thank all participants for their open and candid discussion, as well as B. E. Smith for sponsoring this event.

M ODERATOR (John Combes, M.D., AHA’s Center for Healthcare Governance): Our task today is to have a conversation about the value of strong governance, how it’s helped your organization, how it’s helped you, and where you see governance going in the future, especially with regard to health care reform. What kinds of skills and competencies are you looking for in board members to help make your job easier? Are boards as they exist and operate today truly necessary for future success in health care, or are they unnecessary and actual impediments to organizational success?

KEVIN LOFTON (Catholic Health Initiatives): I think, for me, the key phrase is “as they exist today.” In our organization, we have asked that very question. We have a national board and local boards, and we determined that it is best to keep it that way. We can’t run a national system out of Denver. Local boards provide a valuable resource. Its members are vested in the community and can help us make sure that we’re addressing the community’s needs, and that we have people on the board who have the qualities, capabilities and expertise to help guide the organization into the future. The competency, mix and focus of the board are very important. So, yes, we need to continue with our local boards and make sure the value is being given back to the community.

SCOTT DUKE (Glen view Medical Center): That is true, especially from a rural perspective where the relationship is a little more intimate. We do all we can to make sure the connection to the community is balanced between what we do in our day-to-day operations and knowing what our patients need and desire. We have an independent board as well. More than ever, we’re looking to meet the challenges of tomorrow, and we’re exploring opportunities for certification, training and collaboration for our board.

MARGARET HEPBURN, R.N. (Sierra Vista Regional Medical Center): I agree with what’s been said. I think another critical element is the board’s relationship within the hospital. The triad relationship among the board, administration and physicians is essential and it’s going to be more important as we go forward.

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KIMBERLY MCNALLY, R.N. (Harborview Medical Center): I’ve had experience with that in several ways. We’re a Level 1 trauma center serving four states in our area, we’re basically a safety-net provider and medical center. The combination of trustees, physicians and administrators creates a tension — or balance — depending on the relationship. In our organization, another triad exists among the owner, King County, the University of Washington that was hired to manage us, and the hospital. It’s been a 40-year relationship and, as you can imagine, there have been some interesting relationships and dynamics. But the creative tension has helped us work very well together, and we’ve gotten through some pretty challenging times.

JOHN COMBES, M.D., AHA’S CENTER FOR HEALTHCARE GOVERNANCE: I think, for me, the key phrase is “as they exist today.” In our organization, we have asked that very question. We have a national board and local boards, and we determined that it is best to keep it that way. We can’t run a national system out of Denver. Local boards provide a valuable resource. Its members are vested in the community and can help us make sure that we’re addressing the community’s needs, and that we have people on the board who have the qualities, capabilities and expertise to help guide the organization into the future. The competency, mix and focus of the board are very important. So, yes, we need to continue with our local boards and make sure the value is being given back to the community.

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DONNA KATEN-BAHENSKY (University of Wisconsin Hospital and Clinics): There’s a great deal of uncertainty in health care today. As a CEO, I like having a board that can bounce strategies off of and discuss issues as they come up. I feel that our board is not only necessary for
rear-view mirror versus looking out
looking in the
are essentially
reports, then they
Jim Hinton
windshield.

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m ent doesn’t have to look to the vagaries and
governm ent. W e are vested w ith stew ardship
for us to im prove.

RICHARD DE FILIPPI (Cambridge Health
Alliance). Let me expand on that, from a board
member’s perspective. To some extent, we are
the community representatives. If we weren’t
there, how would the organization develop a
strong sense of what’s going on in the commu-
nity? We can provide a great deal of input in
that respect. W e are a public system and, in
our case, we also serve as a buffer from the city
government. W e are vested with stewardship
and fiduciary responsibilities, and manage-
ment doesn’t have to look to the vagaries and
the variations that might be going on with poli-
cies that are coming from a different level of
public policy.

MODERATOR: Let’s explore this concept of the
trial for a moment. Have you been challenged
personally by the board and how? And board
members, have you challenged your leaders to
expand their horizons and move the organiza-
tion forward?

JIM HINTON (Presbyterian Healthcare Services): It’s hard for me to imagine a “yes” board in this
day and age. The idea raises some questions, of course. Does the organization have the right
board members in place and, more important-
lly, are the topics presented to the board the
right topics? If the board is simply approving
financials and reports, then they are essential-
ally looking in the rear-view mirror versus look-
ning out the front windshield. In our organiza-
tion, there aren’t too many “yes” answers, espe-
cially when planning for the future. There are
a lot of very close calls and a lot of very nu-
canced situations. For organizations that
think they have a “yes,” board, I would suggest
they look at the content of that board meeting.
What percentage of the time is spent looking
into the future? What percentage of the time is
spent on the very difficult decisions? If the dif-
ficult decisions make the bulk of board discus-
sions, then the dynamic you described proba-
bly doesn’t exist.

HEPBURN: The board I’m working with now
has challenged me more than any other board
in my career: In the past, we spent a huge
amount of time talking about the financials
of the organization. That was due, in part, to
the fact that board members feel more comfort-
able in that area because they are business
owners, etc. Now boards are more involved in
quality and credentialing. W e spend a majority
of our time in board meetings talking about
these two issues. Our board is well-educated.
Board members have taken a tremendous
amount of time to educate themselves on qual-
ity. They challenge us to step up to the plate
and look at best practices and high-perform ing
organizations.

LOFTON: As part of our agenda, we try to take a
holistic approach and talk about the health of
the community. For example, we are looking
closely at the impact of health reform and the
management of population health. This process
will take us down some paths that are not
traditionally a part of the health care deliv-
ery system. Our board has challenged the
entire organization to adopt a strategic initia-
tive to curb violence in society. Every one of
our markets will have to take on an initiative
to reduce violence. It can be anything, from
child abuse to elder abuse to gang violence. W e
are trying to show that, in addition to provid-
ing high quality care, we’re focusing on the
health of the community.

FO'TASER: One of the things that really has ben-
efited us is the use of a balanced scorecard.
Our board, however, has questioned whether
we’re looking at things that truly will advance
our mission and vision. It’s not enough for us
to be financially strong. It’s necessary, but it’s
not sufficient. O ur scorecard has driven a lot
of forward-thinking conversation and has led to
a greater focus on our vision, which is to create
Michigan’s healthiest community.

KATEN-BAHENSKY: We’ve come far as an organi-
zeation in being transparent. W e’re a state insti-
tution, reporting to a board of regents. W e have
an active board that’s very engaged and trans-
parent. W e tell the board everything, we ask
for the board’s help, we talk strategy with the
board and we don’t hold anything back. The
audit and finance committee meetings are
really interesting. They always seek to answer
how a decision will impact the patient.

MODERATOR: How about the trustees in the
room? How have you challenged the adminis-
tration? What kind of relationship do you have
with administration?

MCNALLY: As board members, we want to
make sure we are doing our due diligence and
ask the right questions. W e want to make sure
we are providing the appropriate scrutiny. W e
If the board is simply approving financials and reports, then they are essentially looking in the rear-view mirror versus looking out the front windshield.

Jim Hinton
try to do so within the framework of respectful dialogue. That’s what comes to mind for me. It’s important to point out that these discussions always occur within the framework of respectful dialogue. If that’s not there, the situation could be very divisive.

DE FILIPPI: In many ways, our board developed the core mission of our system. Years ago, we had a very foresighted mayor in the city of Cincinnati who combined the department of public health and the department of hospitals and created a new board at that time. As the board assessed the future of the hospital, it was always within the context of what was best for the community.

Our community is racially and ethnically diverse; more than 50 percent of our patient population speaks another language besides English at home. Our board is very responsive to this and is focused on community outreach. That focus is shared and embraced by administration. But it was the board that drove that.

MODERATOR: We’re entering an age where we have to have real partnerships between physicians and our organizations. We need to bring physicians into the system of care that is being developed. How can trustees help us with this process?

HEPBURN: Several years ago, we formed a quality council that comprised administration, the medical staff and patients. That was our first step. That was to have a group of people who could have the expertise to recognize when things were not proceeding as they should. We sat down with our board and shared our concerns.

MODERATOR: What are the challenges of transforming care? As you assess the role of the administrator, this is an area that is always transforming. Are we really leading the issues around safety and quality? And we’re really leading the issues around the patient experience. And that carries over to other strategic initiatives.

LOFTON: My board functions as a corporate board. We have two physicians on our board. But it’s a different dynamic than the local board. We’re trying to take a grid approach to things and drive forward. And that goes back to the things we need to fill our boards of the future. What is best for the community?

LOFTON: We’re trying to do that. We’re trying to bring together our hybrid medical staff, which includes employed physicians and physicians in private practice. When we got to the point of creating the infrastructure that would bring those groups together, our vice chairman of the board, who has been on the board a number of years, said he never thought it would take an act of Congress to lead to an alignment, since that’s been the board’s goal for a long time. That statement was really so compelling, because this is an opportunity to align incentives. And it’s something we’ve been working toward for a long time.

DE FILIPPI: That’s a tough job for a board. Compared with the job of providing guidance to management. Many of us come from management in another environment or some other leadership position, but we’re not physicians. How can boards facilitate an environment in which clinicians lead transformational change?

LOFTON: We have identified the competencies that we need to fill our boards of the future. We felt we needed someone on the board with IT experience and we brought on Blackford Middleton, M.D., corporate director of clinical informatics research and development at Partners HealthCare. We look at other competencies that we’d like to have and then try to find those people. I don’t have a single board member who lives in Colorado except for me. We have a national pool of individuals to get the competencies that we need. The hardest thing is keeping people from delving into more of the day-to-day types of conversations and focusing more on the blue-sky level.

Board reviews and self-reviews are an important part of the process. We do them to modernize them a bit. Competencies are a really important place to start. It’s a great way to identify board members, to recruit them and then to evaluate them as part of the individual governance process. Sometimes we forget that governance is a complex interaction between human beings and a system of governance that includes agendas and retreats and even the mechanics of materials and how they are presented, not to mention the new role of technology.

As board members, we want to make sure we are doing our due diligence and ask the right questions. We want to make sure we are providing the appropriate scrutiny.

Kimberly McNally, R.N.

We use the gap analysis to hone in on an area that provides an opportunity for growth.

Margaret Hepburn, R.N.
competency discussion has really unlocked some things for us. At some extent, it’s put the spotlight on our overall governance system to have the governance process rise up to the level of the trustees and to make sure that we’re not bringing in really great people and putting them in a crummy system.

MODERATOR: That’s a great point. Organizations are looking for trustees who have a new perspective and a focus on team building and on being able to challenge administration. And yet, there may not be the system yet to support them. That’s a real challenge.

TIM MORGAN (J.B. Smith): I work with a lot of boards, and you would be surprised at how many boards are still purely philanthropic boards. That transformation needs to take place in many hospitals across the country. Board composition is more complicated today, given that we need a group of educated, dedicated and strong individuals to navigate our health care organizations through this period of unprecedented transformation.

KATEN-BAHNESKY: Given that yesterday’s strategies aren’t going to work for us in the future, I’m really looking for board members who are willing to learn and are willing to speak up when they don’t understand something. We do have an educational component at all of our board meetings. We’ve had to educate our board on value-based purchasing and other aspects of reform and it’s helped that they can learn along with me. When filling board positions, I also look for someone who appreciates the role of the physician within the hospital.

HEPBURN: I’d like to stress the importance of the annual or biannual board assessment survey. We all have a matrix of attributes that we want board members to have. When a finance person leaves, we look for someone with a financial background. A gap analysis focuses on areas that the entire group identifies as an opportunity. We use the gap analysis to hone in on an area that provides an opportunity for growth. It’s been a useful tool for us.

FOJTASEK: We also engaged Richard Chait and he helped us develop a system to make sure we have good people in place. We use committees to bring in new members, physicians and community leaders. It’s a chance to see those who are really willing to ask the generative questions, the tough questions, and also able to work as a team. It’s been very helpful.

DE FILIPPI: I have worked closely with the board to provide a list of ideas they are practical and that the board needs. The board keeps raising the bar. They keep challenging us as to whether we are doing enough for the community. They keep broadening the sphere of management. The board is not overly concerned just with financials. They are concerned with the quality of the organization, the integrity of the board, and its performance, and the impact on the community and the way it is looked at. In some creative ways that maybe we haven’t been in the past.

KATEN-BAHNESKY: Our board has been proactive in encouraging community partnerships. The board also encourages me, and the entire leadership team, to become involved in advocacy organizations like the American Hospital Association. That’s another way the board supports our political agenda.

MODERATOR: Do boards have any visibility within your organization? Or do they mostly interact with the leadership team?

HEPBURN: Our board has had a huge impact in the area of advocacy. We have several board members who are active with both the state and federal governments. That has made a huge difference in the community in terms of knowledge and awareness. Over the last five years, we have developed a huge network of people throughout the community and within the organization who are ready to respond immediately when there is an issue at hand. There are thousands of people in our network now, from senior citizens to military personnel.

LOFTON: That’s another competency area that you would want on your board. We’ve been blessed over the years with some excellent people in that area. Mary Wakell, our former board chair, is now the administrator for the Health Resources and Services Administration, and Bruce Siegel, M.D., who is now CEO of the National Association of Public Hospitals and Health Systems, was the chair for the quality committee. You need people on the board who are going to push you from within.

DE FILIPPI: We have numerous examples of political connections: we serve a seven-city area just north of Boston. We have personal relationships with the state legislator and our congressman. When health care reform was passed in Massachusetts, the governor assured us that our Medicaid rates would be raised because the uninsured were to be paid for by Medicaid. With that promise in mind, we agreed to support health care reform. Later, when reform came in, Medicaid rates changed two percent. That wasn’t adequate to bridge the difference. We resolved the issue after long discussions with the governor, state legislature and other political leaders. We planned the meeting and contacted everyone we possibly knew to get the meeting assembled. It took the governor a bit by surprise. That would not have been done without the various political connections we had among board members.

Our board has been proactive in encouraging community partnerships. The board also encourages me, and the entire leadership team, to become involved in a community activity.

Donna Katen-Bahensky

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Tim Morgan

Key Findings

1. Practice Generative Thinking. Push board discussions beyond day-to-day operations by challenging board members to tackle issues at a deeper level. Allow time for big-picture discussions. Exploring topics from different perspectives and viewpoints enhances board engagement and creates new ideas.

2. Emphasize Continuous Learning. Boards should adopt a culture of continuous learning. Health care reform will continue to be a complex field. Peer-to-peer board mentoring, education outside of the organization and a focus on team building will provide board members the information and support they need to make sound, strategic decisions.

3. Focus on Board Composition. Board compositions will take on even greater importance in the future. As health care reform takes hold, boards will need specific expertise not found on many boards today. Trustees must be flexible and willing to make significant time investments.

MCNALLY: We certainly look for board members who have technology backgrounds and safety experience in other industries. But we’ve also been interested in people who have either entrepreneurial or innovation skills based on their background. That is going to be important moving forward. We need people who have experience in evolving industries other than health care. And sort of embedded in that are people who really appreciate partnerships, particularly when you’re trying to assist an underserved population. That’s increasingly important. When I think of the board’s competency as a whole, I think the board needs to be the steward of the community’s health, if we don’t do that, then it’s easy to get off course.

MODERATOR: Let’s explore the community issue. How has your board kept you connected to the community? What issues have they raised that arise from the community to make sure that you maintain that very tight relationship?

FOJTASEK: Years ago our board identified pre-natal care for the poor as an area of need within health care. Patiennrs were referred to the University of Michigan, about 40 miles away, while they were in active labor. They would return without a pediatrician or obstetrician. We joined forces with community groups and received some funding from Kellogg to start opening clinics. We really had no idea what it would become, but it is now a federally qualified health center with about 30,000 patients. The hospital had to spin off this entity and we also had to give up governance, although we can maintain some representation. We’ve chosen to continue to support the center. It’s been a 20-year journey and the entire endeavor was started when the board recognized a problem within the community and acted on it.

HINTON: Sometimes the questions board members ask are more powerful than the statements they make. The board keeps raising the bar. They keep challenging us as to whether we are doing enough for the community. They keep broadening the sphere of management. The board is not overly concerned just with financials. They are concerned with the quality of the organization, the integrity of the board, and its performance, and the impact on the community and the way it is looked at. In some creative ways that maybe we haven’t been in the past.

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MODERATOR: Do boards have any visibility within your organization? Or do they mostly interact with the leadership team?

HEPBURN: Our board members participate in many of our functions. Board members are present at staff celebrations. Many of our
employees recognize our board members in our organization and appreciate their encouragement and involvement.

**DUKE:** We determine the board’s purpose, intent and alignment. We have to communicate with the board about significant events that are happening and whether they are connected with the community in some strategic way or whether they are a celebration. We build up a leadership institute and a board member is the commencement speaker at every graduation. It’s great to get board members engaged with the organization, to celebrate milestones or years of service.

**MCALY:** About five years ago, board members began participating in patient safety rounds. It’s worked really well and enhanced board member engagement with our safety and quality strategies. We get updates from our CEO about safety and quality, but hearing about it from front-line staff provides a whole new perspective. And they feel encouraged to speak up about what’s happening. The executive committee made a recommendation, which was endorsed by the entire board, that participation in rounds is mandatory. It’s a requirement of board service that people participate on one inpatient and one outpatient safety round per year. It’s that valuable.

**FOTISER:** We are pretty open relative to staff focus has been on providing a place to piggyback on some of the items that have been presented. We do root cause analysis at board quality meetings and, at times, entire teams are brought in to participate. When we present major projects to the board, we are more generous with who is invited. If an item is going to the board for final approval, people are involved actively by getting to sit and listen to the dialogue. This process doesn’t have to stagnate. Occasionally, someone is there to answer a specific question, and I think that’s broken down some barriers. I share the board’s agenda with the management team every month. It’s rare that I have to make any adjustments. By sharing the board’s focus, we’re able to share what’s important and that cascades throughout the organization.

**MODERATOR:** We’ve all talked about the transformation of health care, but we don’t yet know what’s going to look like. How do you prepare to face this transformation?

**DE FILIPPI:** I’m worried about it. What worries me is the great variation we have in our boards. As Tim pointed out, there still are many institutions where the primary qualification for membership is philanthropy. As a result, there are many boards around the country that are not positioned well to do the kind of evaluation necessary to prepare for this transformation. There’s a high level of strategic planning required to position organizations in the new environment. Will these boards be able to apply good business criteria to assess varying strategies for the future such as a potential merger or participation in an accountable care organization? The education is out there, but you can’t make them learn. What concerns me is there may be many institutions that will not be prepared because they haven’t confronted this kind of critical circumstance in the past. So how will boards change if we find ourselves in a consolidated industry? The best boards will survive and the others may not make it.

**FOTISER:** The focus on population health will be a tough one for boards to grasp unless we really catch them up very quickly. It’s a tough concept to understand, especially when the focus has been on providing a place of care for patients in need. It’s going to be a new way of thinking for most boards.

**MODERATOR:** We are heavily invested in the community, as our prenatal care initiative indicates. We are seriously investing in health improvement. In 1999, we started a task force to examine ways to improve community health. Every service line has to have a place that links to personal and community health. Every service line has to have a place that links to personal and community health.

**HINTON:** Governance is going to be critical. Boards will have to assess all the possibilities of what’s coming down the road. Now is the moment for nonprofit boards to step up and lead in a different way. Successful boards of the future will be smaller and they will have greater responsibilities around policy, advocacy, care transformation and probably finance.

**MORGAN:** We are going to see an upheaval among boards because there are so many that are wholly unprepared for what’s coming. They’re so focused on the day-to-day issues and they are not looking ahead. In some instances, board members are going to leave. It’s going to be a tough job, a lot different from what it is today. I believe we’ll see some upheaval in the executive suite as well.

**LOFTON:** I don’t know how to answer the question, exactly. But we do need to rise to the challenge. We will need to look at talent in certain important areas. Specifically, we may need individuals with expertise in compliance and auditing. It may be difficult to find individuals willing to participate on a nonprofit board with no compensation when for-profit boards have the similar talent for which they will be compensated. I do see more nonprofit hospitals and health systems beginning to pay board members. At some point, that could be a tipping point for nonprofits, so that we’re able to get the talent we need for our boards.

**NEPHERN:** Part of the reason we are all struggling here is because we don’t know what the future will look like. We like to begin with the end in sight. Over the past 50 years, boards have changed as circumstances dictated. I’m optimistic about my board. Even in the past five years, board members have attended as they can interact with local board members. It’s important for us to make that connection.

**MCKALLY:** I share the board’s agenda with the management team and the staff than any meeting we have. They love it. They love asking employees what they like about the organization, what brings them pride and what they would like to see improved. That means more to them and to the staff than any meeting we have.

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**MORGAN:** We are going to see an upheaval among boards because there are so many that are wholly unprepared for what’s coming. They’re so focused on the day-to-day issues and they are not looking ahead. In some instances, board members are going to leave. It’s going to be a tough job, a lot different from what it is today. I believe we’ll see some upheaval in the executive suite as well.

**LOFTON:** I don’t know how to answer the question, exactly. But we do need to rise to the challenge. We will need to look at talent in certain important areas. Specifically, we may need individuals with expertise in compliance and auditing. It may be difficult to find individuals willing to participate on a nonprofit board with no compensation when for-profit boards have the similar talent for which they will be compensated. I do see more nonprofit hospitals and health systems beginning to pay board members. At some point, that could be a tipping point for nonprofits, so that we’re able to get the talent we need for our boards.

**NEPHERN:** Part of the reason we are all struggling here is because we don’t know what the future will look like. We like to begin with the end in sight. Over the past 50 years, boards have changed as circumstances dictated. I’m optimistic about my board. Even in the past five years, board members have attended as they can interact with local board members. It’s important for us to make that connection.
Thanks

Health Forum would like to thank the panelists for taking part in “Governance at a Crossroads,” with special thanks to our sponsor:

B. E. Smith