

# 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.