

# GOVERNANCE AT THE CROSSROADS

## *Post-Millennium Trustees Face Difficult Decisions in a New Age of Health Care*

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It comes as no surprise to anyone that we are entering a new age of civilization. Upon leaving the Industrial Age, we are confronting processes and technologies we had once thought were pure science fiction. We are now living the science fiction we were reading about 10 to 15 years ago.

Health care has been one of the greatest beneficiaries of the technological boom of the last 20 years.<sup>1</sup> Technology has had such a tremendous impact that its definition is barely recognizable from what it was only 50 years ago. The portability of technology and the micronization of its components have altered the whole landscape of health service, and in many ways have thrown it into chaos.

### THE END OF HEALTH CARE

Hospital and health system boards must realize that they are facing the end of health care as they know it. Much of the work of our time is deconstructing a lot of the infrastructure currently in place and shifting resources and services into a new context. There are those who suggest that much of the current leadership is not up to the task of tearing down or shifting the assets to which they have devoted years of resources and energy. The very thought of it is threatening and personally overwhelming.

Yet it is clear that the conditions and circumstances of health care today call for a full reconceptualization of health service and the framework that supports it. Indeed, much of the work of the board is in helping executive leadership see health service differently enough so that they can anticipate and prepare for change before the requirements of the age challenge their ability to thrive. These times are a test of real leadership.<sup>2</sup>

The hospital as we know it is quickly becoming an impediment to the future it must create for

itself. The service infrastructure, the architectural constructs, and the support systems are now a considerable barrier to service and fiscal management. It is anticipated that given the pace of service and technology change in health care over the next 10 years, we will need about 622,000 fewer hospital beds in the United States than we currently have. It is difficult to eliminate beds; but the health care news reports are rife with the costs associated with supporting existing infrastructure, especially that of the newly merged and integrated health systems. The recent University of California-San Francisco and Stanford merger failure is but one classic example of this current common set of circumstances. The merger failed primarily because the two distinct and disparate cultures could not combine and create what would ultimately have to be managed as a single, new culture. The implications for service allocation, financial accountability, and "goodness of fit" issues ultimately overwhelmed the merger and caused it to fail. The political and cultural implications of where beds and service should be changed or eliminated, who should do so, and the personal impact of the job losses or shifts associated with such change can be overwhelming.

The truth is that most boards should consider strategies that begin the process of reducing or eliminating infrastructure. Health care facilities must become something different, and they must do so soon. The vagaries of the 1997 Balanced Budget Act, even with its recent minor givebacks, provide plenty of impetus to think about health service differently. It is time for boards to begin the process of reconceptualizing health care for their hospitals or health systems. Some serious questions are in order:

- How have pharmacotherapeutics and chemotherapeutics altered the service context and content for our patients in the past five years?

And the next five years?

- How many inpatient procedures performed 10 years ago are done as outpatient procedures today?

- How much medical technology, now located in the physician's office or in other settings, was once strictly the domain of the hospital?

- By how many days have patient stays declined because of newer, faster procedures?

- How many staff responsibilities are becoming unnecessary because patients no longer stay around long enough to need these services?

The hard truth for leadership is that much of what both the provider and patient value about health care is no longer available. Often conflict arises when the current reality of short stay and quick intervention flies in the face of the expectation on the part of the provider that everything that was once done for the patient yesterday should still be done today. On the other hand, unrealistic expectations of patients that all their health care decisions will be easily handled and made for them is simply no longer valid. Both providers and patients still have many of yesterday's expectations for care and service that will not ever be delivered again—and they are frequently upset when those expectations are not fulfilled. It is time to recognize that not only is it time to alter those expectations, but also that much of the work of providers is in changing the expectations of the patient. In today's world more of the accountability for choice, action, and response belongs to the consumer of health service. The role of the provider is to make sure the consumer knows what to do with this increased level of personal accountability for health.<sup>3</sup>

### A NEW AGE FOR CATHOLIC HEALTH CARE

The age is ending in which any particular hospital (or health care system) provided all services and met all needs. As health care gets more diversified and decentralized and many services simply disappear because of changing technology, hospitals and health systems must change as well. Many of the more resident, inpatient, longer-term service configurations must be either reconfigured or eliminated. Strategic decisions about who the patient is, what the service is, and what difference the health care system is committed to making are now critical

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elements of board decision making.<sup>4</sup> Catholic health care has even more serious concerns confronting it in this time of tight economic and general technological transformation. Some questions that can no longer be avoided:

- How is Catholic health care different from other forms of care, and what are the implications of that difference when duplication of services, reduced payment for ser-

VICES, and reconfiguration of health systems are altering the entire industry?

- What is the Catholic health care services community? What should it be? How do we focus on it in a way that recognizes the changes in service design but still fulfills a spiritually directed mission?

- How long will health care systems keep “tightening the belt” and continuing to create efficiency instead of addressing the more basic question of whether certain services should be offered at all?

- What models are Catholic health care governance leaders using to envision the future of health care? Is this view defined more by what they have been than by what they should become?

These are but a few questions that are important to Catholic health care services. Yet they form a framework for the strategic work of approaching the tougher questions on what should be affirmed and sustained in providing “Catholic” health care services.

Sr. Judy Cary, SM, regional superior and chair of the Catholic Health East Sponsorship Committee, raises a more fundamental point: Does the Catholic health care ministry out of which we are emerging really continue to focus on the poor, disadvantaged, and disenfranchised as its primary objective? How much does preserving the existing service structures distract us from making these issues the major focus of our attention? Do these times—the early 21st century—place that question at the top of the agenda? Economic, technological, and structural trends are converging to force Catholic governance leadership to examine the basic questions of just what Catholic health care should become.

It is time for boards to focus on the question of whether the times call for a whole new vision

of service. Now that demands are changing, the time is right to ask where Catholic health care goes from here. Boards should consider measures that not long ago would have been labeled "radical." For example, boards should ask themselves:

- Is it time to sell duplicating hospitals and other medical structures coexisting in the same community and invest the resources to yield revenues that can be used to serve specified populations and the underserved?

- Would Catholic health care be better devoted to constructing and managing community-based partnerships for health *as their main mission*, joining public and private efforts to address the health of marginal populations?

- Are smaller, more focused health care activities (located in specific service areas where there is greatest need) that link to the larger health system a better use of the resources of the ministry?

- Should the real work of Catholic health care be founded in advocacy, instead of treatment programs, and processes so that it can connect people to the health care system, rather than trying to be a major provider of service in a field where there is perhaps already too much service?

These are only a few of the kinds of strategy questions that should now be on the agenda of Catholic health care boards. Instead of trying to save what is in place in Catholic health care service through cost-efficient and belt-tightening efforts, the major work of the time is questioning what work should be saved at all.

### NEW BOARD LEADERSHIP NEEDED

It is time to look at the board and raise some questions about who should sit on it and what it should do. Boards, like executive leadership, can be drawn into a prevailing conceptual and contextual framework that informs their thinking and influences their response.<sup>5</sup> Yet a good board's thinking should always lie just outside the existing frame of reference for service, challenging what is going on in specific and meaningful ways.<sup>6</sup>

The problem in the past with many health services has been that boards were primarily drawn from the community and composed of people who were good at what they did but often knew little about health care and its unique circumstances. In the past, if truth were told, senior staff more often managed hospital boards rather than the other way around.<sup>7</sup> Today's health care organizations are so complex that they require a higher level of leadership from the boards that govern them.<sup>8</sup> Broader insights about the nature of health service need to be present, and whole new ways of looking at what health care is becoming in the unfolding age must inform deliberation.<sup>9</sup> Some examples of the issues that should be on

boards' future agendas are:

- With the work of the various genome projects nearing completion in the next five years, what will be the impact on services, technologies, and intervention, and how do we prepare for this new reality of treating people at the genetic level? What will be the emerging ethical considerations?<sup>10</sup>

- As pharmacotherapeutic and chemotherapeutic interventions replace procedures as the predominant method of treatment, what do we do to replace the structures, processes, and services that are no longer required?

- The largest cohort of the American population is now between 43 and 65 years of age. How do we serve a large, highly mobile, better-educated, independent, and longer living population of people when most of the effort will be noninstitutional, technologically advanced, and much more cost sensitive?<sup>11</sup>

- What do we advocate in health care over the next five years when many of the current models of health care are "deconstructed"? How should the future funding of health service, both public and private, be configured to better fit with the impact of changing technology and service?<sup>12</sup>

- What is the role of Catholic leadership in local and national advocacy for the more than 42.6 million people in the United States who lack the insurance and financial resources to pay for health care in a transforming model of health service?<sup>13</sup>

- What part of the growing public involvement in health and prevention of disease (now more than \$26 billion, most of it currently self-paid) should be included in the future configuration of health service and the advancement of personal accountability for health?

- What new partnership models will be developed with physicians around these newer realities in health care, and how will boards be constructed to be more invested in the physician's journey to new behaviors, roles, and practices?<sup>14</sup>

- What role will the Internet play in health information and service, especially as it becomes more interactive, convenient, and commonplace in society?

Here again, these are just a few questions that are now on the agenda of boards preparing for a whole new contextual framework for health service. These and other tough issues now challenge boards to be less concerned with operational and service issues and more with directional and contextual issues.<sup>15</sup>

Boards now need to be composed of people who are less representative of the community and more connected with the direction and construction of new service concepts. Instead of looking at board composition as a reflection of residence in a community, the board must now reflect the

skill sets necessary to develop new approaches to health services. Leaders in systems, communication, technology, pharmacy, vendor services, Internet, business strategy, concept formation, and innovation are now desperately required on boards.<sup>16</sup> Much of the current and immediate future activity of the board itself should now be disciplined by processes that provide:

- Regular and consistent "future search" activities that create a context for seeing the future within the framework of its demands rather than through the eyes of the past.

- Periodic "conceptual blockbusting" that challenges services and structures in place by questioning their value and need.

- Consistent "scenario testing," in which leadership responds to hypothetical specific and opposing scenarios for change.

- Imbedding "value balancing" in decision making in a way that makes decisions on the basis of value added and value balance (Cost + Quality + Service = Value) to ensure that the commitment of people and resources is supportable. Any over-attention to one element of the equation results in the other two paying the price. No leader can simply focus on quality or service without affecting cost, and vice versa. All three elements must be dynamically balanced to ensure sustainability of any system.

- Annual "mission testing" exercises that look both at the continuous inculcation of mission in decisions and work and whether that mission is reflected in the work processes and products.

It is imperative that these and similar exercises be a part of the structure and discipline of the board's regular activity.<sup>16</sup> This kind of format keeps the board focused on setting direction and validating correct thinking and requires it to think about the future—the real work of leadership. It should be clear to board leadership in this time of great transformation that it is creating the future—the real work of governance.<sup>17</sup> This requires all the skills and efforts of strong leadership: creativity, risk-taking, innovation, advocacy, conflict mediating, and living vision and mission as a personal commitment. If board leaders are not excited by the drama of creating a new future for health care, why should they expect anyone else to be excited? Leadership is a commitment and a discipline that engages the challenges and, out of the commotion, builds the future.<sup>18</sup>

### **NEW WORLD, NEW CHALLENGE**

Of course there are a host of additional associated issues attendant to the challenges of governing health systems. While I have focused on contextual and framework issues of governance, there are substantive issues related to doing the business of

board work. Some further issues of substance are:

- Considering paid boards to replace voluntary boards as a way of ensuring the right mix of members, increasing the expectation and accountability for performance, accelerating the stakeholder obligation of members, and advancing the incentive for stronger, informed, and invested board members.

- Increasing the emphasis of board membership and leadership as a form of ministry of the Catholic church as sponsorship by religious institutes diminishes over time. Lay applications of ministry will increasingly be required in board leaders, who will soon become the predominant visual representation of the Catholic mission within the health care arena.

- Taking on the personal and collective willingness to confront the current reality and transform the work of governing changing health services. This means directly confronting the historic, legal, regulatory, payment, policy, ritual, and routine milieu that reflects yesterday's practices and structures that no longer fit the emerging reality.

- Recognizing that health systems are "membership communities" made up of a host of invested stakeholders, from payers and providers to patients, and from employers to communities. It is now the work of governance leadership to gather those disparate constituencies and unite with a common vision and a commitment to carry it out together.

We can all add our own unique local and regional circumstances to the mix of issues that now must be a part of the agenda for the future of health care in general and the Catholic health service mission specifically. There is no more "business as usual" in any part of the social equation. The millennium serves as a reminder to leadership just how significant the emerging age is and how much it changes the script for all who seek to advance the quality of life.

No one questions the drama and trauma present in this next stage of civilization. In order not to be pulled apart by the conflicting agendas, concepts, priorities, and opportunities, health care leadership must enter into the fray with the willingness and intent to have a new dialogue. This colloquy must unfold within the context of what we will become, not solely within the context of what we are. We cannot merely react to current circumstances; we must be able to discern and circumscribe the world in which we are living.<sup>19</sup> In Catholic health care especially, governance leadership must remember that the creative energies that advance quality of life reflect "building the kingdom." It is making God's promise of love and life a living experience available to all. □

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## A DELICATE BALANCING ACT

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believes that developing a screening process to ensure an exclusive focus on the materially poor would not be possible. A score of 5 is assigned. By contrast, the burn unit will serve the entire community, so a score of 0 is assigned.

**Capital Effectiveness** Management's analysis indicates that the immunization program would achieve maximum capacity within two years, yielding a score of 5. However, the burn unit is not expected to be at capacity in the foreseeable future, yielding a score of -5.

**Capital Cost** The calculated cost of the total subsidy for the immunization program is \$480,000, resulting in a score of 3. The \$1.9 million cost for the burn unit yields a score of -3.

Although both are worthy initiatives, the total scores of 13 for the immunization program and a score of 2 for the burn unit indicate that the immunization program would better serve the mission (see Table 3, on p. 33).

### RECOGNIZING ONGOING FUNDING REQUIREMENTS

Mission-focused activities have unique problems. Such activities require initial funding and possibly ongoing subsidies. How should the organization fund ongoing activities? Two possible approaches are:

- Completely fund the mission activities in the year they are initiated. This approach would require segregating amounts in the mission fund to be consumed in future periods for specific mission activities.

- Commit to funding annual cash flow subsidies from annual financial capability allocations to the mission fund.

Because these amounts represent "senior claims" on the mission pool, accurate tracking of mission projects implemented in prior years and very strong control mechanisms are required to ensure that the process of funding proceeds as intended. Monitoring is further complicated by events that could have an adverse impact on

the organization's financial capability and the allocation of funds to mission activities in future years.

In either case, implementing an ongoing monitoring system is important after mission activities have been approved for funding. The health care environment is dynamic, and organizations must be diligent to ensure that they continually deploy resources in the most effective manner. Too often, initiatives (whether mission or strategic) are approved and never reexamined. Initiatives may need some adjustment or possibly divestiture. Unfortunately, many health care organizations are reluctant to confront these difficult decisions because doing so may be viewed as admitting failure.

### BENEFITS OF THE PROCESS

Implementing an investment review process based on a set of criteria that address the organization's unique needs can facilitate the decision-making process. The organization can use such a structured process to consider all alternatives with a common framework, thus eliminating some of the politics of resource allocation.

Incorporating the nonfinancial objectives of a mission-driven organization into its decision making process is legitimate as well as critical for optimal resource allocation. However, without a disciplined review process, poor investment decisions may be passed off as supporting the organization's mission or may continue past their usefulness, thus consuming valuable resources in a suboptimal manner. The key is to identify mission activities during the review process and quantify the value the organization is providing to the community by undertaking those activities. □

### NOTES

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### NOTES

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