Governance vs. Management: What's the Difference?

The hospital's board and management each play a unique and critical role in the organization's ability to fulfill its mission and vision. When working together synergistically, the partnership between the board and management can help hospitals excel in meeting the community's needs in the best and most efficient way possible. But when the board and management overstep their bounds and their responsibilities become blurred, the result can be detrimental for the organization's leadership; and ultimately, the long-term success of the hospital.

Trustee orientation and ongoing education programs often focus on the board's individual functional responsibilities, such as strategic planning, CEO oversight and compensation evaluation, quality and patient safety, medical staff credentialing, ensuring financial stability, and more. All of these areas are essential components of the board's roles and responsibilities. However, before delving into each area, the board and management must first be clear on their roles and responsibilities as they relate to the organization and its oversight.

The leadership actions of the board and management should complement one another, with the board guiding, directing and overseeing the organization, while the management team addresses the "daily" operational details. While the board sets the long-term direction for the organization, the logistical details of how to achieve those goals should be left to the skills and experience of the senior management team.

Getting the Roles Straight

The board and the CEO each play critical roles in the success of a hospital. Board responsibilities focus on CEO oversight, high-level organizational planning and monitoring progress and performance. Many trustees also have volunteer responsibilities related to their organization's not-for-profit status and community-centered mission.

In order to keep the board's and CEO's roles from blurring together, hospitals should develop clear job descriptions for trustees, the board chair and the CEO. Agreement on clearly defined job descriptions ensures the right foundation for a joint leadership effort and prevents the board and CEO from crossing over into areas they shouldn't.

Maintaining the Balance: Lack of Oversight vs. Micromanagement

Strong boards are independent-minded, curious and able to focus on what matters most. Their members are willing to challenge status-quo thinking and stretch themselves intellectually. Weak boards are complacent and submissive. Their members do not ensure that all sides of issues are considered, or that "conventional wisdom" is challenged. Weak boards are not likely to be effective in preparing and leading their organizations for a successful future.

There are two common roadblocks to any board's ability to maintain its effectiveness: 1) a tendency toward "rubber stamping;" and 2) a tendency toward micromanagement. Both are most likely to occur when a majority of members lack interest, drive or the ability to speak from the shadow of one or more overbearing board members.

Rubber Stamping

Some experts' calls for boards to stop "meddling" in business operations has led boards to be reluctant to question staff, tending instead toward "rubber stamping" management recommendations. When boards act in their appropriate governance and oversight roles, it can lead to uncomfortable questions and
tensions in the room. It takes a lot of nerve for a board member to challenge a staff recommendation at a board meeting, and for many trustees avoiding conflict is easier.

As a result, members of rubber-stamping boards fail to ask pertinent questions or engage in deliberative dialogue on solutions to challenges, and do not work successfully together to arrive at independent-minded decisions. They accept recommendations with little questioning or debate, and fail to explore alternatives and scenarios that may reveal the weaknesses of arguments or positions.

From a legal standpoint, individual members of a rubber-stamping board may be considered negligent and liable for their actions or inactions, and may be held personally liable for a lack of adequate oversight.

**Micromanagement**

It's often a challenge for board members to see the fine line between management and governance. Board members must understand that they are expected to be leaders and overseers, not managers and implementers. They should be concerned with the "what," not the "how." Micromanagement is a term generally applied to boards that pay too much attention to details, and not enough attention to the "big picture" strategic issues and implications.

It's up to everyone on the board to guard against micromanagement. The board chair should ensure that its members understand their roles, and consistently adhere to them. In addition, the CEO needs to be willing to candidly discuss problems of micromanagement with the board chair to work out board-driven solutions to this problem.

**Finding the Middle Ground**

Avoiding micromanagement doesn't mean that the board avoids tough questions. The board has a fiduciary responsibility to ask those questions. But ensuring clearly defined roles for both the CEO and the board will help ensure both find the right balance. That balance is something that can't be achieved without both groups on board.

**Governance vs. Management Roles in Key Responsibility Areas**

While the board and CEO have overlapping areas of responsibility, their roles in each area are distinct. Below are a few examples highlighting the differences between the role of the board and management in key responsibility areas.

**Strategy**

The board approves and helps formulate the mission, values and vision, and participates in an annual strategic planning process to update the statements, when necessary. It makes all decisions in light of the mission, values and vision, and uses them to approve and formulate the organization's long-term strategic plan. Management provides input and background materials for the board's discussion of the mission, values and vision, and then carries out the mission determined by the board. The management team also provides relevant materials and recommendations to the board before the board sets the long-term strategic direction. Once the board sets the direction, the management team establishes and carries out the plan, conducts the day-to-day operations, and reports progress to the board.

**Financial Leadership**

The board uses the annual budget process to define the most effective allocation of the hospital's resources, approves the final budget, and identifies performance targets for periodic review. In addition, the board adopts charity care, billing and collections policies, ensures they are clearly communicated to all patients, and evaluates the hospital's billing processes to ensure they are patient-friendly and easy to understand. Management prepares the preliminary budget and presents it to the board for approval, develops targets and objectives, carries out the budget and tracks detailed financial progress, taking corrective action when necessary. The management team develops easy-to-understand reports for the board, and implements the board-approved charity care, billing and collections policies. It also carries out all purchases according to the board's policies.

**Workforce**

The board is responsible for hiring and firing the CEO, CEO compensation and performance evaluation, and CEO recruitment and succession planning. The board also adopts policies related to personnel, and approves budgets for staff salaries and benefits. Management carries out the personnel policies, negotiates labor contracts, approves salaries, hires and evaluates personnel, and address staff grievances.

**Medical Staff Privileging, Credentialing and Oversight**

The board approves medical staff bylaws, appointments and reappointments, and physician credentialing, while management provides support for the process. The board ensures physician
participation in strategic discussion and decisions, seeks medical staff advice and counsel on strategic issues, and ensures physician attitudes and needs are regularly assessed. Management develops and oversees medical staff affairs, maintains relationships with the medical staff, conducts the medical staff assessment and implements medical staff policies.

**Quality and Patient Safety and Compliance**
The board ensures a hospital-wide plan is in place for improving quality and patient safety and reducing medical errors, and a process is in place for monitoring regular progress in achieving the plan. It sets quality and patient safety goals and targets, and has a plan in place for identifying and reporting adverse and sentinel events. It also monitors compliance with Joint Commission, state and federal regulations. Management implements the board's plan for improving quality and patient safety, and takes necessary operational action to ensure adherence to Joint Commission and other federal and state requirements. They establish the operational details necessary to fulfill the quality improvement plan, implement the plan, and track progress that is regularly reported to the board.

Special Thanks to The Walker Company for use of *Governance vs. Management: What's the Difference?*

Was this article of value to you? Please let us know. E-mail Cindy Samuelson to let Kansas Hospital Association staff know if we should continue to feature a governance article in each issue of *Trustee Resource*.

**Strategies to Reduce Hospital Readmissions**
The Agency for Healthcare Research and Quality, partnering with the Health Research and Educational Trust, is funding an initiative to assist a limited number of hospitals in implementing the Re-Engineered Hospital Discharge (Project RED) intervention to reduce readmissions. Project RED redesigns the workflow process. Hospitals who have implemented the program have dramatically reduced their numbers of readmissions. Project RED has proven that patients who have a clear understanding of their after-hospital care instructions are 30 percent less likely to be readmitted or visit the emergency department than patients who lack this information.

Hospital leadership, including trustees, are invited to join us from 1 to 2:30 p.m. on April 13, when the Kansas Hospital Association, in partnership with the Kansas Medical Society and the Kansas Healthcare Collaborative, will host an informational Webinar on Project RED. The brochure and online registration are available on the KHA Web site.

**Trustees Encouraged to Attend the KHA District Meetings**
Whether you're concerned with federal regulations, state and federal health care budgets, or how to navigate the changes in Medicaid and Medicare, you'll want to join the discussions at the Kansas Hospital Association District Meetings. Our district chairs and vice chairs have prepared a robust agenda. The dates and locations for the 2011 Spring KHA District Meetings are listed below. All meetings will begin at 9:00 a.m. and end by 1:00 p.m. after lunch. Attend the meeting of your choice; you are not restricted to your home district meeting. Register online or contact Susan Cunningham at (785) 233-7436 and state which meeting you would like to attend.

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Helping Trustees with Health Care Terms and Abbreviations

The Kansas Hospital Association is pleased to announce the completion of our third edition of the Kansas Health Care Terms and Abbreviations. This resource is designed to help individuals understand the complex and sometimes confusing health care terminology that is used. The print-friendly 8.5 x 11 Microsoft Word version can be found on the KHA Web site. The Kansas Health Care Terms and Abbreviations resource will soon be available in a booklet form. In May, KHA will send this booklet to all the hospital trustees in our database.

Online Trustee Education Now Available

The Kansas Hospital Association is pleased to announce a new educational resource for hospital trustees. The Hospital Governance series is a set of online courses offered through careLearning that provide the basic information a governing board trustee needs to fulfill his or her duties to the organization successfully. The courses are appropriate for the new trustee, as it provides a basic foundation and serves as a broad orientation; or for the experienced trustee, as all trustees may gain additional insight to their responsibilities.

The Hospital Governance series includes the following courses:

- Overview and Board Duty Basics
- Committees, Leadership, Self-Assessment and More
- Conflicts of Interest and Compliance
- Trustee Responsibility for Quality and Safety
- Financial Basics and Background
- Financial Reports - Board Responsibility, Collections, Balance Sheets, Operating Statements, and Audit Report
- Financial Reports - Cash Flow, Financial Dashboard and Board Focus

The Hospital Governance series can be purchased by organizations or individuals. For more information about the series, including a full description, go to www.carelearning.com and click on the Course Catalog. Click on "Leadership/Management" and scroll to the desired series. Multi-year purchases, group discounts and a 30-day free trial are available. All KHA members can purchase these courses (use of other careLearning products is not required). Contact Jennifer Findley at (785) 233-7436, if you have questions.

Health Insurance Exchange in Kansas

The implementation of health insurance exchanges, where new marketplaces would be created for consumers to comparison shop for health insurance - sort of like shopping online for a hotel room or airline ticket, has been almost entirely delegated to individual states. States have the option of setting up their own exchanges, forming coalitions with other states to create regional exchanges - or opting out altogether. In that case, the federal government will run the exchanges for their residents.

And while the deadline for establishing these exchanges isn't until 2014, Kansas Insurance Commissioner Sandy Praeger has made her department extremely active in the development of what an exchange might look like in our state. Early on, the commissioner spearheaded an application for a federal grant to design the backbone technology needed to operate the insurance purchasing exchange. This application was supported by then-Gov. Mark Parkinson and incoming Gov. Sam Brownback. The state was recently notified that it had received a grant of more than $31 million. Much of the grant will be used to help cover the anticipated costs of completing a new Medicaid enrollment system being
developed by the Kansas Health Policy Authority and adapting it to work with the purchasing exchange.

The insurance commissioner also pulled together dozens of people from state government, foundations and the insurance and health industries to lay the groundwork for a Kansas exchange. She has created a number of work groups dealing with a variety of issues, including business operations, legal and the insurance market. She also formed a steering committee to coordinate all of these activities. KHA staff are active in all of these groups, as well as the steering committee.

The planning for health insurance exchanges has really just begun, but because our insurance commissioner has jumpstarted the process and engaged various stakeholder groups, our state is clearly ahead of most of the rest of the country. The commissioner's proactive stance, along with support from the governor, will help Kansas create an exchange structure that makes sense for our state, as opposed to something that would otherwise have been designed by the federal government.

KHA Board Discusses Medicaid

The top agenda item at the Kansas Hospital Association March Board meeting was Medicaid, which is becoming a bigger and bigger issue on both the federal and state level. States, feeling almost universal budget crunches, are asking the federal government for more flexibility to run their programs. At the same time, the federal government is getting increasingly serious about the deficit, and more politicians are indicating their willingness to look at entitlement programs like Medicaid.

Tom Lenz, former Centers for Medicare and Medicaid Services regional administrator and current principal at Matrix Pointe, a Medicaid consulting firm, discussed his perspective on what is happening across the country. Tom pointed out that in Kansas, like many other states, a small proportion of beneficiaries are responsible for most Medicaid spending. These individuals are generally elderly and/or disabled. Lenz also pointed out that the increase in Medicaid managed care has not necessarily saved states money. KHA has created a special task force, chaired by Susan Page, Pratt Regional Medical Center, to examine Medicaid on a more Kansas-specific basis. This task force will be working with Tom Lenz to create a special report for KHA members and state policymakers.

KHIN Forms Rural Health Information Network

Rural hospitals and physician clinics can now come together as early participants in the state's emerging health information exchange efforts (not to be confused with health information exchanges). In forming the Rural Health Information Network, the Kansas Health Information Network is developing a structure through which interested rural providers can convene to share experiences, reduce duplicative work and facilitate HIE around their unique needs. The Rural Health Information Network will provide a venue for rural providers to come together in a forum that represents the vision and needs of rural communities and providers in the establishment of HIE.

KHIN is a collaboration of organizations led by the Kansas Hospital Association, the Kansas Medical Society, the Wichita Health Information Exchange, and eHealthAlign, to facilitate improvement in health care quality, coordination and efficiency through the exchange of health information at the point of care utilizing a secure electronic network. For more information about the rural health information network that is forming, contact Laura McCrary, KHIN executive director, at (785) 861-7490.

HHS Releases National Strategy for Quality Improvement

The United States Department of Health and Human Services released its anticipated National Strategy for Quality Improvement in Health Care (National Quality Standard). The strategy was called for under the Affordable Care Act and "is the first effort to create national aims and priorities to guide local, state and national efforts to improve the quality of health care delivered in the U.S." according the HHS news release. According to HHS, the strategy is designed to move the system to work better for doctors and other health care providers by reducing their administrative burdens and helping them collaborate to improve care. The strategy presents three aims for the health care system:

1. Better Care: Improve the overall quality, by making health care more patient-centered, reliable, accessible and safe;
2. Health People and Communities: Improve the health of the U.S. population by supporting proven
interventions to address behavioral, social and environmental determinants of health in addition to delivering higher-quality care; and

3. Affordable Care: Reduce the cost of quality health care for individuals, families, employers and government.

According to HHS, to achieve these aims, the strategy also establishes six priorities to help focus efforts by public and private partners:

1. Making care safer by reducing harm caused in the delivery of care;
2. Ensuring that care engages each person and family as partners;
3. Ensuring that each person and family are engaged as partners in their care;
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease;
5. Working with communities to promote wide use of best practices to enable healthy living; and
6. Making quality care more affordable for individuals, families, employers and governments by developing and spreading new health care delivery models.

HHS states that this process of engagement with all parties will begin in 2011.

Kansas Project to Reduce Catheter-Associated Infections

In hospitals, health care-associated infections account for an estimated 1.7 million infections and 99,000 deaths each year. The urinary tract is the most common site of health care-associated infection, accounting for nearly 40 percent of all nosocomial infections. An indwelling urethral catheter is associated with 80 percent of these urinary tract infections. Between 12 percent and 15 percent of hospital inpatients will have a urinary catheter at some time during their hospital stay. Each year, more than 13,000 deaths are associated with UTIs. As of Oct. 1, 2008, the Centers for Medicare and Medicaid Services stopped reimbursement for charges related to hospital-acquired, catheter-associated urinary tract infections. Each CAUTI adds approximately $500 to $1,000 to the cost of patient care.

The Kansas Healthcare Collaborative is leading a statewide project, Kansas on the CUSP: Stop CAUTI, aimed at reducing catheter-associated urinary tract infections and improving safety culture. Participating hospital teams will learn how to improve safety culture using the Comprehensive Unit-based Safety Program and reduce CAUTIs using placement, care and removal interventions.

The first phase of this project began in the Kansas City Metro area hospitals in March 2011 in partnership with the Kansas City Metropolitan Healthcare Council and the Missouri Center for Patient Safety. Enrollment for all hospitals in Kansas is available through August 2011. For more information or to enroll your hospital, contact Tonya Crawford, program manager, at (785) 235-0763.

Western Regional Trustee Symposium: June 8-10

The Western Regional Trustee Symposium is a collaboration of the hospital associations from Arizona, Colorado, Idaho, Montana, Nebraska, Nevada, New Mexico, Utah and Wyoming. This year, the symposium will be June 8-10 in Omaha, Nebraska. Due to the close proximity of this event to Kansas, they are extending the "member" registration fee to any Kansas hospital that would like to attend. Themed Riding the Rails Toward Governance Excellence, speakers for the event include Jamie Orlikoff, Joy Johnson Wilson and Clint Maun. Registration materials and additional information can be found at http://www.trusteesymposium.org.

KHA Critical Issues Summit: Aug. 18-19

Mark your calendars for the Critical Issues Summit for Hospital Boards, Aug. 18 and 19, at the Airport Hilton in Wichita. Topics to be covered at the summit include governance effectiveness, accountable care organizations and a panel discussion on issues keeping boards up a night. An optional pre-session on Thursday will discuss legal issues important to hospital boards.

Registration information will be available in May. Questions can be directed to the KHA Education Department at (785) 233-7436.
Kansas Supreme Court Hears Tort Reform Case Again

In February, for the second time, the Kansas Supreme Court heard oral arguments on the issue of whether the Kansas cap on non-economic damages in personal injury cases is constitutional. As you may remember, the Court has had this case before it since April of 2009, almost two years. The first oral argument was held in October of 2009.

Usually, the Kansas Supreme Court allows each side about 30 minutes of argument. When the case was argued this time, the Court took the almost unprecedented step of allowing each party 90 minutes to present their case. As such, the weighty constitutional issues before the court were thoroughly examined.

Even though each side had more time, neither had much chance to stick to their respective scripts, as the well-prepared Court peppered each side with questions. Despite the number of constitutional challenges, the Court's interest was largely focused on whether the cap violates Section 5 of the Kansas Constitution, which states that "[t]he right of trial by jury shall be inviolate." The two parties arguing the issues before the court clearly differed on their interpretation of those provisions.

The plaintiff argued that under Section 5, a jury has an unfettered right to award unlimited non-economic damages in a case, even though such damages are intangible and incapable of numeric calculation. That is, they cannot be determined to an amount certain like other types of damages such as medical bills, lost wages, etc. In essence, the plaintiff seemed to be arguing that neither the court nor the legislature could interfere with any determination by the jury through the entry of judgment.

The defendant argued that nothing about the existence of the cap or its application violates or limits the jury's proper function of determining the facts. The defendants pointed out that while the jury determines the facts, the laws established by the legislature define what remedy, and the extent of the remedy, is available to a plaintiff. The defendant made clear that the law is replete with examples in which a plaintiff's remedy is appropriately limited.

The Kansas Hospital Association joined with the Kansas Medical Society in filing a friend of the court brief in this case. As such, our position is clearly aligned with the defendant. In our view, the proper role of the jury is to determine the facts based on the evidence. Once a jury listens to the evidence and renders a decision based on the facts, the court is charged with applying the law to the facts, including applying any limitations imposed by law on the remedy available to a plaintiff in a given case. The remedies society gives a plaintiff at a given point of time are issues of law that necessarily factor in the delicate balance among competing individual and societal needs and desires.

It is impossible to say what the Kansas Supreme Court will do, or even when a decision will be rendered. Clearly, the Court has struggled with this case as the rehearing and the extra time for argument show. What is known is that the cap is the cornerstone in our ability to recruit and keep physicians in Kansas. Striking down the cap would have a significant destabilizing effect on health care in Kansas and on the overall health of the economy in Kansas since health care is a significant economic center for much of our state. We can only hope that the Court will appreciate the impact of its decision as it provides careful consideration to this case.

Collaborating on Community Health Needs Assessments

The federal requirement that non-profit hospitals must complete a "community health care needs assessment" every three years has been discussed in numerous venues. And although this is a hospital requirement, this assessment must take into account input from persons who represent the "broad" interests of the community served by the hospitals - with special knowledge of, or expertise in, public health. Once the assessment is complete, hospitals must identify priority health needs and adopt an implementation strategy to meet these needs. Hospitals are required to make information gathered through their local assessment broadly available to the citizens of their community.

In addition, a community health needs assessment will be a recommended practice for all 105 counties in Kansas, as local health departments strive to meet public health accreditation requirements in the next few years. Because of these parallel requirements for hospitals and local health departments, the Kansas Hospital Association has created a collaborative educational effort.

In January, we convened a Community Health Needs Assessment Work Group charged with
researching, reviewing and recommending options and strategies that will assist KHA members in meeting the community health needs assessment requirements. In addition to large and small hospitals from across the state, there was representation from the Kansas Association of Local Health Departments, the Kansas Department of Health and Environment, the Kansas Health Policy Authority, the Kansas Health Foundation, The University of Kansas and Kansas State University.

This work group will recommend collaborative approaches in which communities will be able to complete assessments that address both health department and hospital needs, as well as take into account the needs and requirements of all organizations focused on the health of Kansans. In addition, this group has identified a set of indicators important for all hospitals to review when determining health priorities in their community. A lot of work has already been done in the area of data that communities will need to have easy access to, but this group will make the process of data collection easier for communities and is looking at Web-based tools that will be available in September.