Good to Great Healthcare Boards: Lessons for ACOs

By Kimberly Smith, FACHE, and James Gauss

It is no great secret that boards can be slow to change, and those within healthcare are no exception. This is understandable given that boards are not typically expected to exercise vision and move ahead of the curve. Hospital and health system boards by tradition are reflective, reactive, and consultative. The proactive, visionary stuff is usually left for the CEO and executive team, or perhaps nowadays a Chief Strategy Officer who’s been installed to shepherd change, or outside consultants who bring with them creative advice about new delivery models, cost structures, and collaborative partnerships.

Healthcare boards can also lag due to their composition, which often reflects where the organization has been rather than where it is going. Board members may include pillars of the local community and other leaders who have known and served the organization well through the years and have helped keep the ship steady. With ACO boards, over-familiarity with the organization may not be a primary concern. Trustees may in fact hail from various participating organizations. They may have had little previous interaction with each other and need time to warm up to each other, and they may bring to the boardroom table different preconceptions about governance. The challenge in such settings is often getting members acclimated to each other and speaking the same language about agreed-upon objectives.

There is no shame in all this, but the time has come in healthcare for boards to engineer their own role reversals: proactive rather than reactive; strategic more than operational; collaborative (with the CEO and others) in addition to consultative. As we write in the introduction to a new guidebook on healthcare governance recently published by our firm, “Every board is perfectly designed to achieve exactly the results it gets. Boards that demonstrate excellence tend to be ‘intentional’ about improvement.” (See “Building Better Healthcare Boards,” Witt/Kieffer, 2015.) Improvement is the key, with the chair needing to be the catalyst. No one is expecting healthcare boards to transform themselves overnight, but they need to be on a path of continual improvement, so that a serviceable board gets good, and a good board can one day get to great.

There is no shame in all this, but the time has come in healthcare for boards to engineer their own role reversals: proactive rather than reactive; strategic more than operational; collaborative (with the CEO and others) in addition to consultative.

(continued on page 2)
Good to Great Healthcare Boards…continued from page 1

Members must wrap their arms around and be intentional about some of the more prominent elements of ACOs and larger, more complex healthcare organizations. These include:

- **Systemness.** Boards at hospitals and other affiliates within larger systems need to gain an appreciation for the values and objectives of the broader organization. This may include abandoning old narratives and shifting ideas about the “community” one serves, shifting from fiduciary to more advisory capacities, and embracing mandates and initiatives conceived by executives at the system level.

- **Succession.** This involves anticipating turnover among the organization’s executives and taking a proactive approach to building a leadership team that is agile and capable of addressing the uncertainty of the accountable care era. A question boards must be asking: who should succeed each C-suite executive?

- **Consolidation.** Partnerships between historic rivals or previously strange bedfellows are commonplace in today’s market, and boards can accept the uncertainty this brings. Boards themselves may need to consolidate and retool their memberships, and this is not something that trustees should resist if it is for the good of the organization.

- **Physicians as Partners.** Physicians and nurses will be critical in making ACO models work. Good boards will see clinicians as educators and informants about the state of the organization and what it can do to improve quality and its standing in a competitive marketplace.

**Instilling Good Habits.**

What can boards do to position themselves for change and improvement? A few fundamental best practices:

1. **Make board self-assessment a regular activity.** Skills audits, “right-sizing,” and other evaluative and introspective activities help a board to understand its weaknesses (to be addressed) and strengths (to be leveraged).

2. **Encourage diversity.** This is diversity in the broadest sense of the definition. Does the board have members with different viewpoints and experiences? Do trustees look and act differently from each other? Do they represent the diversity of the organization and the population it caters to? Are there trustees from different generations? In other words, is the board a collection of diverse thinkers who can challenge each other, ask different questions of the CEO and executives, and together develop a style of proactive governance that works for that organization?

3. **Value competitive intelligence and market knowledge.** Intentional boards make it a point to learn as much about what other organizations are doing in terms of delivery, quality, finance, governance, and other matters that, if understood, convey competitive advantage in the healthcare and/or ACO marketplace.

4. **Get out of the boardroom.** A board that goes offsite together can get serious about self-assessment, strategic planning, communing with outside consultants, and engaging with the CEO and other leaders in meaningful dialogue. Intentionality about a change of scenery can pay dividends in many ways.

5. **Engage with the CEO.** This is a challenge, as boards must keep an appropriate distance from the CEO in order to remain objective, and yet the board-CEO relationship must be more collaborative than in the past. Good boards make it a point to schedule meaningful time with the CEO, as well executive sessions without the CEO, to foster engagement while maintaining objectivity.

6. **Get to know and appreciate the leadership team.** In the ACO world, the “team” is not always a traditional set of senior managers inside a single institution. Rather, to deliver on the goals of an ACO, the leadership is both inside and outside the organization—some employed by the organization and some representing partners and joint ventures.

ACO boards have opportunities that traditional hospital boards may not have had. Trustees in an accountable care setting know that they are expected to question traditional governance practices and help set a new course for their evolving organizations. This can be daunting yet also liberating, freeing members to be intentional in moving towards an improved brand of governance.

Kimberly Smith, FACHE is a Managing Partner and Board Vice Chair of the executive search firm Witt/Kieffer. She may be reached at ksmith@wittkieffer.com. James Gauss is Chair of the firm’s Board Services practice and a former Witt/Kieffer CEO. He may be reached at jimg@wittkieffer.com.