Is Your Hospital's Board Prepared to Govern?

Rural Acute Care Hospital Boards Of Directors: Education and Development Needed

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Executive Summary

Our study examined the structural, leadership, and educational needs of rural hospital boards, as viewed by rural hospital board chairs and chief executive officers (CEOs). We mailed surveys to the board chairs and CEOs of 802 rural hospitals, receiving responses from 95 rural board chairs and 209 rural CEOs, just over half of whom served critical access hospitals (CAHs). Overall, we found that many rural chairs and CEOs lacked full confidence in their board's ability to conduct its oversight and governance functions effectively.

Key Findings

Board Membership Requirements Are Often Undefined

Few chairs or CEOs reported that board members are selected or removed based on defined criteria. The problem appears particularly acute at CAHs; only 13.5% of CAH executives strongly agreed that their hospital has defined criteria for selecting board members, and only 3% strongly agreed that there was an effective process for removing a member. Of concern, 17 of 95 board chairs (18%) and 39 of 209 CEOs (19%) did not answer the question, "How many members does your board have?"

Board Members May Not Understand Their Responsibilities

While 75% of chairs agreed or strongly agreed that "board members clearly understand their role," only 59% of CEOs held this opinion ($p = 0.02$). CEOs at CAHs had less positive views than their PPS peers on five of the six measures of board responsibilities. Only 27.1% of CEOs at CAH hospitals strongly agreed that board member responsibilities are clearly defined, and only 30.4% strongly agreed that these responsibilities are in writing, versus 50.5% and 54.4%, respectively, among PPS CEOs.

While Boards Adopt Budgets, Only a Small Proportion of Members Are Believed To Understand Healthcare Finance

Most respondents strongly agreed that their board adopts an annual budget (71% of both chairs and CEOs). However, only 19% of chairs and 10% of CEOs strongly agreed that board members understand third party reimbursement, while 14% of boards and 16% of CEOs disagree or strongly disagree. CAH executives were particularly pessimistic, with only 14.9% "strongly" agreeing that their board identifies poor financial performance. Board training in healthcare financing was identified as needed by 36% of CEOs (ranked third of 16 topics) and by 32% of chairs.

Strategic Planning May Not Be Effective

Only a minority of chairs and CEOs strongly agreed that their boards understand and effectively use a strategic plan for their hospital. The problem was greater at CAH hospitals, with fewer than half of CAH executives (48.2%) agreeing that the hospital's strategic plan is used to

evaluate efforts across the year, versus 72.4% of PPS executives. When asked to identify training needs for board members from a list of 16 topics, strategic planning was selected most often by CEOs (49.0%) and was the third highest topic among chairs (37.1%).

Many Boards Lack Quality of Care / Patient Safety Committees

Despite the increasing importance of quality of care for reimbursement by major funders, a substantial minority of rural hospital boards may lack committees that provide oversight for this function. The presence of quality/safety committees within rural boards appears to be limited, with a sharp divide between PPS and CAH hospitals. Only 38% of CAH executives, versus 69% of those at PPS hospitals, agreed that their board has a quality/safety committee. In addition, CAH boards may lack context for reviewing quality data, as the use of industry comparisons was less commonly reported by CAH than PPS CEOs (57.1% versus 86.6%, respectively).

Orientation for New Members Is Often Lacking

There was little agreement that the respondents' hospitals had a well developed orientation process that could provide the necessary background for new board members, that ongoing education was based on needs, or that all members participated in ongoing development. The problem is most extreme at CAH hospitals: the majority of CAH executives do not agree that their boards have an orientation for new members (63.1%), that development is based on identified needs (61.8%), that all members participate (80.7%), or that members engage in annual self-assessment (69.9%).

Planning and Governance Top Training Needs

The top three topics selected by board chairs were board governance responsibilities (38%), legislative concerns (37%) and strategic planning (37%). The top three topics chosen by CEOs were strategic planning (49%), board governance responsibilities (47%) and third-party reimbursement issues (36%).

Board Members and CEOs Are Principally White, Male

Small board size may lead to an absence of race and gender diversity, with nearly all chairs identifying themselves as white (95%) and male (78%). CEOs were also primarily white (98%) and male (82%).

Conclusions

Board Roles and Responsibilities Need To Be Clarified

Rural hospitals, particularly CAHs, need to place additional emphasis on creating job descriptions for board members, communicating expectations prior to appointments, and conducting orientation of new members, to ensure that all board members fully understand their role and their relationship to hospital executives and staff.

Rural Hospital Board Development Is Urgently Needed

Rural hospitals, particularly CAH hospitals, are experiencing a crisis in board development. Rural hospitals need to make maximum use of pre-existing resources for board development,

including materials from the Joint Commission for the Accreditation of Healthcare Organizations, the Institute for Healthcare Improvement (IHI), the Governance Institute, the American Hospital Association (AHA), and state-level organizations.

Boards Require Champions and Support

The development of job criteria for board participation and the institution of training/ development standards for board members will not take place without champions within each hospital and, for rural hospitals in particular, without state or regional champions who can advance the interests of multiple institutions. These responsibilities cannot be delegated to clerical staff.

CAHs Are a Priority

CAH hospitals need targeted assistance in multiple areas, with reimbursement/health care finance and patient safety / quality of care issues potentially having the greatest importance. Since CAH hospitals operate on a cost-reimbursement basis for CMS funding, clarification of the degree to which development activities may be highlighted as costs of operation may be helpful.

Rural Hospital Boards, CEOs Need To Become More Diverse

Rural hospitals take an "outside the box" approach to recruiting new board members, identifying individuals in leadership roles in social, faith community, and other settings, and industries outside of healthcare.

Research and Demonstration Projects Are Needed

Foundations and other funders with an interest in rural hospitals are encouraged to provide financial support for the development and scientific evaluation of programs to educate board members and improve board function.

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Chapter One: The Need to Study Rural Hospital Boards

Hospital board members have traditionally been locally appointed community leaders, who served to give back to their communities. Changes in healthcare delivery, healthcare organization and in healthcare financing have greatly affected how governing boards function in hospitals and health systems. With increasing competition, rising costs and greater expectations of accountability, hospitals and their governing boards have become more involved in the strategic planning and management. Hospital boards are expected to adhere to rigorous standards and to demonstrate that board members are fulfilling stringent performance, fiduciary and educational requirements.

Rural hospitals face unique challenges when recruiting board candidates. The available human capital is limited in many rural areas. Rural hospitals have fewer local corporate executives available to serve on their boards compared to urban hospitals and individuals recruited may serve multiple leadership functions within the community, limiting the time they can devote to the hospital. At the same time, the rural health care context is challenging: the population served by rural hospitals is becoming poorer, older, and progressively more likely to be covered by public insurance. As small and rural hospitals are confronted with changing dynamics in areas of finance, reimbursement, quality of care and workforce shortages, strong governance and management are essential.

Our study explored the structural, leadership, and educational needs of rural hospital boards through a mail survey of rural hospital board chairs and chief executive officers (CEOs). A complete copy of the survey is provided in the Technical Notes. The survey was mailed to 802 rural hospitals, of which 457 were critical access hospitals (CAH). Responses were received from 95 rural board chairs and 209 rural hospital CEOs. The report that follows describes our survey participants, then presents responses of each group to items regarding their board's structure, function, and training needs. A separate page illustrates differences between CAHs and PPS hospitals. Summary recommendations in each area are italicized.

Chapter Two: Findings

Rural Hospital Board Chairs and CEOs: Who They Are

Who Responded to the Survey

Board chairs at 95 hospitals responded to the survey (11.8% response rate). Low response rates among board chairs reflect the degree of difficulty in contacting them. We were not able to obtain a national list of chairs by name, thus surveys were addressed to "Board Chair" at each sampled hospital. Among respondents, 56 (58.9%) were drawn from critical access hospitals (CAHs;), 30 (31.6%) from prospective payment system hospitals (PPS), and 9 (9.5%) did not respond to the item regarding hospital type.

CEOs at 209 hospitals returned surveys (26.0% response rate). Among CEOs, 114 identified their hospital as a CAH (54.1%) and 93 reported working at another rural hospital (43.5%). Two CEOs (1.0%) did not report the type of hospital. Details about survey administration are provided in Appendix A.

Personal Characteristics

Most board chairs were white (94.6%), male (78.4%), and in the 50 – 64 age group (58.5%). Slightly more than a quarter of all board members were 65 years or older (27.7%). Most commonly, board chairs reported having a college degree (52.1%), with 18.1% reporting a non-clinical graduate degree, 11.7% reporting an MD/DO degree, and the remainder either had less than a college education (11.7%) or an unspecified graduate degree (4.3%).

The characteristics of board chairs reached through the current survey were comparable to the characteristics of board members in non-metropolitan hospitals reached by a 2005 survey by Margolin and Associates, of whom 75% were male and 6% were non-white.[1] Board chairs reached by our survey were slightly older than the board members cataloged by Margolin. Among board members in 2005, 70% were aged 51 or older, while 86% of chairs responding to the current survey were age 50 or above (slightly different cutpoints). Since chairs are likely to be more experienced than other board members, this age difference is not unexpected. Board members at CAH and PPS hospitals were similar.

Like board chairs, most CEOs were white (97.6%), male (81.9%), age 50 – 64 (65.7%). About a quarter of CEOs (26.1%) were younger than 50, and only 8.2% were 65 or older. CEOs reported higher educational attainment than chairs, with most CEOs reporting a non-clinical graduate degree (75.9%), or a college degree (12.6%), with only 2.9% having less than a college degree. The remainder (7.2%) held clinical degrees.

CEOs in CAH hospitals were more likely to be women than were CEOs at PPS hospitals (25.5% versus 8.9%, $p = 0.0035$), but did not differ in other demographic considerations (age, race, education) from their peers.

[1] Margolin FS, Hawkins S, Alexander JA and Prybil L. *Hospital Governance: Initial Summary Report of 2005 Survey of CEOs and Board Chairs*. Health Research & Educational Trust, Chicago IL. 2006.

Type of Hospital and Years of Experience

Most responding board chairs reported that their hospital was free-standing (72.9%), with 27.1% noting their hospital was part of a public or private multi-hospital system. The majority of board members reported that they served on a governing board (89.5%), with the remainder serving on advisory boards (10.5%). Chairs reporting that their board was advisory rather than governing were more likely to be associated with hospitals that were part of a multi-hospital system. Thus, seven (7) of 24 board chairs from hospitals located within a larger system reported that their board was advisory (29.2%), versus four (4) of 70 board chairs from free-standing hospitals (5.7%). Years of service reported by board chairs ranged from a single year through a high of 39 years, with an average of 10.7 years (95% confidence interval (CI), 9.3 – 12.2) and a median of nine years. Chairs at PPS and CAH hospitals did not differ in years of service.

Most CEOs (73.0%) characterized their hospital as free-standing, with the remainder working in systems (27.0%). The majority of responding CEOs described their board as governing (84.4%) rather than advisory (1.6%) in purpose. CEOs averaged less time in their role at their current hospital than did chairs. CEO length of service ranged from less than a year through 40 years, with an average of 6.9 years (95% CI, 6.0 – 7.8) and a median of four years. CAH executives had been in their current job a shorter period of time than had PPS executives (5.9 years versus 8.0 years; $p = 0.03$).

Non-response to individual questions about the hospital was more common among chairs than among CEOs, although the implications of this are uncertain. As noted earlier, nine chairs did not respond to the item on hospital type ("Hospital Type (please check one): Critical Access Hospital Other rural hospital"). In addition, 10 chairs did not respond to the item asking whether their hospital was "part of a system (corporate/multi-hospital organization, for-profit or not-for-profit)" or "free-standing (not part of a corporate/multi-hospital organization – private or public)."

Board Size

The average rural hospital board was reported to have between nine and 10 members (average reported by CEOs, 9.3, CI 8.7 – 9.8; average reported by chairs, 9.8, CI 8.8 – 10.7). This is comparable to the average of 10 members among rural boards found by Margolin and Associates. The majority of chairs (62%) and CEOs (53%) "strongly agreed" that board membership is appropriate in size.

CAH and PPS boards differ in size, as reported by chairs and CEOs. Responding board chairs at CAHs reported that their board had an average of 8.6 members (95% CI 7.6-9.5), while chairs at PPS hospitals reported an average of 11.7 members (95% IC 10.1-13.3; $p= 0.0005$). Similarly, responding CEOs at CAHs reported an average of 8.0 board members (7.4-8.5), while their PPS peers reported 10.8 members (9.9-11.7; $p <0.0001$). There were differences in whether the reported size was deemed appropriate. While 63.5% of PPS CEOs believed their board membership was appropriate in size, only 47.2% of CAH CEOs did so ($p. = 0.0366$). Unfortunately, the question did not ask respondents to specify a "better" size if their opinion was negative.

Recommendations:

Rural hospital boards and CEOs should seek to expand diversity in race and gender to ensure better community representation. Looking outside healthcare to leadership in faith communities, local service organizations, and other industries may be helpful for expanding the pool of potential board member recruits.

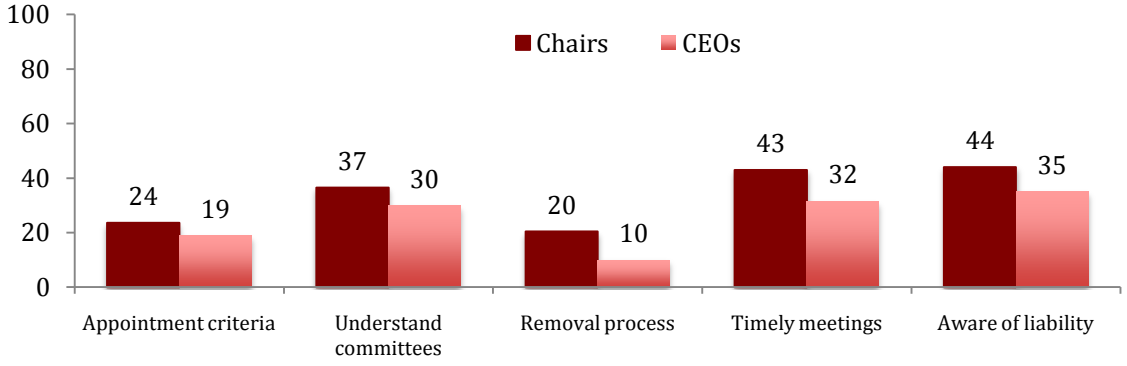
Board Structure

Many rural hospital boards may lack clear appointment and removal criteria. Less than a quarter of CEOs or chairs strongly agreed that board members are elected/appointed based on defined criteria, while 31% of chairs and 35% of CEOs disagreed with this statement. In the comment area, one CEO noted that the "selection process is purely political."

The process of removing a board member also appears to be undefined in most rural hospitals. Few chairs or CEOs expressed strong agreement that the removal process is effective, and a substantial group either disagreed/strongly disagreed regarding the removal process (chairs, 39.4%, CEOs, 50.8%; p=0.0265) or responded "don't know" (chairs, 12%, CEOs, 14%). It is likely that this uncertainty stems from the infrequency with which board members are deemed non-performing. An additional concern surrounds the question of board knowledge of legal liability associated with board membership. A small group of chairs (17.9%) and CEOs (18.6%) did not agree that their boards recognized this issue.

Given the potential for community divisiveness and legal action in the event a board member is involuntarily dismissed, it is essential that all rural hospitals establish written criteria for both appointment and removal and communicate this information to relevant parties. Criteria should be crafted to specify the importance of each member's responsibilities and his/her accountability for these responsibilities. Clearly defined responsibilities will assist in the recruiting process and can serve as a structure for specifying training needs.

Percent of Board Chairs and CEOs Who Strongly Agreed Regarding Board Structure Items



Complete wording for questions:

- Board members are selected/appointed based on defined criteria.
- Board members have a clear understanding of board committees.
- The board follows an effective process for removing non-performing board members.
- Board meetings are conducted in a manner that ensures timely resolution of issues.
- The board is aware of potential liability or legal responsibility associated with board membership.

Board Structure: CAH and PPS Hospital CEOs

CEOs of CAHs were more pessimistic regarding the effectiveness of their boards' structure than were CEOs at other rural hospitals. As shown in the table below, only 3.3% of CEOs strongly agreed that their hospital has an effective process for removing board members; similarly, only 13.5% strongly agreed that there are criteria for selecting members. Even time management within board meetings is viewed less favorably by CAH CEOs, with 29.8% expressing neutral or dissatisfied views among CAH CEOs, versus 7.7% at other hospitals. Of concern, 25.7% of CAH executives, and 10.0% of PPS executives, did not agree that their board is aware of potential liability associated with board membership ($p<0.0001$),

> *Problems with rural board structure are more severe at CAH than at other rural hospitals. Additional research is needed to ascertain whether problems stem from the smaller size of CAH communities, or limits within the hospitals.*

	Strongly agree	Agree	Neutral through strongly disagree	P value
Board members are selected/appointed based on defined criteria.				
CAH	13.5	23.4	63.1	0.0137
PPS	27.1	29.4	43.5	
The board follows an effective process for removing non-performing board members.				
CAH	3.3	10.9	85.9	0.0002
PPS	21.5	17.7	60.8	
Board meetings are conducted in a manner that ensures timely resolution of issues.				
CAH	24.6	45.6	29.8	0.0003
PPS	39.6	52.8	7.7	
The board is aware of potential liability or legal responsibility associated with board membership.				
CAH	20.3	54.0	25.7	<0.0001
PPS	52.8	37.3	10.0	

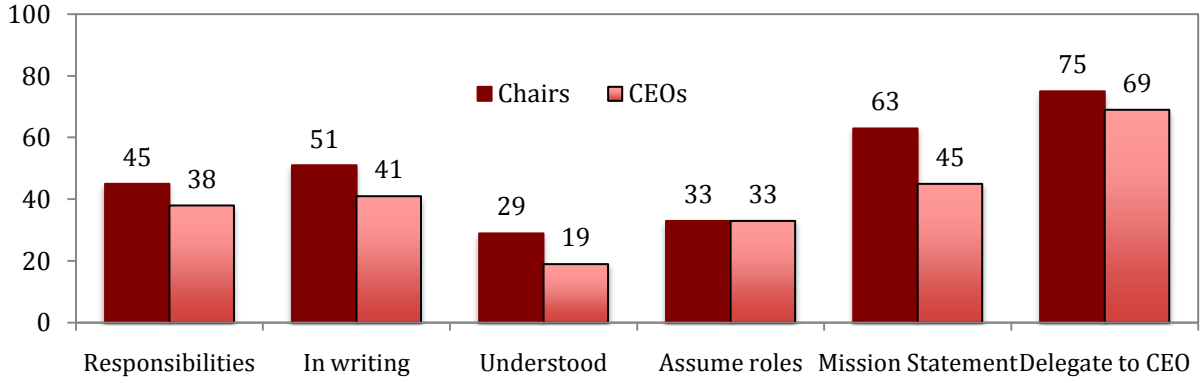
Board Responsibilities

The majority of chairs "strongly agreed" that members of the boards on which they serve are familiar with the hospital's mission statement and delegate authority to lead the hospital to the CEO. However, chairs were less strongly confident that all board members understand the role of the board (29% "strongly agree"), or that board members do not assume roles and responsibilities that belong to administrative staff (33% "strongly agree").

The views of CEOs generally paralleled those of the chairs. However, while 74.7% of chairs agreed or strongly agreed that "board members clearly understand their role," only 59.3% of CEOs held this opinion (p = 0.02).

Rural hospitals need to place additional emphasis on creating job descriptions for board members, communicating expectations prior to appointments, and conducting orientation of new members to ensure that all board members fully understand their role and their relationship to hospital executives and staff.

Percent of Chairs, CEOs Who "Strongly" Agreed About Selected Board Responsibilities



Complete wording for questions:
• The responsibilities of board members are clearly defined.
• Descriptions of board member responsibilities exist in writing for this board.
• Board members clearly understand their role on this board.
• Some board members assume roles & responsibilities that belong to administrative staff.
• Board members are familiar with the hospital's mission statement.
• The board delegates to the CEO the authority to lead the staff and carry out the organization's mission.

Board Responsibilities: CAH and PPS Hospital CEOs

CEOs at CAHs had less positive views than their PPS peers on five of the six measures of board responsibilities. Only 27.1% of CEOs at CAH hospitals strongly agreed that board member responsibilities are clearly defined, and only 30.4% strongly agreed that these responsibilities are in writing, versus 50.5% and 54.4%, respectively, among PPS CEOs. Given the potential absence of clear definitions of board member responsibilities, it is not surprising that only 10.5% of CAH executives "strongly agree" that board members understand their roles.

> *The possible absence of written descriptions of board member responsibilities at a large subset of CAH hospitals, coupled with the similar absence of clear criteria for selecting and removing board members, creates a potentially divisive situation for these institutions. In addition, the ability of board members to contribute effectively to the institution is impaired if they are uncertain of their role.*

	Strongly agree	Agree	Neutral through strongly disagree	P value
The responsibilities of board members are clearly defined.				
CAH	27.1	41.2	31.6	0.0017
PPS	50.5	32.3	17.2	
Descriptions of board member responsibilities exist in writing for this board.				
CAH	30.4	36.6	33.0	0.0016
PPS	54.4	28.3	17.4	
Board members clearly understand their role on this board.				
CAH	10.5	39.5	50.0	0.0008
PPS	29.2	40.9	30.1	
Some board members assume roles & responsibilities that belong to administrative staff (reversed coding)				
CAH	30.7	45.5	51.8	
PPS	36.6	24.7	38.7	
Board members are familiar with the hospital's mission statement				
CAH	33.3	44.7	21.9	0.0010
PPS	58.1	32.3	9.7	
The board delegates to the CEO the authority to lead the staff and carry out the organization's mission.				
CAH	64.0	24.6	11.4	0.0327
PPS	74.2	23.7	2.2	

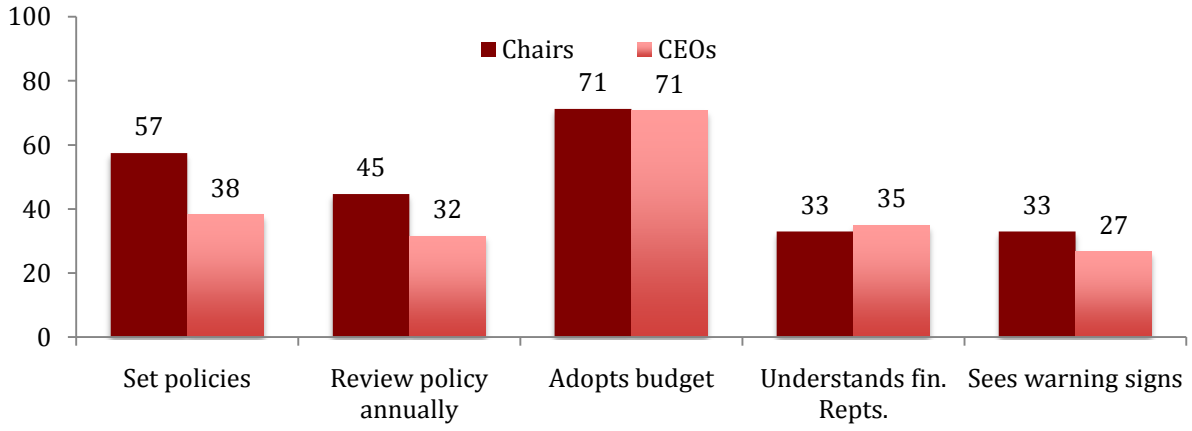
Policies and Finance

Board chairs and CEOs both expressed strong agreement that their boards adopt an annual budget that sets revenue and expense targets (71%, both groups). However, only about a third of board chairs or CEO's "strongly" agreed that their board understands financial reports or can detect poor financial performance early. Further, 9% of chairs either disagreed (7%) or responded "don't know" (2%) to the item about financial reports, while 12% either disagreed (11%) or responded "don't know" (1%) to the item about early signs of poor performance.

Chairs and CEOs also differed in their responses to items regarding the board's actions in setting and reviewing policies. While 57% of chairs checked "strongly agree" for setting policy, only 38% of CEOs did so ($p = 0.014$). Similarly, chairs were more likely than CEOs to agree that the board reviews policies, while CEOs were more likely to disagree or strongly disagree with this statement (18.2% versus 11.6% disagree; p 0.0043).

Additional training for rural boards on policy setting and review, and in interpretation of financial reports and warning signs, is merited. Training should be preceded by specification of a list of competencies that a board member should have in order to participate effectively in financial oversight. While competencies need not be present when an individual is recruited, a process for ensuring that the board member has acquired the required skills and abilities within a specified time after appointment should be established.

Percent of Chairs, CEOs Who "Strongly" Agreed About Board Handling of Policies and Finance



Complete wording for questions illustrated above:
• Our board accepts the responsibility for setting the organization's policies.
• The board reviews policies at least annually, and updates them as needed.
• The board adopts an annual budget that sets revenue and expense targets.
• Financial reports are clearly understood by the board.
• The board identifies any early warning signals of poor financial performance.

Policies and Finance: CAH and PPS Hospital CEOs

CEOs at CAHs and PPS hospitals were similar in their perception of the board activities with regard to setting policy, reviewing policies, and establishing an annual budget. However, CEOs at CAHs were less confident that their board understands financial reports or can identify early warning signs for poor financial performance.

> *Boards at all rural hospitals need additional training if they are to deal effectively with financial reports and their implications. The need for assistance in this area is particularly acute among CAH hospitals.*

	Strongly agree	Agree	Neutral through strongly disagree	P value
Our board accepts the responsibility for setting the organization's policies.				
CAH	33.3	34.2	32.5	
PPS	43.0	37.6	19.4	
The board reviews policies at least annually, and updates them as needed.				
CAH	33.3	26.3	40.4	
PPS	28.0	25.8	46.2	
The board adopts an annual budget that sets revenue and expense targets.				
CAH	65.8	18.4	15.8	
PPS	76.1	16.3	7.6	
Financial reports are clearly understood by the board.				
CAH	25.5	47.8	27.0	0.0031
PPS	47.3	37.6	15.1	
The board identifies any early warning signals of poor financial performance.				
CAH	14.9	46.5	38.6	0.0002
PPS	39.8	35.5	24.7	

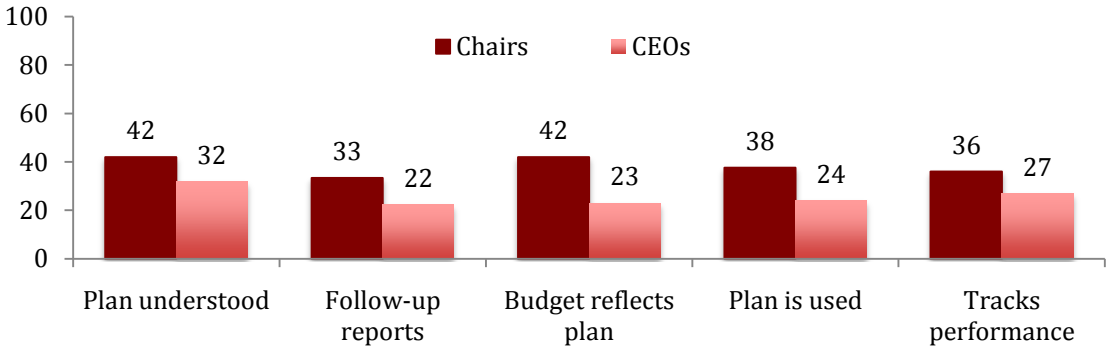
Strategic Planning

Fewer than half of chairs expressed strong agreement that the hospital had a strategic plan that was easily understood, or that the budget accurately reflects priorities established in the strategic plan. Similarly, only 38% of chairs strongly agreed that the strategic plan is used to guide and evaluate efforts, 33%, that follow-up reports are reviewed, or 36%, that the board keeps itself well-informed of progress toward goals.

Less than a third of CEOs selected "strongly agree" for any item pertaining to strategic planning. Further, 17% of CEOs *disagreed* that their hospital has an easily understood strategic plan, or that it is used to guide and evaluate efforts during the year, 15% disagreed with statements that board members review follow-up reports, and 10% disagreed that the board keeps itself informed of progress.

Overall, responses from both chairs and CEOs raise concerns about the degree of strategic planning present in rural hospitals, as well as the degree to which rural boards play an oversight role for plan implementation. Because strategic planning may require skills that are in short supply in small communities, cooperation across small rural hospitals, or between small rural institutions and urban hospitals, should be encouraged.

Percent of Chairs, CEOs Who "Strongly" Agreed About Board Understanding and Use of Strategic Plan



Complete wording for questions illustrated above:
• The hospital has a strategic plan that is easily understood.
• Board members review follow-up reports on programs they approved, such as joint ventures.
• The budget accurately reflects the priorities established in the strategic plan.
• The strategic plan is used effectively to guide and evaluate efforts during the year.
• This board keeps itself well informed about our organization's performance against predetermined plans and goals.

Strategic Planning: CAH and PPS Hospital CEOs

The majority of CAH and PPS executives (59.9% and 73.7%) agreed or strongly agreed that the board does keep itself informed of performance. However, more than half of CEOs at CAHs (51.8%) did not agree that their strategic plan is used effectively. On other items, a substantial minority of executives at CAHs, ranging from 40.2% to 45.6%, did not agree that their institution's board keeps itself informed of progress toward goals, that the budget accurately reflects the strategic plan, or that the hospital plan is easily understood.

Additional research is needed to determine how to improve the performance of CAHs at developing, communicating and monitoring strategic planning. Small size at CAHs may reduce the resources allocated to planning and reporting.

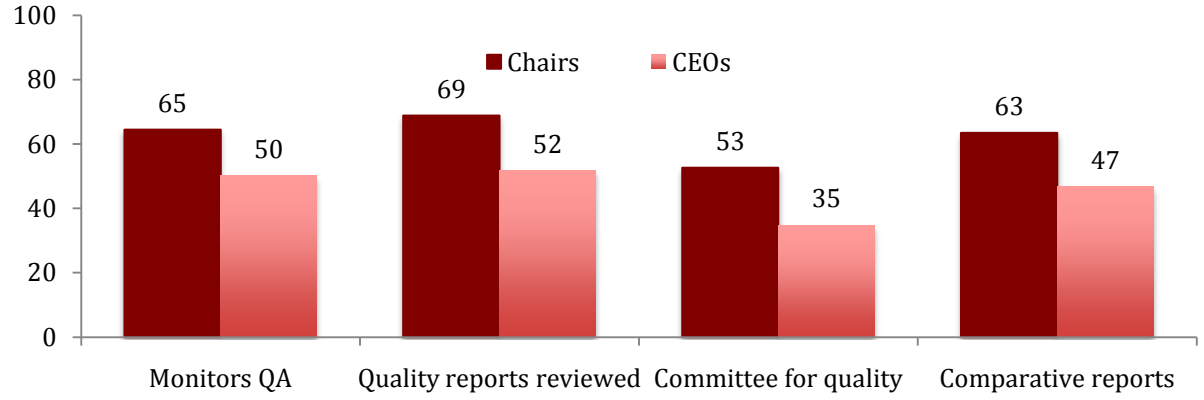
	Strongly agree	Agree	Neutral through strongly disagree	P value
The hospital has a strategic plan that is easily understood.				
CAH	22.8	32.5	44.7	0.0037
PPS	43.3	30.0	26.7	
Board members review follow-up reports on programs they approved, such as joint ventures.				
CAH	16.7	37.0	46.3	
PPS	30.3	30.3	39.3	
The budget accurately reflects the priorities established in the strategic plan.				
CAH	12.3	42.1	45.6	<0.0001
PPS	35.6	46.7	17.8	
The strategic plan is used effectively to guide and evaluate efforts during the year.				
CAH	18.4	29.8	51.8	0.0023
PPS	31.0	41.4	27.5	
This board keeps itself well informed about our organization's performance against predetermined plans and goals.				
CAH	18.8	41.1	40.2	0.0124
PPS	36.3	37.4	26.4	

Quality of Care Activities

The majority of rural hospital chairs strongly agreed that their board monitors quality assurance activities regularly (65%), that quality reports are reviewed and discussed (69%), that the hospital has committee responsible for quality of care and/or patient safety (53%), and that quality reports use external standards, such as industry or peer institution data (63%). However, 27% of chairs and 34% of CEOs disagreed or strongly disagreed with the statement "The board has a committee responsible for quality of care and/or patient safety," making the level of rigor of board review uncertain. In general, CEOs were markedly less positive than chairs in their view of board participation in quality; differences across all four questions were statistically significant.

Despite the increasing importance of quality of care for reimbursement by major funders, a substantial number of rural hospital boards may lack committees that provide oversight for this function. Board members should be advised that they may be liable for board failures in oversight in the event of a suit. Rural hospitals and boards need to ensure that patient safety/quality committees are active and effective in their institution, especially as incentives for health information technology (HIT) adoption are rolled out through the American Recovery and Reinvestment Act. In addition, board meetings should be structured to allocate a substantial amount of time to the review of quality and safety outcomes.

Percent of Board Chairs and CEOs Who Strongly Agreed With Statements Regarding Quality of Care Processes



Complete wording for questions illustrated above:
• The board monitors quality assurance activities & processes regularly.
• Quality of care reports are reviewed and discussed at board meetings
• The board has a committee responsible for quality of care and/or patient safety.
• Quality reports provided to the board compare your hospital's quality indicators to industry standards and/or peer level institutions.

Quality of Care Activities: CAH and PPS Hospital CEOs

The majority of CEOs at both CAHs and PPS hospitals agreed or strongly agreed that their boards monitor quality assurance activities and that quality of care reports are reviewed and discussed, although both activities were less common at CAH hospitals. The largest difference was in the presence of a committee for quality/safety: only 37.7% of CAH executives, versus 68.8% of PPS executives, agree that their board has this committee. Without a formal committee responsible for quality / patient safety, it is uncertain how effective board review of patient safety information may be. In addition, CAH boards may lack context for reviewing quality data, as the use of industry comparisons was less commonly reported by CAH than PPS CEOs (57.1% versus 86.6%, respectively). While CAH boards may interpret quality standards for a limited range of diagnoses when compared to larger institutions, this activity is still key.

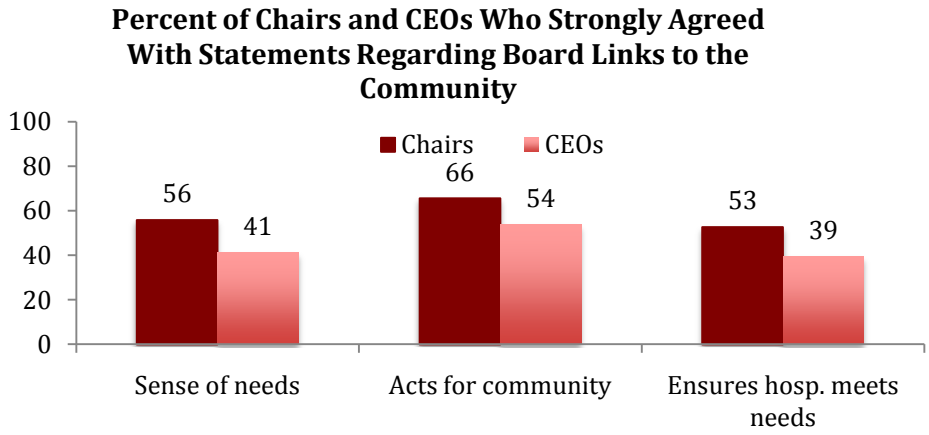
> *CAH boards lag far behind other rural hospital boards in their oversight for patient safety and quality of care. CAH boards need to develop committees for and expertise in patient safety and quality of care, both for legal and ethical reasons and to respond to financial incentives that CMS is anticipated to implement.[2] A means for CAH hospitals to access peer data inexpensively should be explored.*

	Strongly agree	Agree	Neutral through strongly disagree	P value
The board monitors quality assurance activities & processes regularly				
CAH	43.0	30.7	26.2	0.0332
PPS	58.9	27.8	13.3	
Quality of care reports are reviewed and discussed at board meetings				
CAH	43.9	32.5	23.7	0.0499
PPS	61.1	22.2	16.7	
The board has a committee responsible for quality of care and/or patient safety.				
CAH	19.3	18.4	62.4	<0.0001
PPS	54.4	14.4	31.1	
Quality reports provided to the board compare your hospital's quality indicators to industry standards and/or peer level institutions.				
CAH	34.8	22.3	42.9	<0.0001
PPS	62.2	24.4	13.3	

[2] Examples include reduction/no pay by CMS for "never" events [CMS press release, "ELIMINATING SERIOUS, PREVENTABLE, AND COSTLY MEDICAL ERRORS - NEVER EVENTS", May 18, 2008; accessed Sept 15, 2009 at http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1863].

Links to the Community

Virtually all chairs and CEOs took a positive view of their board's relationship to the community, with most agreeing or agreeing strongly that the board has a strong sense of important community health care needs, that the board acts at all times in the interest of the community, and that the board ensures that the hospital meets the community's healthcare needs. CAHs and PPS hospitals did not differ in these measures.



Complete wording for questions illustrated above:
• The board has a strong sense of important community health care needs and issues.
• The board acts at all times in the interest of the community.
• The board ensures that the hospital meets the community's healthcare needs.

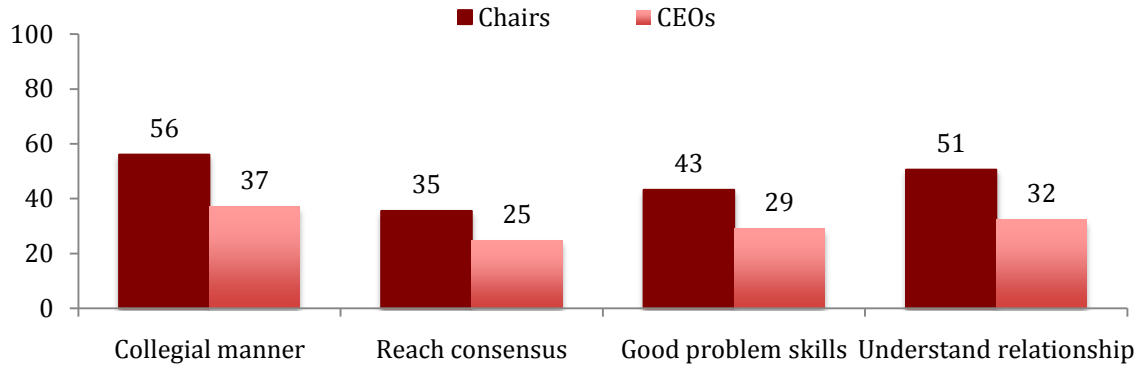
There were no differences in the views of CAH and PPS hospital CEOs regarding board links to the community.

Collegiality Among Board Members

More than half of board chairs strongly agreed that their board "consistently functions openly in a collegial, team building manner" (56%) and that "board members clearly understand their relationship to management, employees and medical staff" (51%). There was less certainty that "consensus is easily reached whenever there is board member disagreement" or that the board "demonstrates good problem solving skills." Opinions of CEOs were similar to those of chairs, although from 5% to 12% of executives expressed disagreement, depending on the item.

Training in techniques for attaining consensus, or agreeing to disagree when consensus is not possible, may be beneficial for rural hospital boards.

Percent of Board Chairs and CEOs Expressing Strong Agreement With Items Pertaining to Collegiality Among Board Members



Complete wording for questions illustrated above:

- The board consistently functions openly in a collegial, team building manner.
- Consensus is easily reached whenever there is board member disagreement.
- The board demonstrates good problem solving skills.
- Board members clearly understand their relationship to management, employees and the medical staff.

Collegiality Among Board Members: CAH and PPS Hospital CEOs

Board collegiality and the ability of members to work together were perceived similarly by CEOs at CAH and PPS hospitals. The only exception fell in the area of reaching consensus, as shown below.

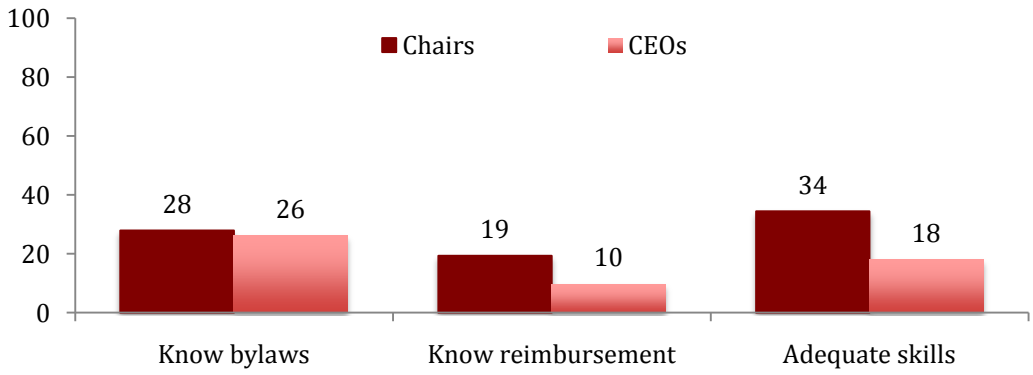
	Strongly agree	Agree	Neutral through strongly disagree	P value
Consensus is easily reached whenever there is board member disagreement.				
CAH	20.4	45.1	34.5	0.0287
PPS	30.8	50.6	18.7	

Board Skills and Knowledge

Rural board chairs and CEOs were more confident in their boards' basic skills than in members' actual knowledge of board by-laws, or in particular, knowledge of the way health care is financed. Only 19% of chairs and 10% of CEOs strongly agreed that board members understand third party reimbursement, while 14% of Boards and 16% of CEOs disagreed or strongly disagreed. Twelve percent (12%) of chairs disagreed with the item pertaining to members understanding bylaws, as did 10% of CEOs.

Results suggest the need for innovative ways of quickly orienting rural board members in third-party reimbursement and other unique aspects of healthcare financing, as well as in board bylaws.

Percent of Chairs and CEOs Who Strongly Agreed With Items Pertaining to Board Knowledge and Skills



Complete wording for questions illustrated above:

- The board is knowledgeable about the bylaws of the board.
- Board members understand the third-party reimbursement system in healthcare.
- The expertise/skill levels needed to be an effective board for this organization are adequately represented among current board members.

Board Skills and Knowledge: CAH and PPS Hospital CEOs

The problem of recruiting and retaining board members who are familiar with the healthcare reimbursement system is more acute in CAH than in other rural hospitals. Only 4.4% of CAH executives strongly agreed that their board members have this knowledge, while 57.5% expressed no agreement on this item. Board chairs were generally more positive in their assessment of members than were CEOs; nonetheless, only 13.2% of Chairs from CAH hospitals "strongly agreed" that their boards understood healthcare reimbursement. While CAH and PPS hospitals did not differ in other assessments of board skills, the proportion of CEOs who "strongly agree" regarding each of the three skill areas is low.

> *Both CAH and PPS rural hospital board members need orientation in both board bylaws and the financing structure in health care, however, the problem of lack of knowledge appears to reach critical proportions in CAHs.*

	Strongly agree	Agree	Neutral through strongly disagree	P value
The board is knowledgeable about the bylaws of the board.				
CAH	21.9	38.6	39.5	
PPS	30.8	41.8	27.5	
Board members understand the third-party reimbursement system in healthcare.				
CAH	4.4	38.1	57.5	0.0082
PPS	16.9	39.3	43.8	
The expertise/skill levels needed to be an effective board for this organization are adequately represented among current board members.				
CAH	12.3	50.0	37.7	
PPS	24.2	47.3	28.6	

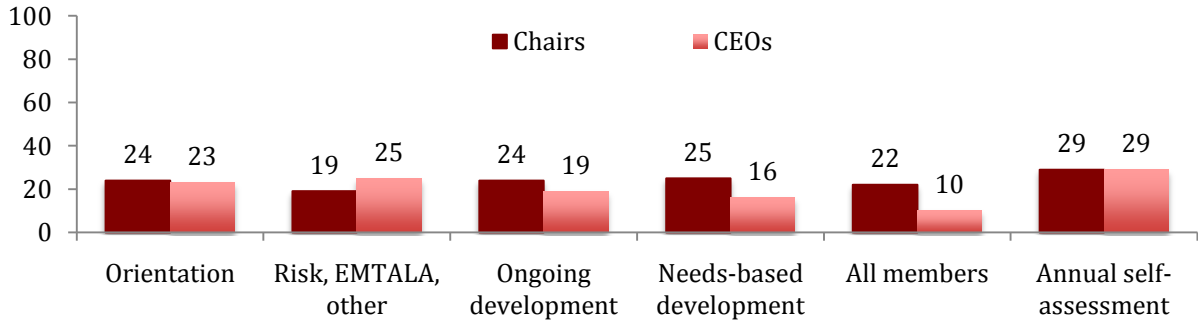
Orientation and Development

Neither chairs nor CEOs expressed confidence in procedures for board orientation and ongoing development. Only a quarter or fewer of respondents strongly agreed that their hospital has a well developed orientation for new members, that orientation covers a broad range of topics, that orientation is reinforced by ongoing development, or that development is based on needs. In fact, 17% of chairs and 27% of CEOs disagreed or strongly disagreed that their hospital has a good orientation for new members, and 15% of both chairs and CEOs disagree that they provide a comprehensive orientation.

Regarding ongoing development, 14% of chairs and 20% of CEOs did not agree that their hospital has a "well developed ongoing orientation process," 13% of chairs and 22% of CEOs disagreed that development is "based on identified needs," and 27% of chairs and 41% of CEOs disagreed that all board members participate in continuing education. There was similar pessimism regarding board member participation in annual self-assessment, with 17% of chairs and 35% of CEOs disagreeing with the item.

Results suggest that rural hospitals need to improve the ways in which board orientation and development are conducted. Lack of effective development may be one cause for the perceived lack of understanding of health care finance among board members documented in the previous section. Outside resources for technical assistance may be key to this process. The problem is particularly acute at CAH hospitals.

Percent of Chairs and CEOs Who Strongly Agreed With Items Pertaining to Board Orientation



Complete wording for questions illustrated above:

- The board has a well-developed, formal orientation process for new members.
- Board members get a basic orientation about risk management, EMTALA, HIPPA, medical liability and medical staff credentialing
- Orientation is reinforced by an ongoing program of education and development.
- Board development is based on identified needs.
- All board members participate in a well developed continuing education process.
- Board members actively participate in a formal annual self-assessment.

Orientation and Development: CAH and PPS Hospital CEOs

Differences in the views of CAH and PPS executives suggest that board orientation and development is a much more serious problem in these smaller rural hospitals, and a less serious concern at PPS institutions. The majority of CAH executives do not agree that their boards have an orientation for new members (63.1%), that development is based on identified needs (61.8%), that all members participate (80.7%), or that members engage in annual self-assessment (69.9%).

> *Board development activities at CAH hospitals fall far short of meeting the demands of this challenging role. While rural PPS hospitals could also use improvement in this area, the needs of CAH hospitals for improved board education and development are critical.*

	Strongly agree	Agree	Neutral through strongly disagree	P value
The board has a well-developed, formal orientation process for new members.				
CAH	8.1	28.8	63.1	<0.0001
PPS	39.8	28.4	31.8	
Board members get a basic orientation about risk management, EMTALA, HIPPA, medical liability and medical staff credentialing				
CAH	17.9	36.6	45.5	0.0018
PPS	34.8	41.6	23.6	
Orientation is reinforced by an ongoing program of education and development.				
CAH	30.7	17.5	51.8	
PPS	36.6	24.7	38.7	
Board development is based on identified needs.				
CAH	10.0	15.6	61.8	0.0149
PPS	23.6	1.5	44.9	
All board members participate in a well developed continuing education process.				
CAH	4.4	14.8	80.7	0.0022
PPS	16.9	22.5	60.7	
Board members actively participate in a formal annual self-assessment.				
CAH	12.4	17.7	69.9	<0.0001
PPS	49.5	16.5	34.1	

Perceived Board Training Needs

The survey asked chairs and CEOs to indicate, via a checklist of possible topics, areas in which training would benefit their hospital boards. Checklist topics had been generated by South Carolina stakeholders subsequent to a similar survey in that state. Results are shown at right, sorted by the order in which topics were chosen by chairs.

Chairs and CEOs did not differ extensively in their collective ranking of board training needs, with both placing board governance responsibilities and strategic planning in the top three, based on frequency. Differences between the two groups may be instructive.

Training Areas	Board Chair	CEO
Board Governance Responsibilities	**38.2**	**47.1**
Legislative Concerns	**37.1**	20.8
Strategic Planning	**37.1**	**49.0**
Financial Performance	32.6	25.2
Medical Staff Relations	31.5	32.5
Third-party Reimbursement Issues	31.5	**35.9**
Market/Community Awareness	30.3	14.1
Patient, Physician, Staff Satisfaction	29.2	18.9
Measuring Patient Care Outcomes	25.8	35.4
Joint Ventures with Physicians	23.9	21.4
Leadership and Management	22.6	23.8
Patient Quality/Safety	21.4	35.4
Public Relations/ Crisis Management	19.1	10.2
Staff Development and Training	16.9	8.7
Access Measures	12.5	14.6
Patient Care Related Processes	7.9	14.6

A higher proportion of chairs than CEOs wanted more training in legislative concerns. While CEOs may not wish their board members to advocate, it is likely that they will. CEOs may wish to ensure that appropriate content is provided.

Chairs differed from CEOs in the relative frequency with which training regarding patient care outcomes and quality/safety issues were selected. These issues tied for fourth place in the CEO selections, but were eighth and twelfth, respectively, among chairs. Given the increasing importance of quality and outcomes for reimbursement, boards may need additional education in these areas.

Two open-ended questions were used to clarify potential board development needs. First, chairs and CEOs were asked "What area of governance / board performance, if any, needs improvement?" Twenty-seven (27) chairs and sixty-one (61) CEOs responded. A second open-ended item at the end of the list of training options generated less response, perhaps because many of the "needs improvement" suggestions pertained to training and development and had already been offered.

Open-ended suggestions for board improvement were offered by 27 rural chairs. Board development, variously worded as "orientation," "continuing board education," and "training," received the most mentions (12). The second category noted by chairs was financial management, with comments such as "financial performance," "better understanding of financial reports," and "adaptation to our changing state funding for Medicaid," with six mentions. Remaining comments addressed how the board met and worked (three comments), strategic planning (two mentions), and assorted issues (four topics).

Open-ended comments on board improvements were offered by 61 CEOs; many offered more than one suggestion. In general, CEO comments reflected the concerns from the checklist. Specifically noted was the need for additional training in:

- board governance responsibilities (eg, "understanding of their roles," "board strategic goals versus operational goals," "chain of command"), and
- strategic planning, and finance (e.g., "understanding hospital finance," "reimbursement system," "issues caused by reduced Medicaid/Medicare").

Quality was also raised as an area in which board performance needs improvement by several CEOs. As noted earlier, board understanding of quality/safety issues and board committees devoted to these topics may not be adequate in rural hospitals.

> *Rural board chairs chose board governance, legislative concerns, and strategic planning as their top priorities for board training. Given that there was little agreement that board members have a deep understanding of their roles, and also the perceived lack of board participation in strategic planning, these priorities are in line with survey findings. Based on survey responses, additional important educational topics would include the importance of patient safety/quality of care, and key elements of the current healthcare reimbursement system.*

Chapter Three: Conclusions and Recommendations

Board Roles and Responsibilities Need To Be Clarified

Obtaining a "clear, common understanding" of roles is key to developing a productive board.[3] While a majority of board chairs and CEOs agreed or strongly agreed that the responsibilities of their board are clearly defined, there was less agreement that board roles are understood by board members. Executives at CAHs were particularly pessimistic: 50% agreed or strongly agreed that board members understand their role, while 50% did *not* agree. The differences between the governance role of boards, versus the executive role of hospital management and staff, may be difficult for new members to disentangle. In rural communities, where board, employee and patient populations may all know one another personally, maintaining appropriate distinctions may be particularly difficult.

Rural hospitals, particularly CAHs, need to place additional emphasis on creating job descriptions for board members, communicating expectations prior to appointments, and conducting orientation of new members, to ensure that all board members fully understand their role and their relationship to hospital executives and staff. The development of written procedures should extend to board membership itself, specifying the criteria for member recruitment and, if necessary, dismissal. The possible absence of written descriptions of board member responsibilities at a large subset of CAH hospitals, coupled with the similar absence of clear criteria for selecting and removing board members, creates a potentially divisive situation for these institutions.

The creation of a clear job description for board members has advantages for members and for the hospital itself, even when an outside entity (e.g., county government) may be responsible for appointment and removal of board members. Job descriptions allow impartial annual governance evaluation, required by the Joint Commission on Accreditation of Healthcare Organizations, by specifying what each member should have been doing in the evaluation period. By identifying deficiencies, comparison of job description and job performance clarifies the criteria for board participation and member removal, if indicated. Finally, well-defined job descriptions form the basis for board development by specifying the skills and competencies needed for effective performance.

Rural Hospital Board Development Is Urgently Needed

Rural hospitals, particularly CAHs, are experiencing a crisis in board development. Only a quarter or fewer of respondents strongly agreed that their hospital has a well developed orientation for new members, that orientation covers a broad range of topics, that orientation is reinforced by ongoing development, or that development is based on needs. Fewer than half of executives at CAHs agree that board members understand health care reimbursement, and only 4.4% checked "strongly agree" for this item. Across a range of topics from finance to quality of care, both board chairs and CEOs perceive performance gaps.

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[3] Prybil LD. Characteristics of effective boards. *Trustee*. 2006 Mar;59(3):20-3,

The perception of hospital board membership as an honorary position is outdated. Hospital governing boards are faced with interpreting, responding to and implementing public policy at the local level. In the collapse of the non-profit Allegheny Health Education and Research Foundation (AHERF) in Pennsylvania in 1999, management failed to exercise due diligence, but AHERF's board also failed to protect community assets.[4] Hospital boards are expected to adhere to rigorous standards and to fulfill performance, fiduciary and educational requirements.[5] The importance of education and training to completing these responsibilities cannot be overly stressed. On April 30, 2007, The Hospital Trustee Training bill was signed into law in New Jersey. The law states:

> "Hospital trustee training must be completed no later than six months after the date the person is appointed as a member of the board….the subject matter of the training will include (but not necessarily be limited to) types of financial, organizational, legal, regulatory, and ethical issues that a hospital trustee may be required to consider in the course of discharging his/her governance responsibilities."[6]

In difficult economic times, ensuring that board members travel to attend orientation sessions, or developing internal workbooks and materials that can explain the board member's role, may appear to be unnecessary. However, boards are central to representing community interests. One CEO offered an instructive comment about board improvement, noting that the board needed to "understand when it's time to close a hospital." A decision of this magnitude cannot reflect community interests if it is made by a poorly informed board that does not understand health care reimbursement and has received no effective education on the topic.

Rural hospitals need to make maximum use of pre-existing resources for board development. Educational resources are available from multiple national sources, including the Joint Commission for the Accreditation of Healthcare Organizations, the Institute for Healthcare Improvement (IHI), the Governance Institute, and the American Hospital Association (AHA). Both the Joint Commission and the AHA have multiple print offerings that can help provide information to boards and CEOs; many of the materials available from the AHA's Center for Healthcare Governance[7] can be downloaded free of charge. IHI, in particular, has a number of educational packages including the recent launch of "Improvement Map," an initiative aimed at facilitating process improvements for patient care and safety and IMPACT, a leadership curriculum. The Governance Institute, an organization for hospital and health system board members, offers a range of conferences, videos, books and other educational materials. Complementing these resources is the Rural Health Resource Center, which provides services on a more affordable scale. Hospitals are able to access resources around quality measurements, strategic planning, and leadership development.

The Center for Medicare and Medicaid Services is a resource that boards can access for additional help with quality improvement and patient safety issues. On its website, CMS offers

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[4] Burns, Lawton R., Cacciamani, John, Clement, James and Aquino, Welman (2000). The Fall of the House of AHERF: The Allegheny Bankruptcy. *Health Affairs*. January/February: 19(1).

[5] Sandrick, Karen, (2001). A New Governance Framework: A Rural System Reinvents Its Board Structure. *Hospitals and Health Networks*. April 2001:48-50.

[6] New Jersey Assembly bill 3633.

[7] http://www.americangovernance.com/

MedQuick, a repository of tools for quality submitted by hospitals across the country.[8] In addition, CMS maintains ten regional offices intended to help providers achieve maximum compliance with certification, quality improvement initiatives, and general operational issues. Rural hospital boards could proactively establish relationships with their regional CMS coordinator, who can be instrumental in meeting their educational needs on Medicaid and Medicare reimbursement. CMS Independent Quality Review contractors also offer consultants who help meet educational needs of boards on third-party payment and quality improvement topics.

Finally, state-level resources for development are available through five primary sources: state hospital associations, state offices of rural health (SORHs), statewide or local AHECs, state chapters of American College of Healthcare Executives (ACHE) and private consultants. These organizations are the best sources for understanding state-specific regulations and advocacy issues. Because Medicaid rules can vary by state, hospital associations and SORHs will likely be best informed to provide education to rural hospitals. They are, in addition, generally well informed about quality improvement and HIT policies, since they typically have personnel dedicated to monitoring these types of federal and state regulations. A list of state programs for board education and development, together with contact information, is provided on the following page. AHECs and state chapters of ACHE can also be important partners in empowering rural hospital boards. They typically have rich curricula on leadership, communication, and strategic planning. Both entities often partner in providing continuing education for healthcare professionals. Private consultants are also plentiful, although caution is needed. Most of the previously noted organizations will be familiar with reputable private sources of assistance and should be consulted prior to contracting with a private organization.

Development in any form takes time and money. If a CEO chooses to devote his or her time to develop educational resources for local use, or to download and implement one of the training resources developed by the Center for Healthcare Governance, that time is not free, nor is the time of board members. When management and boards seek to access development activities offered by professional organizations, they may encounter costly membership dues or registration fees. For example, an IHI workshop entitled "From the Top: The Role of the Board in Quality and Safety," September, 2009, is priced a $2,950 per participant or $2,500 per participant for IHI members, exclusive of travel expenses.[9] Locally produced events are markedly less expensive; registration in the South Carolina Hospital Associations Trustee (board) Development Conference, also September 2009, is only $450, again exclusive of travel.[10] In either case, however, a commitment of time and resources for education and training is required.

An innovative program being implemented by the South Carolina Hospital Association combines one-time board education with continuing education and certification for board members. The Best On Board (BOB) program is characterized as the first program of its

[8] http://www.qualitynet.org/dcs/ContentServer?pagename=Medqic/MQPage/Homepage
[9] Downloaded from the Institute for Healthcare Improvement, September 15, 2009: http://www.ihi.org/IHI/Programs/ProfessionalDevelopment/FromtheTopRoleoftheBoardinQualityandSafetySept2009.htm?TabId=5
[10] http://www.scha.org/images/stories/registration/TAP09.pdf

State Programs for Board Member Training/Certification

Alabama

Alabama has a voluntary certification program, which requires trustees to complete a self assessment that measures participation, basic knowledge, continuing education and other skills. The hospital then sends a list those eligible for certification to the Alabama Hospital Association for approval and certification. The assessment is required to be completed annually and there is a $20 processing fee for the initial approval and each annual renewal.
http://www.alaha.org/uploadedFiles/Resources/Trustee%20Certification%20Instructions.doc.pdf

Colorado

The Colorado Hospital Association plans to provide a Trustee Certification program within their "Boards on Board" Initiative. Details are not yet posted.
http://www.cha.com/images/stories/PatientSafety/board%20governance.pdf

New Jersey

New Jersey currently has an administration code under the New Jersey Office of Administrative Law (8.43G-5.22), which requires trustees must go through general orientation and at least seven hours of instruction through their training program. The instructions are offered in-person at a classroom or seminar, audio/webinar or through simulcast.
Contact: NJHA Trustee Relations, 609-275-4224

Minnesota

The Minnesota Hospital Association Trustee Council has a voluntary board certification program that requires completion of 35 training units: 12 units in Principles of Effective Governance, 8 units in Strategic Planning and Positioning, 4 units in Fiduciary Duties, 4 units in Board Development and Self-Assessment, 4 units in Quality/Patient Safety, and 3 units in General. There is also a required minimum of one year board experience prior to beginning the certification process. The entire process takes about two years.
http://www.mnhospitals.org/index/tools-app/tool.378

Texas

Texas currently offers a recognition program through the Texas Health Care Trustees – Texas Academy of Governance Program. The application consists of a checklist for the applicant to fill out with a list of standards and supporting documents that include personally signed statements, attendance records, newspaper articles, board meeting minutes, governance education certificates of attendance, resume, letters or statements from the hospital CEO or board chair, records of offices health and copies of board agendas. Each trustee is also encouraged to attend at least 6 hours worth of continuing education, with 3 hours of in-person classroom instruction.
http://www.tht.org/programs/texas_academy_of_governance/index.asp

Georgia

The Georgia Hospital Association offers board member certification based on participation in training. Initial certification requires 12 hours of approved course work, with continuing education requirements to retain certification. At least 4 hours over every two-year period must be in a face-to-face setting.
http://www.gha.org/Trustee/TrusteeCertificationBrochure.pdf

Tennessee

Tennessee has a voluntary certification process that began in 2006. This program offers Individual board member and hospital board certifications. Individual board members are required to complete 6 continuing board education units (1 unit = 1 hour) each year and complete a checklist divided into five areas with basic and advanced criteria listed for certification. The five areas include preparation and participation standards for board and committee meetings; meeting the fiduciary duties of care, loyalty and obedience, and governance obligations to bylaws, accreditation standards and laws; commitment to governance educational development; participation in performance evaluation of self, the board and the CEO; and participation in advocacy efforts on behalf of your hospital and the health care industry. The hospital board certification requires a certain percentage of board members be certified, which will gradually increase from the onset of the program to 100% within 5 years of implementation.

Note: A 2005 nationwide comparison of governance education from state hospital associations conducted by the Governance Institute indicates California, Massachusetts, and Alaska as states having certification programs in place for board members. We were unable to find information on the state hospital association websites.
Link to study:
http://www.governanceinstitute.com/ResearchPublications/ResourceLibrary/tabid/185/ProductID/649/CategoryID/17/List/1/Level/a/Default.aspx?SortField=DateCreated%20DESC,DateCreated%20DESC

kind to including testing as a requirement for certification (See Appendix B). BOB is a "voluntary, evidence-based certification" program for board members and hospital leadership. Certification may be obtained at one of three levels and is effective for three years. The program includes both education and testing for skills verification and is offered in both in-person and on-line formats. The SCHA has partnered with BlueCross BlueShield of South Carolina to offer financial incentives to hospitals that achieve 75% board member participation in the certification process. The structure of this program contains concepts particularly relevant to rural boards. First, BOB offers education linked to both testing and the concept of continuing verification of ability. Verification of competencies is particularly important for rural boards, which we found to have relatively few persons to draw upon (10 – 11 members). Second, the use of community partners to help hospitals meet their development goals parallels the resource sharing that is essential for small rural institutions, particularly CAHs.

Boards Require Champions and Support

The development of job criteria for board participation and the institution of training/ development standards for board members will not take place without champions within each hospital and, for rural hospitals in particular, without state or regional champions who can advance the interests of multiple institutions. Hospital-specific activities, such as board performance criteria, require in-hospital advocates to ensure that they are accomplished. Activities with a multi-institution scope, such as the South Carolina Hospital Association Board certification program described above, need one or more individuals at the state level to advocate for their development and implementation.

Boards require support for ongoing governance as well as for orientation and development. Support for both purposes requires dedicated staff at an appropriate level of training and authority. A clerical staffer who passes on papers is not adequate support for a functioning hospital board. If members are not engaged in the discussions and the information shared, through adequate support before and between meetings, then the process of making informed decisions becomes absent.[11] The support person should ideally be trained and experienced in hospital management, while independent of leadership in the institution (that is, not the hospital's own CEO).

For a single CAH or small PPS hospital, dedicating a full time employee to board support may not be financially feasible. Thus, partnering with other hospitals, or with a state hospital association or Office of Rural Health, to support a single individual or group of persons who provide support to small hospital boards is advisable. The larger partners, the state associations or Offices of Rural Health, could work with small hospitals to create a job description for the appropriate support person.

CAH Hospitals Need Priority Assistance

CAH hospitals need targeted assistance in multiple areas, with education in health care finance and patient safety/quality of care issues potentially having the greatest importance. In

[11] Middleton, E.G, Jr. Priority Issues for Hospital Boards. *Frontiers of Health Services Management* 2005; Spring, 21(3):13 -24.

nearly every measure of effectiveness assessed through our survey, CAH executives were less positive in their assessment of their boards than were PPS executives.

Targeted research into the sources of disparities between CAH and PPS hospital boards is needed to identify structural solutions, if any, to potential governance shortfalls at these institutions. The small size of CAH hospitals may limit their ability to recruit strong boards. However, the positive responses received from some chairs and CEOs at these hospitals suggest that success is possible even in small settings. Success stories should be identified and shared. Since CAH hospitals operate on a cost-reimbursement basis for CMS funding, clarification of the degree to which development activities may be included as costs of operation may be helpful.

Board Characteristics: Diversity Needed

Rural hospital boards are small, as found by our survey and by previous national research (an average of 9 – 10 members).[12] Small board size may lead to an absence of race and gender diversity, with nearly all chairs identifying themselves as white (95%) and male (78%). Although board chairs and CEOs view board links to the community positively despite an absence of diversity, it is possible that community views may differ.

Industry observers recommend that rural hospitals take an "outside the box" approach to recruiting new board members to increase the degree to which boards, and thus eventually chairs, reflect the community. Recommendations include looking for individuals participating in activities requiring leadership outside of healthcare, including local social, faith community, and industry settings.[13] Development of criteria for member recruitment which are specific to the tasks of the board, stemming from the job descriptions, can help ensure that recruitment is broad enough to provide new and independent points of view.

CEOs parallel board chairs in being principally white and male and thus may need help in looking beyond similar individuals when helping to recruit board members. A greater proportion of CAH hospital CEOs than PPS hospital CEOs were women. Gender diversity at small hospitals may lead to increased gender diversity in rural boards, as these individuals advance to larger institutions across their career.

Research and Demonstration Projects Are Needed

Innovative practices are more likely to be widely adopted if it can be demonstrated that such programs actually improve board and hospital outcomes. Foundations and other funders with an interest in rural hospitals are encouraged to provide financial support for the development and scientific evaluation of programs to educate board members and improve board function.

[12] Margolin, op cit.
[13] Dunn, P. Diversity on the Rural Hospital Board: Challenges for Today and Beyond. *Trustee* 2007; (June) p. 12 – 16.

Appendix A: Technical Notes

Research Design

We conducted a cross-sectional analysis of rural hospital boards, drawn from a convenience sample of rural hospitals. The research was approved by the Institutional Review Board of the University of South Carolina.

Population

All rural short-term, acute care general hospitals were the initial population. To define the sample, we first obtained a list of all rural hospitals from the American Hospital Association. This yielded a list of 2,227 hospitals across the whole US. We then obtained a list of all critical access hospitals (CAHs; 1,292) as of December 17, 2007. We next selected states from which hospitals would be drawn, with an overall goal of reaching approximately 400 prospective payment system (PPS) and 400 CAH institutions, while including at least two states from each census region. The resulting list of states and the initial sample are shown in Table A-1.

Survey Instrument:

Survey contents were adapted from an instrument that had been administered to CEOs and boards of directors at all rural hospitals in South Carolina in 2007. A copy of the board / CEO survey is provided at the end of this section. The instruments were identical except for questions that specifically related to the individual's position (e.g., "How many years have you been CEO (alternatively, served on the board) at this hospital?"). To reduce the length of the original instrument, we first developed a correlation matrix within each subject area for responses to the South Carolina survey. When individual responses were highly correlated (e.g., answers to 2 questions were correlated at 0.7 or more), one of the two items was dropped. The reduced questionnaire was then reviewed by the director of the South Carolina Office of Rural Health, the executive director of the South Carolina Hospital Association, and several hospital CEOs and board members within South Carolina for overall content and brevity.

Mailing and Data Procedures

Surveying chief executive officers (CEOs) and board chairs presents unique challenges. While hospital CEO names are available in the AHA hospital list, there is no central list known to the researchers which contains hospital board chairs. Thus, in the first mailing, we attempted to access board chairs through the CEOs at each institution. This approach was used previously by Margolin and Associates (2005; op cit). We sent an individualized introductory letter to the CEO of each hospital, working from the AHA list. [Due to invalid addresses, the total was reduced from 802 to 780 institutions.]

The letter introduced the survey and its intent (hospital executive plus board chair), and included a copy of the survey for the CEO, with a separate introductory letter and copy of the survey for the board chair. CEOs were asked to forward the packet to their respective board chairs. Self-addressed stamped envelopes were provided for both potential respondents. The first set of letters was mailed in October 2008, with a limited response. Following our first

mailing, we attempted to increase response by attempting an e-survey. Due to technical problems, we obtained only 17 responses to that survey. Thus, our third contact, conducted in January, 2009, was again by mail. We sent individually addressed letters to CEOs that included, in the signature, a small photo of the investigators (Drs. Adams and Probst). Subsequent to the second mailing, we had a total response of 95 board chairs (95/780; 12.2%) The final response among board chairs is less than that achieved by Margolin and Associates (2005 op cit) of 19% among board chairs. We also received responses from 209 CEOs (209/780; 26.8%), again, slightly less than the 33% attained by Margolin and Associates. Details of the number of respondents of each type, by state, are provided in Table A-1, on the next page.

All completed responses were entered into an EpiData data base with appropriate data edits. Materials were then converted into SAS files for analysis. All data analysis was conducted using SAS version 9.1. To test whether chairs and CEOs differed significantly in item responses, Chi Square was used for categorical items and t-tests were used for continuous variables. However, since the research was primarily descriptive in nature, extensive statistical modeling was not conducted.

Table A.1. Hospital Sample and Respondents, Rural Board/CEO survey

	Initial hospital sample					Board respondents				CEO respondents			
State:	Per state	CAH	PPS	State as percent of total	All hospital types	% of state	CAH	PPS	All hospital types	% of state	CAH	PPS
Arkansas	48	28	20	6.0%	6	12.5%	5	1	12	25%	7	5
Colorado	38	25	13	4.7%	9	23.7%	8	0	24	63.2%	18	6
Illinois	66	51	15	8.2%	11	16.7%	6	5	13	19.7%	6	7
Kansas	110	84	26	13.7%	8	7.3%	7	1	25	22.7%	18	7
Louisiana	74	27	47	9.2%	5	6.8%	1	2	8	10.8%	1	7
Maine	23	15	8	2.9%	4	17.4%	1	3	4	17.4%	1	3
Michigan	60	34	26	7.5%	8	13.3%	5	3	19	31.7%	10	9
Montana	57	45	12	7.1%	11	19.3%	10	1	13	24.6%	11	2
Ohio	60	34	26	7.5%	3	5.0%	2	1	14	23.3%	8	6
Oklahoma	79	33	46	9.9%	7	8.9%	1	5	17	21.5%	2	15
Pennsylvania	53	13	40	6.6%	6	11.3%	0	3	12	22.6%	2	10
South Dakota	50	38	12	6.2%	3	6.0%	1	2	12	24.0%	9	3
Tennessee	58	16	42	7.2%	4	6.9%	1	2	10	17.2%	3	7
Wyoming	26	14	12	3.2%	3	11.5%	1	2	8	30.8%	7	1
Unidentified *					7				18		---	---
	802	457	345	100.0	95		56	30	209		114	93

*Unidentified are missing state or type, or both. Totals may not equal because of missing in state or hospital type.

Appendix B: Board/CEO Survey

Board/CEO survey, first page
(Note: Surveys were identical except for title and question pertaining to respondent's tenure as CEO/Board member.)

2008 CEO SURVEY RE RURAL ACUTE CARE HOSPITAL BOARDS

SECTION I: Your Hospital and Board

Hospital Type (please check one): [ ] Critical Access Hospital [ ] Other rural hospital

Which of the following best describes the autonomy and authority of this hospital's Board of Directors?

[ ] Governing Board (sets direction, makes decisions, provides oversight, establishes policies)

[ ] Advisory Board (provides advice, advocacy and monitoring)

[ ] Other. Please explain_____

Which of the following best describes your hospital?

[ ] Part of a system (corporate/multi-hospital organization – for-profit or not-for-profit)

[ ] Free-standing (not part of a corporate/multi hospital organization – private or public)

[ ] Other. Please explain_____

How many members does your board have? _____

SECTION II: Your Board's Operations

For each of the statements in this section, please indicate the degree to which you believe that statement describes <u>your</u> Board. Please circle your response

A. FUNCTION
1. Responsibilities

	Strongly Agree ↔ Strongly Disagree					Don't know
The responsibilities of Board members are clearly defined.	1	2	3	4	5	DK
Descriptions of Board member responsibilities exist in writing for this Board.	1	2	3	4	5	DK
Board members clearly understand their role on this Board.	1	2	3	4	5	DK
Some Board members assume roles & responsibilities that belong to administrative staff.	1	2	3	4	5	DK
Board members are familiar with the hospital's mission statement	1	2	3	4	5	DK
The Board delegates to the CEO the authority to lead the staff and carry out the organization's mission.	1	2	3	4	5	DK

2. Policies & Finance

Our Board accepts the responsibility for setting the organization's policies.	1	2	3	4	5	DK
The Board reviews policies at least annually, and updates them as needed.	1	2	3	4	5	DK
The Board adopts an annual budget that sets revenue and expense targets.	1	2	3	4	5	DK
Financial reports are clearly understood by the Board.	1	2	3	4	5	DK
The Board identifies any early warning signals of poor financial performance.	1	2	3	4	5	DK

Board/CEO survey, second page

3. Strategic plan	Strongly Agree ⟷ Strongly Disagree					Don't know
The hospital has a strategic plan that is easily understood.	1	2	3	4	5	DK
Board members review follow-up reports on programs they approved, such as joint ventures.	1	2	3	4	5	DK
The budget accurately reflects the priorities established in the strategic plan.	1	2	3	4	5	DK
The strategic plan is used effectively to guide and evaluate efforts during the year.	1	2	3	4	5	DK

4. Quality of Care						
The Board monitors quality assurance activities & processes regularly.	1	2	3	4	5	DK
Quality of care reports are reviewed and discussed at Board meetings	1	2	3	4	5	DK
The Board has a committee responsible for quality of care and/or patient safety.	1	2	3	4	5	DK
Quality reports provided to the Board compare your hospital's quality indicators to industry standards and/or peer level institutions.	1	2	3	4	5	DK

5. Community Links						
The Board has a strong sense of important community health care needs and issues.	1	2	3	4	5	DK
The Board acts at all times in the interest of the community.	1	2	3	4	5	DK
The Board ensures that the hospital meets the community's healthcare needs.	1	2	3	4	5	DK

B. STRUCTURE						
Board members are selected/appointed based on defined criteria.	1	2	3	4	5	DK
Board membership is appropriate in size.	1	2	3	4	5	DK
The Board reflects the racial composition of the community.	1	2	3	4	5	DK
Board members have a clear understanding of Board committees.	1	2	3	4	5	DK
The Board follows an effective process for removing non-performing Board members.	1	2	3	4	5	DK
Board meetings are conducted in a manner that ensures timely resolution of issues.	1	2	3	4	5	DK
The Board is aware of potential liability or legal responsibility associated with Board membership.	1	2	3	4	5	DK

C. BOARD COMPETENCIES AND TRAINING						
The Board has a well-developed, formal orientation process for new members.	1	2	3	4	5	DK
Board members get a basic orientation about risk management, EMTALA, HIPPA, medical liability and medical staff credentialing	1	2	3	4	5	DK
Orientation is reinforced by an ongoing program of education and development.	1	2	3	4	5	DK
The Board is knowledgeable about the bylaws of the Board.	1	2	3	4	5	DK

Board/CEO survey, third page

	Strongly Agree ⟷ Strongly Disagree					Don't know
Board members understand the third-party reimbursement system in healthcare.	1	2	3	4	5	DK
The expertise/skill levels needed to be an effective board for this organization are adequately represented among current board members	1	2	3	4	5	DK
This Board keeps itself well informed about our organization's performance against predetermined plans and goals.	1	2	3	4	5	DK
Board development is based on identified needs.	1	2	3	4	5	DK
All Board members participate in a well developed continuing education process.	1	2	3	4	5	DK
Board members actively participate in a formal annual self-assessment.	1	2	3	4	5	DK
The Board consistently functions openly in a collegial, team building manner.	1	2	3	4	5	DK
Consensus is easily reached whenever there is Board member disagreement.	1	2	3	4	5	DK
The Board demonstrates good problem solving skills.	1	2	3	4	5	DK
Board members clearly understand their relationship to management, employees and the medical staff.	1	2	3	4	5	DK

Section III. Addressing future needs

What areas of governance / Board performance, if any, need improvement? _____

_____

_____

Our Board would benefit from training in the following areas: (**Check all that apply**)

[ ] Board Governance Responsibilities
[ ] Medical Staff Relations
[ ] Leadership and Management
[ ] Strategic Planning
[ ] Patient Quality/Safety
[ ] Patient Care Related Processes
[ ] Market/Community Awareness
[ ] Joint Ventures with Physicians
[ ] Measurement of Patient Care Outcomes
[ ] Staff Development and Training
[ ] Legislative Concerns
[ ] Financial Performance
[ ] Third-party Reimbursement Issues
[ ] Patient, Physician and Staff Satisfaction
[ ] Public Relations/Crisis Management
[ ] Access Measures (emergency, primary care, home health)
[ ] Other_____

Please turn to the last page

Board/CEO survey, fourth page

SECTION IV: About you
(*Please check the appropriate response).*

How many years have you been CEO at this hospital? _____Years

What is your age? [ ] 35 years or below [ ] 36–49 years [ ] 50–64 years [ ] 65 years & up

Gender: [ ] Male [ ] Female

Race or ethnicity: [ ] American Indian or Alaska Native [ ] Asian/Pacific Islander
(*check any that apply*) [ ] Black or African American [ ] Hispanic or Latino
[ ] Some Other Race [ ] White

Your highest level of education:
[ ] High School [ ] Attended College
[ ] College Degree [ ] Graduate Degree, non clinical (MBA, PhD)
[ ] Medical degree (MD, DO) [ ] Graduate Degree, clinical (e.g., MSW, PhD)
[ ] Other_____

Anything else we should know about your Board or rural hospital boards in general?

_____

_____

_____

In case you have questions:

Lead Researcher: Jan Probst
South Carolina Rural Health Research Center
University of South Carolina
803 251 6317
jprobst@sc.edu

Thank you for your time and participation.

Appendix C:

"Best on Board" Brochure from the South Carolina Hospital Association

Best on Board
South Carolina

Shaping Hospital Governance & Leadership

A Program of the South Carolina Hospital Association

A Message from Your South Carolina Hospital Association

We are pleased to bring you Best on Board—also known as "BOB"—an exciting new program designed to advance hospital governance and leadership in our state. This program is the first of its kind for hospital trustees anywhere, offering participants an evidence-based approach to learning about the critical issues facing hospitals today. Participating in Best on Board and earning certification will demonstrate to your patients, employees and community that you are committed to safe, high quality, efficient hospital care.

Leadership can make a huge difference in how well your hospital meets its mission. BOB will empower you with the knowledge and confidence necessary to ask the right questions and make the right decisions in discharging your responsibility as a hospital board member. Hospitals are a vital resource for a community's wellbeing. Your strength and preparedness as a leader is vital to its success.

Sincerely,

Thornton Kirby, FACHE
President and CEO

AN INTRODUCTION

Hospitals are among a community's most valued and important resources. Hospitals look to their communities for people willing to serve on their boards as volunteer leaders and stewards of an increasingly complex resource.

The stakes are high. Recently, trusted American companies have experienced serious breakdowns in leadership and governance, shaking public confidence. There's a heightened awareness of the activities of all boards, regardless of industry. Lawmakers, the media, and the public are demanding greater accountability. With healthcare reform at the forefront of the national debate, hospital boards are under particular pressure to exercise strong governance and leadership. The ever-changing medical, social, legal, and ethical issues can make hospital board service a daunting responsibility.

As the state's advocate for hospitals, the South Carolina Hospital Association believes that we must invest in hospital board members so that they may fulfill their roles with knowledge, competence and confidence. This investment comes in the form of an exciting new program called Best on Board.

WHAT IS BEST ON BOARD

Best on Board (BOB) is a voluntary, evidence-based certification program for South Carolina hospital board members and hospital leadership. The first of its kind in the country, Best on Board has three core purposes:

- To provide participants with knowledge and insight into the complex issues facing hospitals today.
- To instill participants with the tools needed for sound decision-making so the community they serve has confidence and trust in their actions.
- To demonstrate to all stakeholders that South Carolina hospitals and the leadership governing them are engaged, informed and committed to governance excellence.

WHAT IS INVOLVED

Best on Board offers a progressive curriculum, with three levels of certification. Participants can choose to complete one or all three levels. Level One certification involves completing the Essentials of Healthcare Governance course. Levels Two and Three are for those who wish to achieve a deeper understanding of specific governance responsibilities and achieve the skills necessary for board leadership. The course is offered in two formats: online or in person.

After successful completion of the course, participants are awarded a certificate of completion. The certification remains in effect for three years.

A Special Best on Board Incentive from BlueCross BlueShield of SC

SCHA has partnered with BlueCross BlueShield of South Carolina to offer a special incentive for hospitals who participate in Best on Board. As a component of the 2011 Hospital Recognition Program, participating hospitals who have 75 percent of their board members and senior hospital leaders obtain certification by completing both the Essentials of Healthcare Governance and Quality courses will receive some financial support —either lump sum or increase in reimbursement—from BlueCross BlueShield of South Carolina and BlueChoice Health Plan.

BENEFITS TO HOSPITALS

South Carolina hospitals can expect many benefits from having a Best on Board certified board and leadership team.

- A special financial incentive from BlueCross BlueShield of South Carolina
- The capacity for better board teamwork and collaborative leadership
- Shared foundational knowledge and skills for governance and leadership
- A rapid "on-boarding" process for new board members and hospital leadership
- Enhanced leadership development that promotes a higher performing organization and board

BENEFITS TO PARTICIPANTS

Serving as a hospital board member requires a major commitment and is a tremendous responsibility. Best on Board certification prepares board members to more competently serve the hospital and community and builds confidence in decision-making. This program helps build better leaders because:

- It enables board members and hospital leadership to more effectively serve the hospital and community.
- It prepares board members, potential board members, and hospital leadership for further levels of leadership and service.
- It provides personal recognition for good service and sound governance to the hospital and community.

THREE LEVELS OF CERTIFICATION

LEVEL 1: BOARD & LEADERSHIP ESSENTIALS (THREE-YEAR CERTIFICATION)	
Requirement	Completion of Essentials of Healthcare Governance course and pass test.
Fast Track Option	Seasoned or experienced participants can opt out of the Essentials of Healthcare Governance course and complete the test only.
Recertification	At the end of three years, BOB certificate holders must complete an updated Essentials of Healthcare Governance course and/or pass the test.
LEVEL 2: ADVANCED (THREE-YEAR CERTIFICATION)	
Requirement	Completion of at least one Level Two course—Finance, Quality or Leadership Development—and pass test.
Fast Track Option	More seasoned or experienced participants can opt out of the Level Two course and complete the test only.
Recertification	At the end of three years, BOB certificate holders must complete an updated Level Three course and/or pass the test.
LEVEL 3: BOARD LEADERSHIP (THREE-YEAR CERTIFICATION)	
Requirement	Completion of Level Three board/leadership learning activities.
Recertification	At the end of three years, Level Three BOB certificate holders must complete Level Three learning activities.

GET ON BOARD—ENROLL NOW

For pricing information or to enroll in Best on Board, contact:

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