GOVERNANCE PRACTICES OF REGIONAL HOSPITALS IN AN INTEGRATED HEALTHCARE DELIVERY SYSTEM

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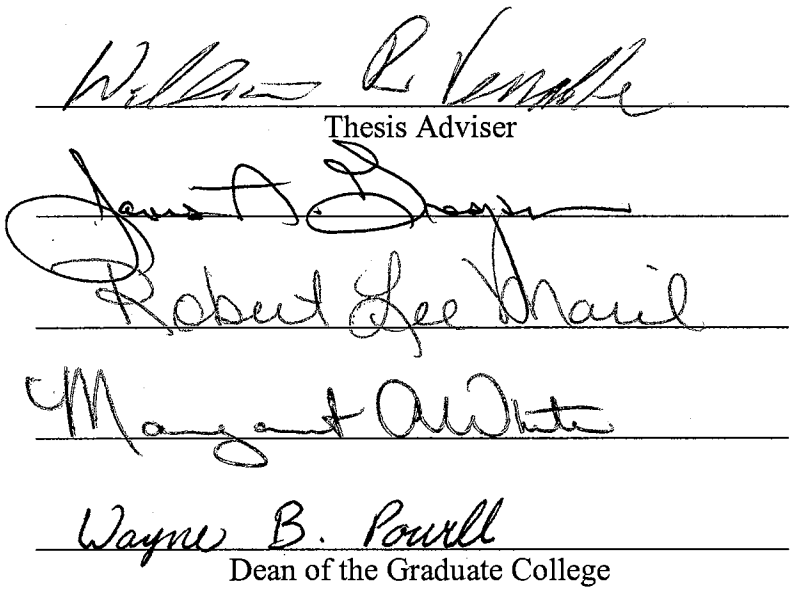

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Life is a journey marked with many milestones. Milestones represent significant events in our lives. They are invariably life changing. It is with great pride that I will add completion of this degree as a major milestone successfully achieved.

None of us accomplish things alone. There are always those who assist us along the way, and without whose help many of our endeavors would never be completed. I would like to take a brief moment to reflect on those who have supported me throughout this journey.

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This dissertation is dedicated to the memory of Francis Thomas Baxter Burdett, who started me on this path so many years ago.

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INTRODUCTION

One of the trends in the hospital industry over the last several decades has been consolidation and corporate reorganization. Whether through merger or acquisition, Many hospitals across the country have abandoned self-governance to form integrated healthcare systems (Pointer & Ewell, 1994).

The integrated healthcare system has been proposed as the future organizational model for healthcare delivery (Shortell et al., 1993). Shortell and colleagues define an integrated system as "a network of organizations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and health status of the population served" (p. 447).

While many aspects of integrated healthcare system development are being addressed in the literature, one area deserving of more attention is governance. The distinctive governance challenges that will be faced by systems often remain unrecognized and unaddressed (Alexander, Zuckerman & Pointer, 1995).

The integration of diverse operating entities under the umbrella of the system has been identified as an important responsibility of integrated healthcare system

governance (Alexander, Zuckerman & Pointer, 1995). Pointer and Ewell (1994) suggest that the coordination of governance activities can pose difficulties for developing integrated systems and that issues such as board responsibility, authority, and accountability, at both the system and regional levels, have to be resolved. Communication challenges may arise as systems grow in size and complexity. System boards may lose touch with the unique circumstances and needs of system member organizations. Governance may serve as a facilitator of, or a barrier to, achieving integration.

Problem Statement

The problem which has led to this study is that hospitals have evolved into integrated healthcare delivery systems without establishing governance responsibilities.

Research studies have identified the key issues and challenges related to integrated healthcare delivery system governance: establishing governance functions, defining roles, responsibilities, and authority levels, establishing coordination between governing bodies, establishing system goals and strategies, establishing board membership, establishing physician participation in governance, and establishing the flexibility to change and adapt governance structures in response to delivery system evolution (Alexander, Zuckerman & Pointer, 1995; Conrad & Shortell, 1997; Toomey & Toomey, 1993). However, healthcare researchers have yet to identify the aspects of governance, which facilitate effective constituent representation in integrated delivery systems.

Purpose of the Study

The purpose of the study was to describe the governance practices of regional hospital boards of an integrated healthcare delivery system in advocating the healthcare needs of their local communities.

This was a case study of eight regional hospitals operating within one integrated delivery system. The case study method is a research strategy which focuses on understanding the dynamics present within single settings (Eisenhardt, 1989). According to Eisenhardt, case studies can be used to accomplish various aims, which include providing description (Kidder, 1982), testing theory (Pinfield, 1986; Anderson, 1983), or generating theory (Gersick, 1988; Harris & of Sutton, 1986).

Both Eisenhardt (1989) and Yin (1989) suggest that the case study method is a valuable research tool. "Case studies typically combine data collection methods such as archives, interviews, questionnaires, and observations. The evidence may be qualitative, for example, words, quantitative, for example, numbers, or both" [sic] (Eisenhardt, 1989, p. 534). By employing various procedures, Denzin and Lincoln (1998) suggest that the likelihood of misinterpretation is reduced, and that multiple perceptions serve to clarify meaning by verifying the repeatability of an observation or interpretation. Because the case study method uses multiple forms of data collection, it is possible to address a broader range of historical, attitudinal and observational issues than would be possible in survey research (Yin, 1989).

The case study method was utilized for the study because it allowed for the collection and analysis of both qualitative and quantitative data and was better suited for the tasks of investigation and discovery than are conventional quantitative methods alone.

Research Questions

The study responded to the following research questions:

Research Question #1: What do regional board members understand about their roles as community representatives?

Research Question #2: How do regional board members identify the healthcare needs of their local communities?

Research Question #3: How do regional board members apply the knowledge they acquire about community health needs?

Research Question #4: How do healthcare system board members identify the healthcare needs of their regional hospital communities?

Assumptions

The following assumptions guided the study:

1. Regional hospital board members responded honestly in identifying perceived local healthcare needs.

2. Regional hospital board chairs, by virtue of their experience, accurately assessed the overall quality of their respective board governance processes.

3. Corporate staff and regional hospital administrators accurately assessed the overall quality of the governance processes within their organizations.

Limitations

Limitations of the study included the singularity of the integrated healthcare delivery system investigated, the narrow scope of perspectives sought, and subjectivity on the part of the researcher.

The case study methodology was applied to one integrated healthcare delivery system only. No attempts were made to gather data on other integrated healthcare delivery systems for comparison purposes.

The study was based exclusively on regional hospital administrator and board member perspectives. Their comments and observations reflect the perspectives of insiders to the organization. No attempts were made to solicit community member or patient perspectives.

A final limitation was researcher subjectivity. The potential for researcher bias existed because the researcher was a former healthcare administrator with the system being studied.

Definition of Terms

Advisory board. Subordinate body that provides advice and counsel to the governing board.

Affiliation. An agreement, usually formal, between two or more otherwise independent hospitals, programs or providers describing their relationship to each other.

Ancillary services. Support services and procedures offered in hospitals or outpatient settings, such as laboratory, radiology and pharmacy services.

Coordinated care. Health care provided on a continuing basis from the initial contact with a physician or clinic and following the patient through all episodes of his or her medical care needs.

Cost containment. Control or reduction of inefficiencies in the consumption, allocation or production of health services that contributes to the high cost of health care.

Governing board. Legally mandated, superordinate body that assumes ultimate responsibility for the affairs of the organization on behalf of the organization's owners for whom it serves as agent.

Healthcare system board. Legally mandated, superordinate governing body of an integrated healthcare delivery system that assumes ultimate responsibility for the affairs of the organization.

Horizontal integration. The linkage or network of similar types of providers, often in different geographic regions and serving different markets. It is used as a

competitive strategy by some hospitals to control the geographic distribution of health care services.

Hospital. Health care institution with an organized medical and professional staff and with in-patient beds available around the clock, the primary function of which is to provide inpatient medical, nursing, and other health-related services to patients for both surgical and non-surgical conditions, and which usually provides outpatient services and emergency care.

Hospital, acute. Hospital that treats patients in an acute phase of illness or injury.

Hospital, investor-owned. Hospital that is owned and operated by a corporation or an individual and which operates on a for-profit basis.

Hospital, non-profit.: Hospital that is owned and operated by a corporation and which operates on a non-profit basis.

Hospital, not for profit. Hospital that operates on a not for profit basis under the ownership of a private corporation. Typically, a not for profit hospital is run by a board of trustees, is exempt from federal and state taxes, and uses its profits to cover capital expenses and future operating costs.

Hospital, regional. Hospital, usually short-term, general and non-federal, the services of which are available for use primarily by residents of the community in which it is located.

Indigent care. Medical care for those who cannot afford it.

Integrated healthcare delivery system. "A network of organizations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and health served." (Shortell et al, 1993, p. 447).

Liaison board. Advisory governing body that coordinates the activities of regional hospitals. Acts as a link between the regional hospital boards and the healthcare system board. Membership consists of one representative from each regional hospital board, one representative of the healthcare system board and healthcare system management. Officially known as the Regional Services and Facilities Board.

Organized delivery system. A network of organizations that provides a coordinated continuum of services to a defined population. This term is equivalent to integrated delivery system.

Provider. Hospital or health care professional who provides healthcare services to patients. May be an entity (hospital, nursing home or other facility) or a person, such as a physician or a nurse.

Regional hospital board. Governing body of a rural hospital, which provides healthcare services to a regional community.

Trustee. A member of a hospital governing body.

Vertical integration. The combination of different types of providers to make available a comprehensive array of services. Full vertical integration exists when the full continuum of care is represented.

Significance of the Study

"More than fifty percent of all hospitals in the United States are now members of multi-facility systems" (Pointer & Ewell, 1994, p. 7). Hospitals have integrated, both vertically and horizontally, to cope with increased competition and achieve financially viability. Pointer and Ewell state that the basic fabric of the healthcare industry has undergone profound change, and suggest that the implications of this evolution have yet to be fully appreciated.

As health care delivery organizations develop into integrated healthcare systems, new and important challenges arise about how to create effective linkage mechanisms between the various governing levels and the communities they represent. Research is lacking on integration strategies for developing integrated delivery systems and on how governance processes should be organized to enhance organizational effectiveness.

The development of integrated healthcare delivery systems represents a new stage of evolution within the healthcare industry. Data about integrated delivery system development are just beginning to emerge and need to be fully explored. Many questions remain unanswered, including those related to the role of governance in facilitating or hindering system integration.

The study examined the role of regional boards in functioning as community representatives, explored the potential of community representation as a vehicle for enhanced system integration, and investigated governance and board development strategies to enhance community representation. The study sought to augment the literature on healthcare integration, governance, and board development.

Chapter Summary

This chapter presented an introduction to the study. The remainder of the study is presented in four chapters. Chapter II is a review of the literature relevant to the study. The study design and method are outlined in Chapter III. The findings are presented in Chapter IV. Chapter V includes conclusions, recommendations for further research, recommendations for future practice, and the implications of the study.

CHAPTER II

REVIEW OF LITERATURE

Research has been defined by Gay (1992) as " . . . the formal, systematic application of the scientific method to the study of problems." The goal of research is to explain, predict and/or control phenomena. This goal is based on the assumption that all behaviors and events are orderly and that they are responses that have discoverable causes. Progress toward this goal involves the acquisition of knowledge and the development and testing of theories. In the absence of a well developed body of knowledge concerning the governance of integrated healthcare delivery systems, the study seeks to explore some of the underlying factors and relationships resulting from this new model of healthcare governance in order to augment existing knowledge and provide data for later research.

While no substantive body of knowledge exists, the study did not begin without a foundation. This chapter presents an overview of the literature that guided the study and continues to inform our understanding of governance and board development.

Background information about the development of integrated healthcare delivery systems is presented. The governance of integrated healthcare delivery systems follows. Literature pertaining to board roles and responsibilities is presented. An overview of resource-dependence theory is provided. The chapter then presents case study methodology and concludes with a summary.

Development of Integrated Healthcare Systems

Healthcare providers cannot ignore the current driving forces that mandate that hospitals and physicians establish a new paradigm for providing healthcare. Like other industries, healthcare is undergoing a revolution in which traditional methods of operation are being challenged (Berwick & Nolan, 1995; Roberts, 1996; Shortell, Gillies, et al., 1996).

Background

If healthcare has been a growth industry for the past 50 years (Pointer & Ewell, 1994; Shortell, Morrison & Friedman, 1992), this has been especially true for hospitals. Private health insurance coverage was introduced in the 1930s. In the 1940s and 1950s, the Hill-Burton Act encouraged and supported extensive postwar hospital expansion. With the passage of Medicare and Medicaid legislation in the 1960s, healthcare for the elderly and the poor was more financially accessible. Health manpower legislation led to the successful expansion of providers and increased the public's access to healthcare services (Pointer & Ewell, 1994; Shortell, Gillies, et al., 1996).

With the explosion of medical knowledge, the hospital became an essential partner for the physician. Advances in surgery required radiology and laboratory diagnostic facilities, operating theaters, anesthesiologists, trained surgical personnel and facilities for postoperative care. The hospital's ability to provide these services and personnel made it an important resource for the community.

These community not-for-profit hospitals financed the heavy capital expenditures, providing facilities and equipment which were paid for by the community. The Hill-Burton Act, federal legislation enacted after World War II, assisted hundreds of communities to build not-for-profit hospitals. By the 1980's there were 6000 community hospitals. Regional community hospitals are found in all but the smallest villages across the country.

Most hospitals in the United States are community hospitals. There are three major types of ownership: the government, not-for-profit and for-profit. Government hospitals are owned by federal, state, or local governments. Not-for-profit hospitals are owned by corporations established by private groups for the common good rather than for individual gain. As a result, they are granted broad federal, state, and local tax exemptions. Not-for-profit hospitals constitute to be the largest single group of community hospitals. As a consequence of their commitment to not distribute profits or assets to any individual, not-for-profit hospitals are legally dedicated to the collective good. For-profit hospitals are owned by private corporations which are allowed to declare dividends or otherwise distribute profits to individuals. Often referred to as investor-owned, they pay taxes like other private corporations (Griffith, 1995).

The vast majority of community hospitals in the United States are owned by the communities they serve. The owners of record hold the assets, including any accumulated profits, in trust for the citizens of the community.

During the last decade, the United States has witnessed the beginning of a major reorganization in its healthcare delivery system (Alexander, Zuckerman & Pointer, 1995; Conrad & Shortell, 1997; Pointer & Ewell, 1994). The 1970s and early 1980s

were dominated by the horizontal integration of hospitals at the local, regional, and national levels. The movement in the last few years has been toward organized, vertically diversified, and integrated delivery systems (Conrad & Dowling, 1990; Robinson, 1994).

Integration is defined as the process by which activities are formed, coordinated, or blended into a functioning or unified whole (Merriam-Webster, 1989). Integration is a central component of health system change (Conrad & Shortell, 1997; Miller, 1996; Shortell, Gillies, et al., 1996). Integration is seen as a means to an end, rather than an end in itself. Several types of integration activities are seen as offering the possibility of lowering administrative costs, reducing medical care prices, utilization, and expenditures, and producing higher quality medical care (Conrad & Dowling, 1990; Miller, 1996; Shortell, Gillies, et al., 1996). As Shortell, Gillies, et al. report, "A variety of healthcare organizations, including hospitals, physician groups, health plans, home health agencies, skilled nursing facilities, and others are joining together to form organized or integrated delivery systems with the intent of delivering a broad array of services across the continuum of care in a cost effective manner." (1996, p. 7).

Definition of an Integrated Delivery System

An integrated delivery system is defined as "a network of organizations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and health status of the population served." (Shortell. Gillies, et al., 1996, p. 7; Shortell, Morrison & Friedman, 1992). Integrated delivery systems can take many forms.

Integration may occur horizontally and vertically. Horizontal integration involves affiliation under one management umbrella of organizations which provides similar levels of care. Horizontal integration usually involves consolidation of resources among the organizations, with the goals of increasing efficiency and taking advantage of economies of scale. Vertical integration involves affiliation under one management umbrella of organizations which provides different levels of care one from the other. Goals include increasing efficiency, enhancing coordination of care, and providing "one stop shopping" for managed care purchasers and physicians (Conrad & Shortell, 1997; Miller, 1996; Shortell, Gillies, et al., 1996).

Models and Types of Integration

Several authors have attempted to classify approaches to health care integration (Alexander et al., 1996; Burns & Thorpe, 1993; Charns & Tewksbury, 1993; Miller, 1996; Shortell, Gillies, et al., 1996). Charns and Tewksbury (1993) identified nine configurations of organizational collaboration among providers, all reflecting the functional to product line organizational designs advanced by Galbraith (1973). Burns and Thorpe (1993) suggested four basic models: physician-hospital organizations (PHOs), management service organizations (MSOs), foundations, and integrated healthcare organizations (IHOs). Researchers involved in the Health Systems Integration Study (Gillies et al., 1993; Devers et al., 1994) identified three types of integration: clinical, physician/system, and functional. The clinical, physician/system and functional categories "largely reflect the degree to which hospitals in a system share similar administrative systems, physician contract opportunities, medical staff

organizations and credentialing processes, quality assurance processes, clinical protocols, medical record features, support services and clinical services" (Alexander et al., 1996, p. 73). The variety of integrative approaches now found in the healthcare industry reflect varying solutions to the problem of managing interdependence between physicians and hospitals (Alexander et al., 1996; Conrad & Shortell, 1997; Miller, 1996).

Integration approaches have also been driven by the parties' desires to align their economic and strategic interests. The most visible are mergers and acquisitions, although an early integration form was contractual networks (Conrad & Shortell, 1997; Miller, 1996; Shortell, Gillies, et al., 1996).

Contractual networks are nonownership contractual relationships between organizations with separate managerial hierarchies and which agree to coordinate activities with each other over time. A contractual network is formed by a healthcare system contracting with a family practice clinic to provide services on its behalf.

An integrated organization of physicians and hospitals is vertically or horizontally integrated with one managerial hierarchy. Vertical integration exists when one organization generates the products that either suppliers or producers can manufacture or acquire. An example of vertical integration is a healthcare system that employs physicians directly. Horizontal integration involves acquiring an organization that produces similar goods or services. A healthcare system that purchases an outpatient surgery clinic is an example of horizontal integration.

Physicians and hospitals have become more closely aligned with the onset of integration. Physicians are increasingly linked economically to individual systems.

They may use a particular system's facilities and services somewhat more exclusively, and participate more actively in planning, management, and governance (Conrad & Shortell, 1997; Miller, 1996; Shortell, Gillies, et al., 1996).

Creating integrated organizations and contractual networks can be prerequisites to other types of integration (Miller, 1996; Conrad & Shortell, 1997). Clinical integration, physician/system integration, and functional integration become the logical next steps for organizations aspiring to positively affect health care costs and enhance medical practice (Conrad & Shortell, 1997; Miller, 1996; Shortell, Morrison & Friedman, 1992).

Clinical integration is defined by Gillies (1993) as "the extent to which patient care services are coordinated across the various functions, activities, and operating units of a system" (p. 468). This type of integration focuses on the ultimate customer, the patient. Physician/system integration is "the extent to which physicians are economically linked to a system, use its facilities and services, and actively participate in its planning, management, and governance" (Gillies, 1993, p. 469). Functional integration is defined as "the extent to which key support functions and activities, such as financial management, human resources, strategic planning, information management, marketing, and quality improvement, are coordinated across operating units so as to add the greatest overall value to the system" (Gillies, 1993, p. 469).

Many of today's successful community hospitals have evolved into integrated health care organizations (Griffith, 1996). These organizations typically share several common characteristics. According to various authors, successful integrated healthcare organizations have a community rather than a membership orientation (Conrad &

Shortell, 1997; Gillies, 1993; Griffith, 1996; Shortell, Gillies, et al., 1996). A community orientation occurs when an integrated healthcare organization seeks to improve the health status of those living in those regions it serves. A membership orientation occurs when the organization seeks to expand its geographic coverage for the additional prospective patients. Having a community orientation is seen as a distinguishing source of market appeal. Griffith (1996) predicted that the transition to integrated healthcare systems would be slow and that newly integrated organizations would have to expand their technical skills and capabilities to control costs and quality.

There are several driving forces behind the move to develop integrated health care organizations (Conrad & Shortell, 1997; Griffith, 1996; Shortell, Gillies, et al., 1996) . One such force is the sharply increased price orientation by health insurance buyers who have shown a willingness to move away from traditional relationships and toward new contractual arrangements. As price orientation has been shown to be effective in reducing cost, it may become more widespread, with a potential for cost reductions in the 20 to 30 percent range (Griffith, 1996). The strength of commitment to price orientation, and the speed of the transition, varies from community to community based on buyer beliefs about managed care. Another driving force behind the move to develop integrated delivery systems is the large number of Americans concerned about what they perceive as the quality of medical care under managed care.

Provider response is seen as a factor that can encourage the spread of price orientation (Griffith, 1996; Miller, 1996). As Griffith explains, "If providers can make actual clinical practice more cost-effective and still attractive to the patient and buyer, resistance is reduced" (1996, p. 10). Griffith observes that while demand for price

orientation is strong and likely to be permanent, it is neither universal nor uniform across communities. He predicts that gradual and muddled change toward integrated healthcare organization development may be the more realistic scenario for most communities.

The state of the current health care system in America is one characterized by conflicting financial incentives, escalating cost containment pressures, and often unrealistic patient expectations (Shortell, Gillies, et al., 1996). A comprehensive, four-year study of eleven integrated health systems conducted by Shortell and Gillies examined successes and failures and made recommendations for developing and implementing better integrated, more cost effective delivery systems. The systems included in the study were the following:

- Baylor Health Care System, Dallas, Texas
- EHS Health Care, Oak Brook, Illinois
- Fairview Hospital & Health Services, Minneapolis-St. Paul, Minnesota
- Fransiscan Health System, Aston, Pennsylvania
- Henry Ford Health System, Detroit, Michigan
- Mercy Health Services, Farmington Hills, Michigan
- Sentara Health System, Norfolk, Virginia
- Sharp HealthCare, San Diego, California
- Sisters of Providence Health System, Seattle, Washington
- Sutter Health, Sacramento, California
- UniHealth, Burbank, California

An excellent health system, according to Shortell, Gillies, et al. (1996) is one that has the ability to consistently provide well coordinated, continuous care that produces desired outcomes for each patient. The authors cite the key elements of an ideal health system. They are as follows:

- Focuses on meeting the population's health needs
- Matches service capacity to meet the population's needs
- Coordinates and integrates care across the continuum
- Has information systems to link patients, providers and payers
- Is able to provide information on cost, quality outcomes and patient satisfaction to multiple stakeholders
- Uses financial incentives and organizational structure to align governance, management, physicians, and other caregivers in support of achieving shared objectives
- Is able to continuously improve the care that it provides
- Is willing and able to work with others to ensure that the community's health objectives are met" (p. 17).

Developing an ideal system, according to the authors of the study, involves overcoming the fragmentation of the current systems. Fragmentation is caused by imperfect information, incomplete communication, conflicting incentives, and organizational and professional biases (Institute for the Future, 1993).

Based on their research, Shortell, Gillies, et al. (1996) recommend that in order to counteract these influences, healthcare administrators in the process of forming integrated healthcare delivery systems should develop a "community health care management system". Figure 1 outlines the key components.

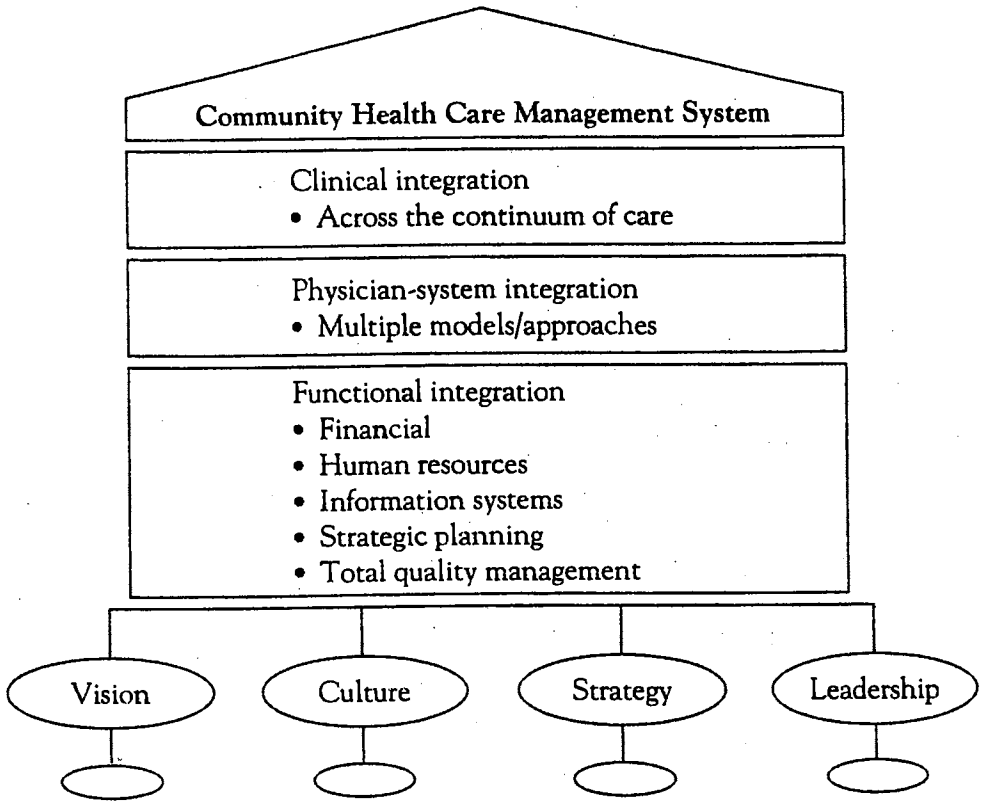

Figure 1. Community Health Management System (Shortell, Gillies, et al., 1996, p. 43)

Shortell and Gillies (1996) recommend that the new healthcare system begin with knowledge of its current and future customers and the communities in which they reside. This is a community/population-based health needs assessment. The process includes defining the specific segments of the population and geographic area that the system wishes to serve. The service area and target population are determined by the system's mission and values and by the presence of other health providers, systems, and resources in the community.

They emphasize that what is important is to project the needs of the various groups and to convert these into the likely utilization of health care services and resources. Shortell, Gillies, et al. (1996) conclude that to the extent that capitated payment or prepayment of some form continues to grow throughout the country, health systems have an incentive to take a more assertive and activist stance toward maintaining and promoting the health of the populations which they serve. Maintaining and promoting community health involves taking a broader perspective of what constitutes good heath and leads the system to becoming more involved in issues that influence community health, such as crime, alcohol and substance abuse, and domestic violence. Examples of systems which have implemented such assessments are the Hospital Association of Pennsylvania, which has developed a five-phase model implemented by The Crozier-Keystone Health System in Media, Pennsylvania, and the Allina system in Minneapolis-St. Paul.

According to Shortell, Gillies, et al. (1996), based on the community/population-based health needs assessment, systems can determine the resources and services to offer. Once the resource requirements and service offerings have been determined, the system then moves to aligning its caregiver, management, and governance structures.

Governance of Integrated Healthcare Delivery Systems

As healthcare delivery organizations develop into organized delivery systems, new and important challenges arise with respect to governance (Alexander et al., 1995). Governance structures must be changed to reflect responsibilities for the health of

defined populations, with greater attention given to achieving systemwide objectives in addition to individual operating unit objectives (Shortell et al., 1996).

The hospital board is legally responsible for hospital affairs. Governing boards of the system are legally responsible for system affairs. A governing board shares power with managers who are its delegates and with physicians, most of who are not employees. While the legal powers of governing boards have not changed in any way in recent years, the increase in the number of healthcare systems has meant that many regional hospital boards now find themselves answering to a governing system board.

Governance can serve as an important facilitator of, or barrier to, healthcare system integration. Alexander, et al. (1995) said that as integrated systems assume greater responsibility for the health status of a defined community, governance will carry much of the burden of transcending the needs and interests of both community and system.

Although organizations have been around for thousands of years, boards date back only several hundred (Pointer & Ewell, 1994). The corporation as we know it emerged after the Civil War. Large and complex tasks needed to be accomplished. Railroads needed to be constructed, oil to be located, pumped, and distributed, goods to be produced and marketed, and health care services to be provided to the community. New mechanisms to raise capital had to be created in order to support the enormous expense of these endeavors. Entities called corporations could raise large sums of money through the sale of stock. Investors, however, sought to protect their ownership interests through boards. With the creation of boards, organizational control was separated from ownership. Stockholders delegated to boards the responsibility of

controlling them on their behalves. Over time, as corporations became larger and more complex, the day-to-day operating responsibility was further delegated to professional managers.

When this country's first hospital opened its doors in 1756, it had a board (Pointer & Ewell, 1994). Since that time, governance has evolved in response to the changing healthcare environment (Alexander, 1990; Hagland, 1997; Johnson, 1994; Pointer & Ewell, 1994; Prybil & Starkweather, 1976; Starkweather, 1988). Pointer and Ewell (1994) divide hospital governance into four stages: the refuge stage, the physician workshop stage, the business stage, and the corporate stage. The refuge stage spans from the mid-1700s to the late 1920s and was primarily a period of institution building. The physician workshop stage dates from the early 1930s through the mid-1960s. During this period power shifted to the physician and the emphasis was on clinical efficiency. The business stage ran from the mid-1960s through the mid-1980s and saw hospitals focusing on implementing effective business practices. The corporate stage began in the mid-1980s and continues to the present. Important challenges facing hospital boards in the 1990s were integration, competition, and financial viability.

The purpose of hospital governance is defined by statute in each state (Johnson, 1994), but how hospital governance carries out its responsibilities and defines its roles is in the process of change. Johnson (1994) suggests that, historically, the hospital has been the centerpiece of a loosely coordinated delivery system primarily held together by informal relationships. He believes that as integrated delivery systems, payor organizations, and physician groups develop contractual relationships, hospital

governance will be radically altered. Hagland (1997) concurs, suggesting that healthcare governance has entered a new era, one that has heavy implications for every facet of who trustees are and what they do. Mergers and affiliations, downsizing and reconfiguring services, provider sponsored health insurance products, and drastically altered government programs are viewed as the key drivers of change.

Four key trends are seen as dominating the marketplace. They are continued price paring, the push to document quality, the reshaping of Medicare and Medicaid, and continued physician organization (Griffith, 1992; Haglund, 1997; Orlikoff, 1996; Pointer & Ewell, 1994; McComb, 1992; Rindler, 1992). The old vestiges of custodial governance are declining and governance in the new healthcare environment will mean overseeing, guiding and monitoring the shift from maintaining disease care organizations to propelling proactive, entrepreneurial healthcare organizations. Trustees are no longer seen as being in the business of filling beds but being in the business of managing health.

Haglund (1997) suggests several questions for trustees planning for the future of their organizations. They are as follows:

1. Who will we be in our market?
2. How can we differentiate ourselves from the competition?
3. What services will we offer?
4. How can we best spend our available capital?
5. What choices are in the best interest of our community?

A board that is unaware of the changing tides of the marketplace and unprepared to chart a new course for their organization can make ill advised decisions, which may have disappointing, if not disastrous, results.

Discussing the current governance evolution, Orlikoff (1996) describes the transition from hospital to health system governance as a paradox. The paradox of governance is that the board must lead the evolution of the organization it governs, but that before it can effectively do so, it must change itself into an integrated, systems-oriented governing board. The new governing board's challenge is to adopt the characteristics required of governance for the new organization to facilitate the transformation from the old. This requires flexible, forward thinking and introspective governance (Johnson, 1994; Kovner, 1990; Orlikoff, 1996).

Governance is defined as "the making or not making of important decisions and the related distribution of authority and legitimacy to make decisions" (Kovner, 1990, p.4). While the definition of the important decision and who makes it varies by hospital, typically there are three key groups of decision makers: board members, management, and clinicians (Alexander, 1990; Kovner, 1994; Orlikoff, 1996). Effective governance involves decisionmaking that is timely, appropriate, and characterized by due process. Effectiveness is the extent to which organizations accomplish their goals.

Updating his 1985 study on hospital board effectiveness, Kovner (1994) recommends three sets of expectations for board behavior in today's healthcare

environment. They are as follows:

1) the board as community steward,

2) the board as strategic decision maker,

3) the board as rational adviser to management.

The role of the board as community steward is receiving attention in the literature (Delbecq & Gill, 1988; Kovner, 1990; Seay & Vladeck, 1989; Shortell, Gillies, et al. 1996; Shortell, Morrison & Friedman, 1992). Seay and Vladeck (1989) suggest that hospitals should be rewarded and approved for commitment to a community. In discussing hospital performance, they say that the well being of any nonprofit organization providing human services ultimately hinges on the relationship between that institution and the broader community it serves.

Delbecq and Gill (1988) studied governance in the evolving healthcare environment of the late 1980's. They suggested that for health care systems to succeed in a rapidly changing competitive environment, smaller boards of directors focus on market driven policy issues. Advisory boards would use lay volunteers and community elites for fund raising and community representation. The governing board provides strategic direction and specific expertise in areas such as joint venture development or marketing. Decisionmaking is shared among board, management and medical staff.

Much of the literature on healthcare governance addresses the issue of board power and the ability of the board to influence decisions (Kovner, 1990; Orlikoff, 1997; Provan, 1988; Shortell, Gillies, et al., 1996; Shortell, Morrison & Friedman, 1992; Starkweather, 1988). Whereas most authors suggest that boards can influence decisions, Starkweather (1988) argues that hospital board power cannot be validated or

tested by real acts. He points out that board members frequently know little of medical care. Top management supports the myth of board power because it increases management power relative to that of physicians. Physicians support the myth because it allows them to use the hospital without yielding any real professional autonomy. Starkweather (1988) observes that hospital effectiveness is sacrificed as a result. He suggests that in a rapidly changing, more competitive healthcare environment, the board's function will be to link, advise, and control.

Board Roles and Responsibilities

Governance is defined by how boards fulfill responsibilities and how they execute roles. Effective governance has been defined as the making of important decisions that are timely, appropriate, and characterized by due process (Alexander, 1990; Kovner, 1990; Orlikoff & Totten, 1996; Pointer & Ewell, 1994).

Pointer and Ewell (1994) define responsibilities as the substantive aspects of governance. They are the specific matters a board must attend to in order to fulfill its obligations to the organization's stakeholders/shareholders. They define roles as the set of functions and activities that a board must execute to meet its responsibilities.

The literature contains many references to healthcare board roles and responsibilities, with authors answering the question a myriad of ways. Alexander (1992) believed that there was much work still to be done in terms of adequately conceptualizing the fundamental responsibilities of the board. While the need for a more widely accepted definition of board responsibilities may exist, according to Pointer and Ewell (1994), any specification of board responsibilities must meet two

criteria. First, the responsibilities must be both necessary and sufficient for boards to fulfill their overarching obligation of agency on behalf of stakeholders. No essential responsibilities should be excluded and no nonessential ones should be included. Second, each responsibility must be non-delegable. That is, due to legal requirements and functional necessity, only board members can fulfill them (Pointer & Ewell, 1994).

A representative sample of healthcare board responsibilities, as listed by various authors, is outlined below:

Pointer & Ewell, (1994):

- envision and formulate the organization's ends: vision, mission, goals
- ensure high levels of executive performance
- ensure the quality of patient care
- ensure the organization's financial health
- assume responsibility for board performance and development

Griffith, (1992):

- appoint the chief executive officer
- establish the long range plan
- approve the annual budget
- appoint members of the medical staff
- monitor performance against plans and budgets
-

Jordon, (1990):

- to be informed
- to make policy
- to select and evaluate the CEO
- to be an advocate
- to assure the financial viability of the organization

Umbdenstock et al., (1990):

- mission and values identification
- policy determination
- plan development
- financial viability
- quality assessment and improvement

- legal and regulatory compliance
- effective customer relations

American Hospital Association, (1982):

- organization, public policy and external relationships
- strategic planning
- resource management
- human resources development
- education and research

Prybil & Starkweather, (1976):

- establish corporate goals and major institutional policies
- ensure that plans and programs are developed and implemented to accomplish corporate goals
- establish and maintain sound procedures for conducting the business of the board
- provide for the hospital's long term financial viability
- select and maintain a qualified medical staff and ensure that this staff is properly organized to fulfill responsibilities the board delegates to it
- evaluate all phases of the hospital's performance, including the quality of patient care, and ensure that established standards are met
- select the chief executive officer, define responsibilities and evaluate performance
- review and approve the hospital's overall organizational structure
- ensure that the community served is well informed about the hospital's goals and performance

Kovner, (1974):

- set policies and make major decisions
- gain access to key resources from the environment
- represent those served by the hospital
- serve as an advisor to top management

In the literature the terms roles and responsibilities are often used interchangeably. Pointer and Ewell (1994) observe that there is an important difference between the what (responsibilities) and the how (roles) aspects of governance. They suggest that boards execute three roles in order to fulfill their ultimate responsibilities: policy formulation, decisionmaking, and oversight. Policies provide the organization

with direction and are the means whereby specific tasks and authority are delegated to management and the medical staff. Policies guide and constrain decisions and actions and provide a framework for the board to carry out its decisionmaking role. The board makes decisions in each of its areas of ultimate responsibility. The board then engages in oversight by monitoring and evaluating decisions and actions to ensure they conform to policy and produce desired results.

There are many other things that boards and their members can do on behalf of their organizations (Carpenter, 1988a, 1988b; Gordon et al., 1992; Hageman & Umbdenstock, 1990; Kovner, 1974; Starkweather, 1992). Among the more frequently referenced activities are serving as a sounding board and advisor to the chief executive officer, being an advocate and providing links to constituents, and fundraising.

The Resource Dependence Perspective

The resource dependence perspective views organizations as needing to strike relationships with individuals, groups and organizations in their environments to acquire the resources to survive. Such relationships create dependencies, which organizations attempt to either minimize or manage (Pfeffer & Salancik, 1978; Pointer & Ewell, 1994; Selznick, 1949; Zald, 1969). The balancing of autonomy and dependence is a daily fact of life for most organizations when dealing with their constituents.

While the most comprehensive treatment of resource dependence theory can be attributed to the work of Pfeffer and Salancik (1978), the roots of this perspective can be traced to Selznick's (1949) study of the Tennessee Valley Authority (TVA).

Selznick found that opposing groups were neutralized when their representatives were included on the governing board. While TVA gave up total control over its decision making, it acquired a resource and simultaneously created a dependency.

Foundational theoretical work applying this perspective to governance was conducted by Zald (1969). In reviewing Zald's work, Pointer and Ewell (1994), point out that Zald saw boards as having two key functions: internal and external control. The first involves overseeing internal functioning, while the second deals with developing linkages with stakeholders/shareholders. These linkages allow the organization to acquire the critical resources that it needs to be successful. Zald (1969) suggested that various factors influence the extent to which a board engages in external versus internal control and the influence the board exercises in the organization relative to management. These factors include the nature of the environment, the size and composition of the board, the characteristics of the chief executive officer, and the life-cycle stage of the organization. Zald hypothesized that the board's ability to influence management would be greater if the organization relied on external resources and the board had access to those resources.

The first empirical studies on boards explicitly employing the resource dependence perspective were undertaken by Jeffrey Pfeffer in the 1970's (Pointer & Ewell, 1994). Pfeffer studied boards both in the commercial sector and in the healthcare industry.

In one study of 80 corporations, Pfeffer (1972) looked at the relationship between board size and composition, the need for the organization to co-opt its environment, and performance. He suggested that board composition reflected an

organization's need to secure critical resources, such as funding and legitimization, from its environment. Pfeffer proposed that a board's impact upon organizational success would depend on the extent to which its composition reflected environmental requirements. He found that board size and composition are not random variables, but are, in fact, systematically related to the organization's apparent need to deal with important external sectors in the environment in such a way as to ensure successful operations and an adequate supply of resources for the future (Pfeffer, 1972).

One year later, Pfeffer studied 57 short-term general hospitals in a large midwestern state. His focus in this study remained the relationships between board size/composition and the resource characteristics of the organization's external environment. The study's findings supported the resource dependence perspective, namely that:

a) hospitals that relied more heavily on private donations tended to place more emphasis on the fundraising functions of the board and select its members accordingly

b) board member influence in the community was less important for hospitals that received a larger share of public funding

c) the importance of regional or subregional representation on the board was inversely proportional to the share of its budget received from the federal government

d) that hospitals relying more on public funding and consequently more influenced by governmental agencies, placed more emphasis on selecting board members who had political connections.

Pfeffer concluded the study by noting that the size of the board was seen to be related to the requirements for co-optation and to the function of the board. The

composition of the board was determined partly by the socioeconomic characteristics of the environment in which it operated, and again partly by the function it served (Pfeffer, 1973). According to Pointer and Ewell (1994), the more a hospital is dependent upon specific external inputs, the more valuable are board members who represent, or are connected to, those resources.

Provan (1988) examined the influence of boards on the major internal decisions of hospitals. Using data on 239 nonprofit community hospitals, Provan concluded that participation in a system created an important resource dependency for member hospitals.

Hospitals in the study were either freestanding or members of a system. Data were obtained from American Hospital Association surveys conducted in 1981 and 1982. The major findings of the study included:

a) the greater a hospital's response to regulation, the less the board's influence over significant internal decisions

b) the more dependent a hospital was on governmental funding, the greater the board's influence over internal decisions

c) hospital size and board influence are inversely related

d) the amount of information received by a board from management was directly related to the board's influence.

The findings also revealed that when the hospital is part of a multihospital system a hospital's level of response to regulation and its external dependence on funds for capital expenditures will be related negatively to board influence over hospital decisions (Provan, 1988).

The effect of the changing healthcare environment on board composition has also received attention in the literature (Boeker & Goodstein, 1991; Orlikoff, 1997; Pointer & Ewell, 1994; Provan, 1988). Boeker and Goodstein (1991) took a longitudinal approach to studying the ways in which boards were affected by changes in their environments. Taking the position that board composition was a conscious response to environmental characteristics, the authors found that changes in the local availability of physicians were inversely related to changes in physician representation on hospital boards. Those hospitals operating in environments with a growing number of beds increased the proportion of physicians on their boards, whereas the proportion of business executive board members increased in response to a growth of beds and the presence of health maintenance organizations in the community. Boeker and Goodstein (1991) concluded that the findings appear to provide further empirical evidence for a dynamic interpretation of the resource dependence perspective of Pfeffer and Salancik (1978), who suggest that organizations are externally influenced because they must attend to the demands of environmental constituencies which provide critical resources.

The Case Study Method

The case study method has been an important form of research in the social sciences and management. It has been used in research involving business and organizational issues, education, family studies, international affairs, evaluation, technology development, and research on social problems (Denzin & Lincoln, 1998; Eisenhardt, 1989; Gay, 1992; Yin, 1994).

A case study is the indepth investigation of an individual, group or organization. According to Gay (1992), the primary purpose of a case study is to determine the factors, and relationships between the factors, that have resulted in the current status, with a view to understanding *why*, not just *what*, has occurred. Yin (1989) defines a case study as an empirical inquiry that investigates a contemporary phenomenon within its real life context when the boundaries between phenomenon and context are not clearly evident and in which multiple sources of evidence are used. Either single or multiple cases can be studied.

While single case studies have been investigated more frequently, multiple case studies have recently become more common. Yin (1989) and Strauss and Corbin (1990) address multiple case studies, but it is Eisenhardt (1989) who has written in detail about their theory building properties. Eisenhardt (1991) maintains that the multiple case approach encourages the researcher to study patterns common to cases and theory and thereby avoid chance associations.

Traditionally case studies were considered appropriate for exploratory research only. Yin (1989) points out that some of the best case studies have been both descriptive and explanatory, for example, Whyte's "Street Corner Society" (1943) and Allison's "Essence of Decision-Making" (1971) about the Cuban Missile crisis. Eisenhardt (1989) identifies other uses for the case study method, such as providing description (Kidder, 1982), testing theory (Pinfield, 1986; Anderson, 1983), or generating theory (Gersick, 1988; Harris & Sutton, 1986). Yin (1993) maintains that, despite its increased use, the case study approach as a research methodology is unappreciated and underutilized. Yin (1989) believes that its major strength is that it

measures and records behavior. Another strength is that data can be collected from a variety of sources, both qualitative and quantitative. These include documentation, archival records, indepth interviews, direct observation, participant observation, and physical artifacts. Multiple data collection methods allow the researcher to conduct a more thorough examination of each organization than is possible with a quantitative study. And because multiple sources of evidence are used, the researcher can address a broader range of attitudinal, historical and observational issues than would be possible in other forms of research. Multiple sources also help to prevent subjective bias. As findings and conclusions are supported by a chain of evidence from varied sources, they are likely to be seen as both more convincing and more accurate.

Yin (1989) uses case studies to test theory while Eisenhardt (1989) uses them to develop theory. According to Yin (1989), the first step in the case study approach is to develop theory, while the second is to select a case. Each case is examined as a separate entity, enabling unique patterns across cases to emerge. Cross case comparisons help the researcher to surpass initial impressions and take a more focused approach to the data. Through data analysis, each case is compared to the theory. The case study data are matched to theory and not analyzed to make statistical generalizations (Yin, 1989).

Eisenhardt (1989) asserts, by contrast, that theory developed from case study research is likely to possess important strengths like novelty, testability and empirical validity. She maintains that theory building should begin as closely as possible to the untainted position of "no theory under consideration" and "no hypotheses to test". While acknowledging that this goal is difficult to achieve, Eisenhardt suggests that the

attempt is important because preordained theoretical perspectives or propositions may bias and limit the findings (1989). She argues that researchers should formulate a research problem, and possibly specify some potentially important variables with reference to existing literature, but should avoid thinking about specific relationships between variables and theories as much as possible, especially at the beginning of the research process.

Eisenhardt (1991) asserts that multiple cases can be used to create theory because they permit replication and extension among individual cases. She means that through replication individual cases can be used to corroborate specific propositions. She defines "extension" as the use of multiple cases to develop elaborate theory. Dyer and Wilkins refute Eisenhardt's position and criticize multiple case approaches (1991). They state that the multiple case approach is a hybrid form of case research, which claims to generate theory, but that it in fact includes many characteristics of hypothesis testing research. Dyers and Wilkins (1991) propose that good storytelling about a single case would provide better theoretical insights than would multiple case research which attempts to develop theory by corroborating specific propositions.

Stablein (1996) asserts that case studies constituted an important source of organizational data during the early years of organization studies. Daft (1980) documents the dominance of case reports in the Administrative Science Quarterly in 1959. The foundational works in organizational sociology are cases (Blau, 1955; Gouldner, 1954a; 1954b). Case studies were the foundation of theory and practice at The Tavistock Institute (Stablein, 1996). Stablein cites evidence of an increased interest in case studies in the 1980s and 1990s in both the USA and Europe.

According to Stablein (1996), the case study method is a well used term that has many meanings. Stablein considers there to be three main types of case data. The types of cases share a common focus upon one complex organizational unit. They differ in aspects of the organizational reality that is studied. Stablein lists the three types of organizational case studies as "ethno" cases, theory generating cases, and exemplar cases.

The ethnographic case produces ethnographic data. It represents the native participants' realities. Stablein provides an example of such a description of participant realities with Jackall's (1988) *Moral Mazes*.

The theory generating case seeks to generalize theoretical propositions. The organizational reality is the world of researcher defined constructs. Stablein (1996) reports that, unlike the world of the questionnaire researcher, the organizational world is a complex and tangled world where cutting the Gordian knot is not as simple as asking the right questions. He suggests that experimentation is not an available strategy because the case researcher's issues are sociological and there are insufficient independent units for a field experiment.

Kanter's (1977) case study of *Men and Women of the Corporation* is frequently cited as a masterpiece of theory generating case research. In justifying her approach to the study, she quotes another pioneer of organizational studies:

> Crozier, framed the methodological problems inherent in studies of large-scale organizations well: 'Comprehensive studies of human relations problems at the management level are usually hampered by two sets of difficulties. First, the complexity of the role structure in modern organizations causes much ambiguity and overlapping, making it impossible to match really comparable cases and use rigorous methods meaningfully. Second, the general emphasis on status and promotions gives a crucial importance to the human relations game, thus preventing

> the researcher from obtaining reliable data on the central problem of power relationships' (Crozier, 1964, p. 112).
>
> Thus, a combination of methods such as used in the classic sociological field studies emerges as the most valid and reliable way to develop understanding of such a complex social reality as the corporation (1977: 297).

The exemplar case is the third type of case study. Stablein (1996) believes this type to be the most influential in organization studies as the exemplar case is frequently presented to organizational participants and students in classrooms. The case study provides a template which organizational participants can follow to intervene in their own organizations. The organizational reality of the exemplar-based researcher consists of nearly universal problems, processes, or solutions relevant to most organizations.

Denzin and Lincoln (1998) have reported extensively on qualitative research. They describe qualitative research as "multimethod in focus, involving an interpretive, naturalistic approach to its subject matter" (p. 3). According to Denzin and Lincoln, qualitative research involves the studied use and collection of a variety of empirical materials, including case study, personal experience, introspective, life story, interview, observational, historical, interactional and visual texts, that describe routine and problematic moments in individuals' lives.

Denzin and Lincoln suggest that case study is not a methodological choice but a choice of object to be studied. They point out that the case is a bounded, integrated system. That is, the parts do not have to be working well, but they must comprise a system. Denzin and Lincoln view case study as both the process of learning about the case and the product of learning. Three types of case study are identified: the intrinsic case study, the instrumental case study and the collective case study. Intrinsic case

studies are undertaken to better understand a particular case. Instrumental case studies are those that examine particular cases to provide insight into an issue or refinement of theory. Collective case studies are instrumental studies extended to several cases. Individual cases may be similar or dissimilar but are chosen by researchers because it is believed that understanding them will lead to better understanding, perhaps better theorizing, about a still larger collection of cases.

Case Study Procedures

A number of alternative procedures for conducting case study research have been suggested (Borg & Gall, 1983; Denzin & Lincoln, 1998; Eisenhardt, 1989; Fehrenbacher, Owens & Huenn, 1978; Spirer, 1980; Van Dalen, 1962; Yin, 1989).

Eisenhardt (1989) outlines nine distinct phases of the research process. She presents broad guidelines for each phase, each designed to contribute to the theory building process. Eisenhardt (1989) suggests the following nine phases for the case study method:

Phase 1: Getting Started

Eisenhardt suggests that an initial definition of the research question, in broad terms, is an important place to start. The rationale for defining the research question is the same as in hypothesis testing research. Without a research focus, it is easy to become overwhelmed by the data. A well defined research focus permits the investigator to specify the kind of organization to be approached and the kind of data to be gathered (Yin, 1989).

A construct is a nonobservable trait, such as intelligence, which explains behavior (Gay, 1992). According to Eisenhardt, early identification of constructs can help to shape the initial design of theory building research. Identification of constructs is valuable because it enables the researcher to design the research to better measure constructs. If the constructs prove important as the study progresses, then the researcher has a firmer empirical ground for the emergent theory (Yin, 1989).

While early identification of the research question and of possible constructs is helpful, Eisenhardt (1989) cautions that it is equally important to recognize that both are tentative. No construct is guaranteed a place in the resultant theory, no matter how well it is measured as the research question may shift during the research.

Phase 2: Selecting Cases

Selection of the population is important because the population defines the set from which the research sample is drawn. Selection of an appropriate population helps to control extraneous variation and helps to define the limits for generalizing the findings (Yin, 1989) The cases may be chosen to replicate previous cases or extend emergent theory, or they may be chosen to fill theoretical categories and provide examples of polar types. Random selection is neither necessary nor preferable, according to Eisenhardt (1989). The goal of theoretical sampling is to choose cases, which are likely to be replicable or which extend emergent theory (Denzin & Lincoln, 1998).

Phase 3: Crafting Instruments and Protocols

Theory building researchers typically combine multiple data collection methods (Denzin & Lincoln, 1998; Yin, 1989). While interviews, observations, and archival sources are most common, Eisenhardt does not limit researchers to these methods. She emphasizes the importance of multiple data collection methods in order to strengthen the validity of constructs and hypotheses.

Eisenhardt also stresses the combination of qualitative with quantitative evidence. Quantitative evidence may suggest relationships which may not be salient to the researcher, while qualitative data are useful for understanding the rationale underlying relationships (Denzin & Lincoln, 1998).

Phase 4: Entering the Field

Eisenhardt (1989) notes that a striking feature of case study research is the frequent overlap of data analysis with data collection. Field notes are an important means of accomplishing this overlap. As described by Van Maanen (1988), field notes are an ongoing stream of consciousness commentary about what is happening in the research.

According to Eisenhardt (1989), a key feature of case research is the freedom to make adjustments during the data collection process. Field notes often provide insights for the researcher which then result in adjustments to data collection instruments, such as additional items for a questionnaire or an interview protocol (Emerson, 1983).

According to Eisenhardt (1989), these adjustments are legitimate and allow the researcher to probe emergent themes, or take advantage of special

opportunities which may be present, in order to better understand each case individually and in as much depth as is feasible.

Phase 5: Analyzing Within Case Data

Eisenhardt (1989) believes that analyzing data is at the heart of building theory from case studies, but acknowledges that it the most difficult and the least codified part of the process.

A key step is within case analysis, which consists primarily of a detailed case study summary for each site (Denzin & Lincoln, 1998). Often simply pure description, the summaries are central to the generation of insight (Gersick, 1988; Pettigrew, 1988) because they assist the researcher to cope with the enormous volume of data. The main goal is to become intimately familiar with each case independently, allowing the unique patterns of each case to emerge before the researcher attempts to generalize patterns across cases.

Phase 6: Searching for Cross Case Patterns

Researchers may reach premature or false conclusions as a result of information processing biases. Eisenhardt (1989) notes that people are notoriously poor processors of information. They leap to conclusions based on limited data (Kahneman & Tversky, 1973). They are overly influenced by the vividness (Nisbett & Ross, 1980) or by more elite respondents (Miles & Huberman, 1984). They ignore basic statistical properties (Kahneman & Tversky, 1973), or they inadvertently eliminate disconfirming evidence (Nisbett & Ross, 1980; Eisenhardt, 1989).

An approach Eisenhardt suggests reducing the potential for information processing biases is to select categories and seek within group similarities coupled with intergroup differences. A second approach is to select pairs of cases and then list the similarities and differences between each pair. A third strategy is to divide the data by source. Cross case research approaches force investigators to go beyond initial impressions through the use of structured and diverse lenses (Denzin & Lincoln, 1998; Eisenhardt, 1989).

Phase 7: Shaping Hypotheses

Tentative themes, concepts, and relationships between variables may begin to emerge from within site analysis and various cross-site approaches and overall impressions. (Denzin & Lincoln, 1998; Eisenhardt, 1989). The emergent hypothesis is systematically compared with the evidence from each case in order to assess how well or poorly it fits with case data.

The first step in shaping hypotheses is the sharpening of constructs through refining the definition of the construct and building evidence, which measures the construct in each case. According to Eisenhardt (1989), many researchers rely on tables that summarize and tabulate the evidence underlying the constructs.

A second step is the verification that the emergent relationships between constructs fit with the evidence in each case. Eisenhardt (1989) maintains that the researcher must judge the strength and consistency of relationships within and across cases and fully display the evidence and procedures.

Phase 8: Enfolding Literature

According to Eisenhardt (1989), an essential feature of theory building is the comparison of the emergent concepts, theory or hypotheses with the extant literature. This involves asking what it is similar to, and what it contradicts, and why. Linking the emergent theory to existing literature enhances the internal validity, generalizability and theoretical level of theory building from case study research (Eisenhardt, 1989, p.545).

Phase 9: Reaching Closure

Eisenhardt (1989) cites two issues as important for reaching closure, when to stop adding cases and when to stop iterating between theory and data. She acknowledges that pragmatic issues, such as time and money, dictate when case collection ends. She adds that while there is no ideal number of cases, a number between four and ten cases is typically appropriate.

Regarding the second issue about when to stop iterating between theory and data, the key is saturation. The iteration process stops when the incremental contributions from data to theory become few and unimportant.

Limitations of Case Study Methodology

Case study methodology has limitations (Eisenhardt, 1989; Gay, 1992; Spirer, 1980). The major limitations are observer bias and the lack of generalizability (Gay, 1992). The insights acquired from a particular case may not apply to any other case,

although Gay suggests that case studies may suggest hypotheses which can be tested using another method of research.

Eisenhardt (1989) suggests that the overuse of empirical evidence can yield theory, which is overly complex. She views the hallmark of good theory as "parsimony" (Eisenhardt, 1989, p. 547). She also acknowledges that theory building from cases may result in theory that is narrow and idiosyncratic.

Stablein (1996) suggests that the case study approach is sensitive to issues of bias, authenticity, and validity, often incorporating a variety of counterbalancing techniques like reliability, experimental control, triangulation, and multiple informants. He observes that the researcher as data generator should take an important position in the representational process. Stablein (1996) observes that researchers may pay insufficient attention to this aspect of the research.

Chapter Summary

The development of integrated healthcare delivery systems is an emerging field of study. The literature concerning integrated healthcare organizations contains few empirical studies addressing the topic. There is limited knowledge available to date about the factors influencing this model of healthcare delivery. Research about the role of governance in integrated delivery system development is especially lacking. The literature about integrated healthcare organizations is composed of consultant reports and case studies in trade publications (Alexander et al., 1996).

Scholars have made some contributions to the literature on the development of healthcare governance and board roles and responsibilities. These works serve to guide current research.

Several authors, including Pointer and Ewell and Shortell and Gillies, have documented the evolution of the healthcare industry over the last 50 years. This period of growth culminated in a major reorganization of the industry. Responding to both economic and public pressures, hospitals across the country have joined together to form integrated delivery systems. Integration activities are seen as offering the possibility of lowering administrative costs, reducing medical care prices and utilization, and producing higher quality medical care (Conrad & Dowling, 1990; Miller, 1996; Shortell, Gillies, et al., 1996).

Early work on integrated delivery systems was conducted by Shortell, who defined this new healthcare organizational model as "a network of organizations that provides, or arranges to provide, a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and health status of the population served" (Shortell, Morrison & Friedman, 1992).

Various approaches to classifying integrated delivery systems have been documented, largely reflecting the degree to which hospitals in a system share administrative and physician services. Charns and Tewksbury (1993) distinguished nine configurations of collaboration among providers. Burns and Thorpe (1993) categorized four basic integrative approaches, including physician-hospital organizations, management service organizations, foundations, and integrated healthcare organizations. Integration of member organizations may take the form of

mergers, acquisitions or the establishment of contractual networks. The creation of an integrated delivery system can be a prerequisite for other types of integration, including clinical integration, physician/system integration and functional integration (Conrad & Shortell, 1997; Miller, 1996; Shortell, Morrison & Friedman, 1992).

Shortell, Gillies, et al. (1996) documented the results of their four year study of eleven integrated delivery systems by outlining recommendations for developing and implementing integrated delivery systems. The authors cite what they view as the key elements of an ideal health system and recommend establishment of a community healthcare management system. Through a community/population based health needs assessment, the healthcare system can project likely utilization of healthcare services with the goal of better maintaining and promoting community health.

The literature suggests that governance can serve as a critical facilitator of, or barrier to, successful healthcare integration (Alexander et al., 1995; Shortell et al., 1996). Governance is defined as the making or not making of important decisions and the related distribution of authority and legitimacy to make decisions (Kovner, 1990). As integrated delivery systems assume greater responsibility for the health status of a defined population, governance processes may serve to bridge the needs and interests of the community and the system.

As healthcare organizations have evolved over time, governance structures have changed in response. Authors such as Alexander, Haglund, Johnson, Orlikoff, Pointer, Ewell, Prybil and Starkweather have written on healthcare governance. Pointer and Ewell (1994) define four distinct hospital governance stages, including the refuge stage, the physician workshop stage, the business stage and, currently, the corporate stage.

The authors identify the important challenges facing healthcare boards in the 1990s as integration, competition and financial viability.

Orlikoff (1996) described the transition from hospital to health system governance as a paradox. The new governing board's challenge is to adopt the governance characteristics of the new organization to facilitate the transformation from the old. He suggests this requires flexible, forward thinking and introspective governance. The literature also suggests that the role of the board as community steward deserves attention (Delbecq & Gill, 1988; Kovner, 1990; Seay & Vladeck, 1989; Shortell & Gillies, et al., 1996), with hospitals being rewarded for commitment to a community. Seay and Vladeck (1989) suggested the well being of any hospital ultimately depends on the relationship between that institution and the broader community it serves.

The literature observes that governance is defined by what boards do, that is fulfilling responsibilities, and how they go about doing it, executing roles. Pointer and Ewell (1994) defined board responsibilities as the specific matters a board must attend to in order to fulfill its responsibilities to the organizations' stakeholders. Roles are defined as the set of functions and activities that a board must execute to meet its responsibilities. While various authors have attempted to outline board roles and responsibilities, no widely accepted definition exists.

Resource dependence theory is presented as a theoretical underpinning describing the relationship between hospitals and the communities they serve. Pfeffer and Salancik observed that the resource dependence perspective views organizations as needing to strike relationships with individuals, groups and organizations in their

environments to acquire the resources to survive. Such relationships create dependencies, which organizations attempt to either minimize or manage. The foundational theoretical work applying this perspective to governance was conducted by Zald (1969), with Pfeffer conducting empirical studies explicitly applying the resource dependence perspective to boards in the 1970s. Various factors appear to influence the extent to which a board engages in external versus internal control. Factors include the nature of the environment, the size and composition of the board, the characteristics of the chief executive officer, and the life cycle stage of the organization.

The case study method was selected as the methodology of choice for the study. Described as an in-depth investigation of an individual, group or organization, the case study method has been an important form of research in the social sciences and management (Denzin & Lincoln, 1998). Yin and Eisenhardt have written extensively on the case study method, each outlining the benefits and limitations of the methodology. Yin (1989) believes major strengths of the case study method are that it measures and records behavior, and utilizes both qualitative and quantitative data. Eisenhardt (1991) stresses the theory building potential of the case study method. Eisenhardt (1989) argues that theory building from case studies is particularly well suited to situations where little is known about a phenomenon or where current perspectives have little empirical substantiation. A number of alternative procedures for conducting case study research have been suggested (Borg & Gall, 1983; Denzin & Lincoln, 1998; Eisenhardt, 1989; Yin, 1989). The procedures outlined by Eisenhardt (1989) were selected for the study and are reviewed in detail. This section of the literature review concludes with an outline of the limitations of case study

methodology. Major limitations are seen as observer bias and lack of generalizability (Eisenhardt, 1989; Gay, 1992; Yin, 1989).

This chapter presented a review of the literature relevant to the study. Chapter III outlines the study design and method. The findings are presented in Chapter IV. Chapter V includes conclusions, recommendations for further research, recommendations for future practice, and the implications of the study.

CHAPTER III

STUDY DESIGN AND METHOD

Overview

Chapter III presents the conceptual framework and systematic approach to exploring the practices used by regional healthcare boards in advocating the healthcare needs of their local communities. The purpose of the study was to describe the governance practices of regional hospital boards of an integrated healthcare delivery system in advocating the healthcare needs of their local communities.

Field research, specifically case study methodology, was selected as the research design best suited to this type of inquiry. Derived from the foundational work of Malinowski, field research is the study of people acting in the natural course of their daily lives. It is a method of study by which practitioners try to understand the meanings that activities have for those engaged in them. Fieldwork is non-descriptive research defined by where the research takes place.

Alternatively, ". . . . some fieldworkers derive the essence of the method less by the place in which research occurs than from the way it is conducted" (Emerson, 1988: p. 2). What distinguishes the field method in this view is the observer's "ability to grasp the symbolic nexus between thought and action in a particular social milieu"

(Schwartz & Merton, 1971: pp. 280-281). This latter view describes ethnographic case studies, which are those that produce data representing the native participants' realities.

Both definitions of field research were important guides in the study. Consistent with the view that field research takes place not in a laboratory setting but where people conduct their daily lives, research was conducted on location in the facilities that comprised the study. Data were gathered and interviews conducted in the rural towns and regional hospitals that formed the integrated healthcare delivery system being studied. A research goal was to observe participants in the specific settings in which they lived and carried on their daily activities.

A separate research goal was to better understand the various factors that might influence opinion and behavior on the part of research participants. This is consistent with the view of field research that suggests it is the observer's ability to grasp the connection between thought and action in a particular social milieu.

Researcher Background

The world of healthcare was very familiar to the investigator of this study. A continuing career of more than 20 years, beginning in the late 1970s, has been in healthcare. Spent almost exclusively at one organization, the investigator's healthcare experience spans the period of development of integrated delivery systems. As a healthcare executive for the system being researched in the study, the investigator participated in the transition of the healthcare system from a single major medical center to a comprehensive integrated delivery system.

A member of the senior executive staff, the investigator was responsible for organization development. Organization development responsibilities included governance processes, board relations and development, strategic planning, organizational policy and procedures, organizational communication, and human resource development. The nature of that role necessitated that the investigator communicate regularly with System and regional executives and board members. The investigator worked especially closely with the System Chief Executive Officer and senior System executives on organization development issues. As the organization evolved into an integrated delivery system and affiliated with area regional hospitals, the investigator worked with regional hospital administrators and board members on organizational and governance integration.

Although no longer an employee of the System, the investigator has continued affiliation by providing consulting services in two primary areas, strategic plan development and board relations. Strategic plan development included working at both the system and regional hospital levels to facilitate and integrate organizational plans. Work in connection with board relations included coordination of annual board retreats.

The relationships the investigator has created with System healthcare executives, administrators, and board members presented a unique opportunity to conduct ethnographic fieldwork.

Researcher Subjectivity

Qualitative research involves the studied use and collection of a variety of empirical materials that describe routine and problematic moments and meanings in

individuals' lives. The multiple methodologies of qualitative research may be viewed as a bricolage, and the researcher as bricoleur (Nelson, Treichler & Grossberg, 1992.) A bricoleur is defined by Levi-Strauss as a "Jack of all trades or a kind of professional do-it-yourself person", who produces a close-knit set of practices that provide solutions to a problem in a concrete situation (1966, p. 17).

Denzin and Lincoln (1998) suggest that the researcher, as bricoleur, is adept at performing a large number of diverse tasks, ranging from interviewing to observing, to interpreting personal and historical documents, to intensive self reflection and introspection. The bricoleur understands that research is an interactive process shaped by his or her personal history, biography, gender, social class, race, and ethnicity, and those of the people in the setting. The bricoleur knows that science is powerful and that all research findings have political implications. The bricoleur also knows that all researchers tell stories about the worlds they have studied. These stories are accounts couched and framed within specific storytelling paradigms.

The product of the bricoleur's labor is a complex creation that reflects the researcher's images, understandings, and interpretations of the phenomenon under analysis.

The investigator of this study views self as a bricoleur. The investigator understands and accepts that personal background and values have shaped this study. The investigator, as bricoleur, has contributed on the positive side to the strengths of study findings and conclusions and, on the negative side, to their subjectivity.

As a seasoned healthcare executive, the investigator knows and understands the complex nature of today's healthcare environment. The investigator is familiar with

healthcare language and terminology, and is conversant with healthcare processes and procedures. Working with senior healthcare executives has enabled the investigator to become conversant in healthcare issues and trends, ethical healthcare debates and healthcare politics. The investigator understands the corporate healthcare world, and is familiar with corporate bureaucracy and politics. The investigator had established working relationships with the majority of those involved in the study. This background, skills, and knowledge assisted the investigator to interpret the data and events that make up this case study and to draw conclusions.

A goal of the study was to explore and understand the processes used by regional hospital boards in representing the healthcare needs of those living in the community. Of primary interest to the investigator was whether community healthcare would be affected by integrated delivery system affiliation. Also of concern were topics such as the impact of affiliation with an organized delivery system on regional hospitals, governance ramifications to system development, the nature of board role and responsibility changes, and the need for board development.

The investigator sought to create an environment that would allow research data to be gathered as naturally as possible. Although viewed as a System executive by most study participants, the investigator attempted to use personal knowledge of the world of the regional hospital to minimize being seen as purely a System person, build rapport and encourage participants to speak candidly of the challenges they faced.

The perspectives of others interpreting study data and conclusions may vary. The investigator acknowledges that the personal position with the System, familiarity with the study issues and relationships with study participants will have influenced

study conclusions. While researcher subjectivity is a natural limitation of any qualitative study, the investigator has made every effort to ensure study design minimizes bias.

Study Design

According to Wax (1980), "the task of the fieldworker is to enter into the matrix of meanings of the researched, to participate in their system of organized activities, and to feel subject to their code of moral regulation" (pp. 272-273).

The case study method is a form of field research. As field research studies people acting in the natural courses of their daily lives, practitioners of the case study method attempt to understand the meanings that activities observed in these settings have for those engaged in them (Emerson, 1983).

An integrated delivery system is a regional health care network or system providing a broad range of services to a defined patient population within a certain geographical area. Integrated healthcare systems have emerged as a new model for delivery of care. Effective governance models for integrated delivery systems are viewed as being in the formative stages. Toomey and Toomey (1993) saw governance as a complicated, sensitive, and complex element of management which, when exercised by individuals not thoroughly conversant with the intricacies of the healthcare business, can lead to a variety of organizational and operational tragedies. From a research perspective, the development of integrated delivery systems represents a new, complex, phenomenon, with little or no precedent in the healthcare industry.

Eisenhardt (1989) argues that in situations where little is known about a phenomenon or where current perspectives have little empirical substantiation, the case study methodology is particularly well suited. Little is known about the factors surrounding and influencing the development of integrated delivery systems and their effects on regional hospitals and the communities they serve. In addition, to date, empirical research on integrated delivery systems is in its infancy. The case study method was selected for the study as it allowed the investigator to address the development of this new healthcare governance model, the integrated delivery system, from a broader range of attitudinal, historical and observational perspectives than would be possible in other forms of research.

The investigator's knowledge of healthcare and insider familiarity with the system being studied were factors contributing to the selection of the case study methodology as a research design. These factors allowed the investigator entry and access to people and data other researchers might have been denied. A unique opportunity to study a developing system was presented. Selection of the case study methodology was primarily supported by the suitability of the model to situations where a lack of knowledge exists and where there is a lack of existing empirical data. Alternate research designs would not have enabled the depth exploration of the factors surrounding integrated delivery system development that is inherent in the case study method.

Three separate research approaches were utilized in the case study: questionnaires, in-depth interviews, and review of historical data. Triangulation of data from these research sources was used to minimize the likelihood of misinterpretation

and to clarify meaning (Denzin & Lincoln, 1998). Triangulation was also used as a methodology seeking consistency of findings across independent measures.

Development of the Case Study

The procedures followed the stages in the case study methodology outlined by Eisenhardt (1989). Pre-fieldwork stages included the establishment of research questions, the selection of cases, and instrument and protocol development.

Research Questions

Four questions were established as the focus for the study. Each question served as a focal point for issues to be raised and information to be sought in completing the case study. In keeping with the purpose of the study, the questions explore the governance practices used by regional hospital board members in advocating the healthcare needs of local communities.

The study responded to the following research questions:

Research Question #1: What do regional board members understand about their roles as community representatives?

Research Question #2: How do regional board members identify the healthcare needs of their local communities?

Research Question #3: How do regional board members apply the knowledge they acquire about community health needs?

Research Question #4: How do healthcare system board members identify the healthcare needs of their regional hospital communities?

Key constructs to be explored during the study have been identified as board responsibilities, board relationships, board accountability and board development. A construct is a nonobservable trait which explains behavior (Gay, 1992).

Case Selection

The unit of analysis in the study was regional hospital boards operating within an integrated healthcare delivery setting.

As the purpose of the study was to describe the governance practices of regional boards in advocating the health care needs of their local communities within an integrated delivery system, selection of regional hospitals was made based on the composition of the integrated delivery system.

An integrated delivery system in the southwest was selected based on the ability of the investigator to acquire access to the system through contacts with a former employer, the stage of its maturity as an integrated system and the composition of regional hospitals. The selected system was comprised of 23 separate corporate entities, of which eight were regional hospital facilities. The facilities were spread throughout the eastern portion of the state and ranged in bed size from 25 beds to 150 beds. The healthcare system was in the early stages of integration, having recently implemented a new governance process in place based on integrating system and community representation.

The investigator's former employment relationship with the system was important in case selection. First, the intensely competitive climate within healthcare made it doubtful that permission to study the system would have been granted to an outsider. Second, healthcare systems often behave as if they are closed systems,

preferring to keep their processes private. Last, the prior establishment of a trusting relationship was important in being granted access to key stakeholders, such as board members. Initial contact was made with the system chief executive officer during Fall, 1997, with permission to conduct the study granted shortly thereafter.

Instrument and Protocol Development

The study incorporated several data collection methods. The first data collection method was a survey by questionnaire. A questionnaire is a written and disseminated effort to acquire information from sources (Rossett, 1987). In the study, a questionnaire was forwarded to regional board members and regional hospital administrators..

According to Rossett (1987), an effective questionnaire has a clear purpose and consists of appropriate, well-worded questions. It has been pilot tested before distribution, and refined in order to ensure the understanding of the questions and the ease of completion. Item development for the questionnaire was accomplished through a literature review and discussions with an expert panel.

A review of the literature yielded insights into questions about board roles and responsibilities in general, but was of limited value in identifying factors related to governance transition.

Discussions with the expert panel provided background information concerning integrated delivery system development and the surrounding factors. The panel consisted of four individuals, a national healthcare planning consultant, a regional healthcare executive specializing in system development, a regional healthcare executive responsible for regional hospital operations, and a regional board chair of a

system not participating in the study. Two panel members were employees of the system under study, two were not. None of the expert panel members were part of the study population. The panel provided insights into regional hospital governance and community representation within an integrated delivery setting. The role of governance and board member involvement in community representation were specifically discussed. The expert panel discussion was audiotape recorded with participant permission. The audiotape was transcribed in order to verify the accuracy of written notes. Information provided by the panel served as the basis for item development on the questionnaire.

The draft questionnaire was pilot tested in two separate ways. First, feedback was sought from several organization development professionals familiar with the development and administration of surveys. Second, the questionnaire was distributed to several regional board members not participating in the study. Feedback was then incorporated into the final questionnaire.

The questionnaire was distributed by mail to board members and administrators of the eight regional hospitals in the study. A total of 49 questionnaires were distributed. The population included 41 board members and 7 administrators. A cover letter was enclosed which stated the purpose of the questionnaire, the reasons for responding, directions about how and when to respond, and the benefits of the research, as well as thanking the respondents for participating.

A second data collection method was survey by indepth interview. Kerlinger (1973) states that the interview is ". . . probably man's oldest and most often used device for obtaining information" (pp. 479-480). A semi-structured interview format

was employed in the study in order to enable response comparisons, as well as to permit the inclusion of additional questions and answers.

Guidelines and criteria for writing interview questions were reviewed (Gay, 1992; Kerlinger, 1973 & Rossett, 1987). Kerlinger (1973) suggests that the following criteria be utilized when writing questions for the interview outline. These criteria were utilized in developing the interview outline for the study:

1. Is the question related to the research problem and the research objectives?
2. Is the type of question right and appropriate?
3. Is the item clear and unambiguous?
4. Is the question a leading question?
5. Does the question demand knowledge and information that the respondent does not have?
6. Does the question demand personal or delicate material that the respondent may resist?
7. Is the question loaded with social desirability? (Kerlinger, 1973, p. 51)

The draft interview schedule was pilot tested in two ways. First, feedback on the interview questions was sought from organization development professionals familiar with the interview process. Second, three mock interviews were conducted with an organization development professional, a healthcare executive and a regional board member. None of these individuals participated in the study. Feedback on both the structure and content of the interview schedule was incorporated into the final instrument.

Seventeen interviews were conducted. Candidates included eight regional board members, four regional board chairs, four regional hospital administrators, and the liaison board chair. One board member was selected from each regional hospital. Candidates were chosen based on their tenure as board members and their level of

understanding of integrated delivery system development as revealed by questionnaire responses.

Ideal candidates were articulate, experienced board members. Board chairs and administrators were also selected based on tenure in their respective positions and the extent of their experience with integrated delivery system development.

The purpose of the interviews was to explore the effects of becoming part of an integrated delivery system on regional hospital governance. The interviews also provided an opportunity to more thoroughly investigate issues arising through questionnaire responses. Interview questions were designed to elicit information concerning the ways in which boards responded to community health needs.

The third data collection approach was a review of historical data pertinent to the research questions. The agenda and minutes of regional hospital board meetings for each facility for the prior sixteen months were reviewed. Minutes of meetings are considered to be primary data sources. They are written reports completed by an individual physically present at the event (Gay, 1992). The goal of this segment of the research was to describe those aspects of community health care issues being raised for consideration at the board level.

Implementation of the Case Study

This section describes how the case study was implemented. It is based on Eisenhardt's (1989) guidelines for entering the field.

Entering the Field

A list of board members and administrators to be interviewed was developed. Potential subjects were selected based on their tenure and experience. Initial contact was made by telephone. The nature of the study was explained and if they agreed to participate an interview appointment was arranged. All interviews were conducted in the subject's respective regional hospital for convenience of the participant and to observe the subject in their natural setting. Subjects had to agree to dedicate at least an hour of uninterrupted time for the interview. Before the interview began each subject was asked to review and sign a standard human subjects consent form. With permission of the subjects, audio recordings of the interviews were made to assist in verifying the accuracy of interviewer notes. The identity of the persons interviewed is known only to the interviewer, and no true names were used in reporting the findings of the study.

Notes taken during board member and administrator interviews constitute a primary data source. Information in the notes included relevant demographic characteristics, the subject's responses to open-ended questions, observations of the subject's environment, and observations of non-verbal behaviors.

The interviews were initially guided by a set of open-ended questions which are outlined in the Appendix A. Changes to this protocol occurred as new questions and issues emerged during the interview or as a result of the need to clarify or augment subject survey responses.

During the course of the study, field notes were maintained to serve as a continuous record of what was happening in the research. Notes included such things as observations made during site visits and interview discussions, perceptions

concerning participant behavior and feelings, and researcher thoughts about issues and ideas raised during the study.

Analysis, Verification and Synthesis of the Case Study

This section presents the analysis, verification, and synthesis stage of the case study. Eisenhardt (1989) outlines the following steps, which include analyzing within case data, shaping hypotheses, enfolding literature, and reaching closure, as components of this stage of case study methodology.

Analyzing Within Case Data

A coding system for organizing the data was developed prior to data collection. Coding is used in order to record questionnaire responses, interview responses, and other respondent information in a systematic manner for the purposes of analysis (Gay, 1992). Coding also facilitates examination of the data within specified categories.

A construct is a non-observable trait, such as intelligence, which explains behavior (Gay, 1992). The key constructs, which formed the basis for the coding system, were board responsibilities, board relationships, board accountability, and board development. Key constructs were identified and selected based on literature reviews on the governance of integrated delivery systems and feedback from the expert panel on factors contributing to effective governance practices. Questionnaire responses, interview responses, and data from archival records were coded according to these key

constructs. Separate sets of coded data were created for each of the eight regional hospitals.

Two data analysis methods were utilized to analyze the interview transcripts. Initially, the interview transcripts were analyzed using an immersion/crystallization approach. Outlined by Miller and Crabtree (1992), this qualitative analytic approach has three key steps: developing an organizing system, segmenting the data, and making connections. Following an extended period of intuition- rich immersion within the text of the transcripts, the investigator served as the editor of the organizing system. The organizing system consisted of the key constructs: board responsibilities, board relationships, board accountability and board development. By reflecting on the text of the transcripts, connections were crystallized and verified against the organizing system.

Second, interview transcripts were loaded into a text management program called Ethnograph, version 5.0 This software contains features designed to facilitate text-based qualitative research. Features include the ability to create and manage data files, the ability to code data files, to exhibit codes and code definitions, the ability to write memos and link them to codes and the ability to display search output in summary reports.

Content analysis of the agenda and minutes of regional hospital board meetings was conducted. Data were reviewed and categorized again using the key constructs of board responsibilities, board relationships, board accountability and board development as an organizing system. Separate data sets were kept for each regional hospital for comparison purposes. Agenda were reviewed and format changes noted. Key governance process practices were identified Information was logged about the

number of community health issues itemized for discussion. Minutes were analyzed to identify governance practices and community health issues. This analysis examined the governance processes used, the apparent quality of the discussion and related decisionmaking, and quantity of community health issues raised..

Shaping Hypotheses

Building on the preliminary identification of case patterns, tentative themes, concepts, and relationships were outlined. This emergent framework was then outlined. Tables were constructed in order to summarize and tabulate the evidence underlying the constructs.

Enfolding Literature

A review of the literature was conducted based on the framework emerging from the shaping hypotheses stage of the study. A comparison was made of the emergent framework with the extant literature to identify research supporting or not supporting early study conclusions.

Reaching Closure

Eisenhardt (1989) cites two issues as important in reaching closure. She describes the decisions to stop adding cases and to stop iterating between theory and data. Eisenhardt believes that researchers should ideally stop adding cases when theoretical saturation is reached. This is the point at which learning is minimal because the researchers are observing phenomena seen before (Glaser & Strauss, 1967).

Iteration between theory and data stops when the incremental improvement to theory is determined to be minimal.

As a single integrated healthcare delivery system was selected for the case study, a decision concerning the number of cases to be included in the study was unnecessary. Emergent concepts from the case study were repeatedly tested against the study data until saturation was reached and further progress toward study conclusions was considered to be minimal.

Case Study Limitations

Case researchers seek out what is common and what is particular about a case, but the end result often presents something unique (Stouffer, 1941). According to Denzin and Lincoln (1998), some social scientists have written about case study as if investigation of a particular case were not as important as studies to obtain generalizations pertaining to a population of cases. The authors report that while case study is seen as exploration leading up to generalization, generalization should not be emphasized in all research. Case study can be seen as a small step toward generalization (Campbell, 1975), but investigators should guard against the researcher bias that can occur when the commitment to generalization or to theory creation runs so strong that attention is drawn away from understanding the case itself (Denzin & Lincoln, 1998). Each case study is an empirical study of the factors and the relationships between the factors that have resulted in the current status. Because investigators seek to understand *why*, not just *what*, has occurred, each case offers the potential to further understanding of the phenomenon being studied and its context.

Chapter Summary

Chapter III presented an overview of the study design and method. Selection of the case study method was outlined. Procedures to develop and implement the case study were reviewed. The findings are presented in Chapter IV. Chapter V includes a summary of the study conclusions, recommendations for further research, recommendations for future practice, and the implications of the study.

CHAPTER IV

FINDINGS

The purpose of this study was to describe the governance practices of regional hospital boards of an integrated healthcare delivery system in advocating the healthcare needs of their local communities. In order to accomplish that goal a case study utilizing three separate research approaches was conducted. An integrated delivery system in the Southwest was selected for the case study. The eight regional hospitals within the System were the primary focus of the study. First, board members and administrators for the regional hospitals were surveyed by questionnaire. Next, in-depth interviews were conducted with selected board members, board chairs, administrators and the chair of the regional hospital board. Finally, a review of historical data consisting of board agenda and minutes was completed. Questions asked throughout the research process sought to disclose the role of regional boards in functioning as community representatives, explore the potential of community representation as a vehicle for enhanced system integration, and investigate governance and board strategies to enhance community representation. The results of an analysis of the data gathered during the case study constitute the findings of the study.

This chapter presents these findings in nine sections. Section One presents an overview of the regional hospitals in the study and describes the characteristics of participating board members and administrators. Section Two presents governance

structures and processes in place at the regional hospitals. Section Three presents board responsibilities as viewed by study participants. Section Four presents board relationships with the community, management and fellow board members. Section Five presents perspectives on board accountability. Section Six presents content analysis of board agenda and minutes. Section Seven presents the rationale, advantages and disadvantages for regional hospitals joining an integrated delivery system. Section Eight presents the future governance challenges for regional hospital boards. Section Nine presents an overview of the purpose and function of the regional Liaison Board.

Section One: Overview of the Data

The data consisted of responses to the survey by questionnaire forwarded to the board chairs, board members and administrators of the regional hospitals, transcripts and notes taken by the researcher during interviews with selected board chairs, board members, administrators and the chair of the regional liaison board, and notes generated by the researcher as a result of content analysis of regional hospital board agenda and minutes.

A total of 56 surveys were mailed out. Fifty-one surveys were completed and returned. Seven surveys were excluded as they were all from the Chief Executive Officer of the System, who was a board member on seven out of the eight regional hospital boards. Of the 49 remaining potential responses, five board member surveys were not returned. All eight regional hospital administrators completed and returned the survey. Seven of the eight board chairs responded. Analysis was completed on 44 questionnaires, for an overall response rate of 89.79%.

Seventeen in-depth interviews were conducted. Each interview lasted approximately one and one-half hours and was conducted either in the subject's office or at the regional hospital with which they were affiliated. In addition to quotations and summaries of answers to the researcher's questions, each set of notes included basic demographic data about the subject of the interview and observations concerning the subject's non-verbal responses.

Agenda and board minutes were received from seven of the eight participating regional hospitals. Data covering a reporting period of approximately sixteen months, from January, 1998 through April, 1999, were analyzed.

Regional Hospital Demographics

Data on the regional hospitals were obtained from staff of the integrated delivery system participating in the case study. Background information was routinely collected on all regional facilities and surrounding communities as part of the due diligence process prior to their joining the System. This information was subsequently updated annually for operational and marketing purposes.

All eight hospitals were located in a state in the Southwest. They were considerably geographically spread throughout the state, ranging from 30 miles to 165 miles away from the major metropolitan city in which the System headquarters was based. Categorizing the hospitals by bed-size, the smallest hospital in the study had 20 hospital beds and the largest had 99 beds. Five of the hospitals in the study had less than 50 beds and three had more than 50 beds. Services provided by the healthcare facilities differed based on factors such as hospital size, physician staffing and community need. All eight facilities provided in-patient and emergency room services.

The communities in which the hospitals were located varied in population size from 1,950 residents to 10,000 residents. Some communities were experiencing growth, with factors such as city out-migration and industry expansion cited, others were losing population for reasons such as industry decline or the desire for city life. The majority of the communities supported both farming and light industry. Larger communities often supported medium-sized companies of 100 to 150 employees, with the occasional large employer with 300+ employees. Small communities frequently had small companies of 25 to 50 employees. In each case the hospital was a major employer in that community.

Subject Demographics

Gender and Age: Of the 36 board members, 31 were male and five were female. Their ages ranged from 45 to 75 years, with the largest number of subjects, 26, being in their 40's or 50's.

All eight regional hospital administrators were male. Their ages ranged from 44 years to 64 years, with the majority falling in the 47 and 55 age bracket.

Residence: Two-thirds of the board members, 24, lived in the region served by the hospital, one-third, 12, did not. Only one of the 24 has lived in the region less than one year, the remainder have lived in the region for more than five years, with the majority, 16, having lived in the community for fifteen years or more.

All but one of the regional administrators lived in the community served by the hospital. Two administrators have lived in the community for two to three years, the

remaining six have lived in the region for five years or more. One administrator was born in the community in 1947.

Tenure: Board members have held their position at the hospital for periods ranging from six months to 25 years. The majority, 22, have been board members for two years or less. The remaining fourteen board members have held their positions between three and 25 years, with eight having tenure of nine years or more.

Administrative tenure ranged from six months to sixteen years. Two administrators have held their positions for six months, two for two years, one for three and one-half years, one for seven years and the remaining two for 14 and 16 years, respectively.

Section Two: Governance

Prior to joining the System in the study, seven of the eight regional hospitals were independent, one was part of a competing healthcare system. Several of the hospitals had, and continued to maintain, relationships with their local city. In some instances, the city had ownership of the hospital, in others the hospital was the recipient of tax dollars from the city. In each case regional hospital affiliation with the System necessitated governance changes. Board and management discussions concerning the regional hospital's desire to become part of the System were followed by the negotiation and signing of operating agreements detailing the new arrangement. Shortly thereafter bylaw changes would have been enacted and new boards formed. Several questions in the survey and the interview attempted to determine board member and

administrator understanding of the nature and ramifications of these governance changes.

Governing Board

A initial governance question in the survey asked whether the hospital had a legally constituted governing board which bore ultimate responsibility for the affairs of the organization. Twenty-five board members replied that it did, and 11 said that it did not. In contrast, seven administrators replied that it did, with one saying it did not.

When asked whether the board was an advisory board that provided advice, counsel or recommendations to the management or board of a system, four board members responded it was, eight saying it was not such an advisory board. Two administrators responded that it was an advisory board to the System.

The question "to which higher board or authority is the hospital board legally responsible?" brought widely differing responses from board members and administrators. Twenty-four board members responded that the regional hospital board was legally responsible to the board or management of a health care system and seven said it was legally responsible to a unit of state, county or local government.

Each interview began with a series of governance questions. When asked to explain the new governance relationship, one of the most concise responses was provided by a board member who was a lawyer by profession and who had probably assisted in drafting the new legal structure. He explained as follows:

> *Let me start at the beginning. The hospital building and grounds and related buildings are owned by the City. The City leases that property to the Hospital Foundation, which is a non-profit corporation.*

In turn the Foundation leases the hospital for management and operation to the System. The System is the parent of the hospital board. The actual management of the hospital is _____ Memorial Hospital Inc., and it is a fully owned subsidiary of the System.

Another board member saw it this way:

Our hospital board, I think, is accountable primarily to the System and then indirectly accountable to the city as well because the hospital building itself is still city-owned and is leased to the System. Through the lease agreement is an indirect way that we're responsible to the city as well.

One board member saw the hospital as responsible to the County Commissioners. Another explained that the board that existed before the affiliation with the System still functioned and that it reported to the _____ Public Works Authority. She outlined that she and one other board member sat on both the old board and the new board.

In one instance, the board member explained that the reporting relationship was actually to two boards.

It's very unusual. There are actually two boards. This hospital is not tax supported. There are no bond issues, no tax base for it. It's a totally freestanding, self-supporting 501 C3 hospital. There are actually three hundred people in the community who make up a Corporate Board. Then there is a _____ County General Hospital Board, made up of three representatives of the three hundred corporate board members and three members from the System.

Another board member viewed the reporting relationship this way:

Well, ultimately, I guess, to the System based on what the relationship is between those the System and the Board. But in actuality we are accountable to ourselves. We make decisions and then just notify the System what we have decided.

Hospital administrators offered more detailed information and were more knowledgeable of the background intricacies of the reporting relationships.

We have worked with the System on an unofficial basis for about ten

> *years. In 1995, the City Commission, who acted as the _____ Hospital Authority Board at that time, made a decision that they needed to be integrated with a larger healthcare system. Because of the relationship they chose to enter into an operating agreement with the System without interviewing any other prospects. In July, 1995, the _____ Hospital Authority Board signed an operating agreement with the System. The new Hospital board is made up of three local members and three System members and is accountable to the Healthcare System Board.*

Another administrator explained the nature of his governance relationships this way:

> *The Hospital Authority is a public Trust that operates as a subdivision of the State. It operates with the city of _____ as it beneficiary. The Hospital Authority owns the hospital. The City Council appoints Board members based upon the recommendations of the Hospital Authority, plus the City has on ex-officio member on the Hospital Authority. The Hospital Authority has an operating agreement with the System.*

System Committee Representation

Board member and administrator understanding of governance relationships was further complicated because, in addition to board formation details and new reporting structures, board members were occasionally asked to serve on System boards and committees. System executives reported that the goal of this governance linking mechanism was to enhance communication between local and System boards, to serve as local board member development, and to serve as a reporting structure whereby the System could learn of local community issues and concerns.

Board members and administrators appeared to differ on their understanding of those board members who had been asked to serve on System boards and committees. Board members from the same hospital reported widely disparate numbers. Information was provided from one hospital indicating that three board members believed one

person served, whereas one person said three were representatives. Another hospital reported that one board member thought one person served, two thought three did and one board member thought four people served on System boards. One board member confessed to not knowing by responding with a question mark. Two board members at one hospital reported that they believed all their board members served on System boards or committees, whereas their fellow board members believed one served or three served.

Administrators provided the following information on how many of their board members served on System boards or committees: Hospital A reported one board member served, Hospital B reported two served, Hospital C reported one, Hospital D reported three board members were representatives and Hospitals E, F, G and H reported that none of their board members served on any System boards or committees.

Board Composition

Gender: The following table outlines the actual composition of each regional hospital board according to System records:

Hospital	Males	Females
Hospital A	4	1
Hospital B	5	1
Hospital C	6	1
Hospital D	6	
Hospital E	4	2
Hospital F	5	2
Hospital G	6	
Hospital H	5	

Tenure: The following table outlines the tenure of those board members responding to the survey:

Hospital	Tenure
Hospital A	1 year, 6 years, 1 year, 1.5years
Hospital B	9 years, 1 year, 2 years, 2 years, 2 years
Hospital C	1 year, 1 year, 2 years, 4 years
Hospital D	10 years, 1 year, 1 year, 6 years, 2 years
Hospital E	1 year, 1 year, 6 months
Hospital F	12 years, 1 year, 1 year, 1.5 years, 10 years, 10 years
Hospital G	1 year, 2 years, 12 years, 15 years, 25 years
Hospital H	1 year, 3 years, 4 years

Voting: All board members responding to the survey, with the exception of one, reported that their position was a voting position.

Board Background and Experience

Political Influence: Fourteen board members described themselves as politically influential within their local communities, nineteen felt they were not politically influential. Two board members appeared unsure, one putting a question mark, the second reporting "Beats me!".

Involved in Community Affairs: Twenty-four board members reported that they would describe themselves as involved in community or civic affairs. Twelve did not see themselves as so involved.

Financial Skills: Thirty-one board members would describe themselves as having financial skills, with only three reporting they did not. One board member indicated they were "somewhat" financially skilled.

Business Skills: Thirty board members would describe themselves as a business person, six would not.

Community Leader: Twenty-one board members reported that they would describe themselves as a community leader, with fifteen indicating they did not see themselves as community leaders.

Board Experience: When asked whether or not they had previous board experience, twenty-eight board members reported they had served on other boards, eight reported this was their first board experience.

Professional Title: Board members were asked to provide their professional job title in the survey. While the majority, 22, were local business executives or managers, other board members included a pastor, school secretary, store owner, medical director and physician. Business titles included a bank president, attorney, retired manager, president/CEO, chairman, vice-president, senior vice-president, executive vice-president, chief information officer and chief financial officer. Four board members indicated they were retired.

One of the early questions in the interviews with board chairs and board members sought to uncover how the subject became a board member at their regional hospital. One of the board members described his experience as follows:

> *I've only been on the hospital board for about a year and a half. Prior to that I was on the Hospital Foundation Board. Oh, I've been on that board forever – since the sixties probably. My father was one of the founding members of the Memorial Foundation in the fifties, early fifties. And he died, I think, in nineteen sixty-two and so after that I just kind of naturally fell into it and I have been very concerned with the hospital and with the welfare of the hospital since that time.*

Another board member was appointed to the board of his regional hospital as a result of having served on the County Commission.

> *I think I've been on the hospital board for twelve, maybe fourteen years. We are appointed by the County Commissioner in our district. I think that probably the hospital administrator called me and asked if I would be interested in serving as a trustee on the hospital authority board. And I told him I would be. So he relayed that to the County Commissioner and it was done.*

The local city mayor was responsible for soliciting the candidacy of one of the board members to the regional hospital board.

> *I got to be a board member here because I was pastor of the United Methodist Church for two years. The mayor of the town was a sometimes member of the church and I went to talk to him about a totally unrelated matter. I guess that jogged his memory or something because he came to me shortly after that and asked if I would be on the board.*

A prominent lady in one community, known for her generous financial support of local endeavors, described her decision to serve on the regional hospital board as follows:

> *Well, I have been board chair for a year now. I was asked to serve on the board by the System shortly after the lease agreement was signed. Before that I had served as a board member for two years. I am trying to think whom asked me to serve on the board. I think a board member asked me at a hospital Foundation dinner one year if I would serve on the board. Weakness prompted me to say yes. Not knowing how to say no. (laugh)*

Some hospitals seek to have physician representation on their board. One physician board member interviewed described his role on the board:

> *I've served on the Board for about a year. I view my role as primarily giving input with regard to patient care and with regard to what a good medical practice is. . . . . having a physician on the board is very important because it is difficult for a layperson, even for someone who has been in the medical field for a long time, to get a physician's perspective.*

Most board members interviewed appeared to have been appointed to the regional hospital board after it became part of the System for one of two reasons: either they had served on the board prior to the hospital joining the System or they were a well-known, and apparently well-respected community member.

Section Three: Board Responsibilities

Data on subject perceptions concerning board responsibilities were sought both in the survey and during in-depth interviews.

One entire section on the survey addressed board responsibilities. Survey respondents were asked to indicate how important they believed it was for their board to change or improve performance concerning fourteen areas of board responsibility. Subjects were asked to indicate whether they believed the item was extremely important, rather important, somewhat important or not important.

Policies: Twenty board members believed it was extremely important to change or improve performance concerning establishing the policies of the hospital in relation to community needs. Fourteen viewed it as relatively important and two board members saw it as slightly important.

Equipment and Facilities: Providing equipment and facilities consistent with community needs was viewed as extremely important by twenty-five board members. Nine saw it as relatively important, two as slightly important.

Professional Standards: Indicative of their responsibility to the community, thirty-one board members considered it extremely important to ensure that proper professional standards were maintained in the care of the sick.

Physician Interests: The importance of the medical staff to a regional hospital revealed itself when nineteen board members reported that it was extremely important to coordinate physician interests with administrative, financial and community needs. In support, fifteen board members viewed it as relatively important. Only two reported it as slightly important.

Financial Viability: Strongest board member support in this section was demonstrated in regard to financial viability. Thirty-three board members reported that providing for the hospital's long-term financial viability was extremely important. Three board members said it was relatively important, two citing it as slightly important.

Community Resources: The need to gain access to key resources from the community was viewed with mixed support. Seventeen board members reported it to be extremely important, fourteen saw it as relatively important, and three considered it slightly important. Two board members did not see it as important at all.

Community Representation: Eighteen board members thought it extremely important to represent those served by the hospital, sixteen other board members agreed reporting community representation to be relatively important. Two board members believed it to be slightly important.

Resource to Management: Not seen as a strong responsibility by board members, serving as a resource to top management was seen as extremely important by nine board members, relatively important by twelve and only slightly important by fifteen board members.

Corporate Goals: Establishing corporate goals received the most diverse responses of any category. Twelve board members thought it extremely important, ten relatively important, ten slightly important and four board members reported it not important.

Plans and Programs: While establishing corporate goals received mixed support, board member support for the development and implementation of plans and programs to accomplish corporate goals was slightly stronger. Nine board members reported it to be extremely important, while twenty-two board members saw it as relatively important. Four board members believed it to be slightly important.

Qualified Medical Staff: Again supporting the importance of the medical staff, twenty-seven board members reported that it was extremely important to select and maintain a qualified medical staff. Eight board members believed it to be relatively important, one saw it as slightly important.

Well-informed Community: Sixteen board members reported that it was extremely important to ensure that the community was well-informed about the hospital's goals and performance. Eighteen board members believed it was relatively important, two saw it as slightly important.

Hospital Advocate: In another show of support for their responsibility to the community, twenty board members reported that it was extremely important for them to serve as advocates for the hospital, with fourteen board members indicating it was relatively important. One board member saw it as slightly important, another viewing it as not important.

Healthcare Trends: Sixteen board members reported that they believed it extremely important that they be informed about current healthcare trends. Seventeen board members indicated it was relatively important, with three viewing it as slightly important.

Regional hospital administrators reported that they saw nine board responsibilities as either extremely important or relatively important. The remaining five received slightly more mixed responses. Only one administrator viewed one board responsibility as not important.

Seen as important by the administrators were policy establishment, the provision of equipment and facilities, establishing proper professional standards, physician interests, hospital financial viability, representing those served by the hospital, ensuring that the community is well-informed, serving as an advocate for the hospital, and being informed about current healthcare trends.

Mixed responses were reported with regard to board responsibility to gain access to key resources from the community, serving as a resource to top management, establishing corporate goals, ensuring that plans and programs are developed and implemented to accomplish corporate goals, and selecting and maintaining a qualified medical staff. The only board responsibility seen as not important by one administrator was ensuring that plans and programs are developed to accomplish corporate goals.

Two interview questions addressed board responsibilities. Selected as important to understanding board meeting processes and board member views concerning the dynamic nature of today's healthcare environment, the questions specifically addressed

board agenda development and board member efforts to stay current on healthcare issues.

As might be expected, administrators understood the most about how the agenda for a board meeting was developed, with board chairs also demonstrating a high awareness. Board members appeared to have some understanding, with a few board members largely in the dark.

One board member confessed his lack of knowledge when asked how the agenda for his board meetings were developed.

> *No, I really don't know. The management does this and of course if board members have something that they want put on there why they can certainly call and I'm sure it would be done.*
>
> Have you ever done that?
>
> *No, I can't really remember doing that. Now I've brought some things up that were not strictly on the agenda because I'd think of something that ought to be addressed.*
>
> Another board member was also uncertain as to the process.
>
> *No, not really. Not in detail. We get a packet two to three days before Our board meeting each month. It includes an agenda and if I wanted To bring something up I'm sure that all I'd have to do is call and ask That it be included and it would be. I've not had a need to do so at this Point. And also at the conclusion of each meeting there is the freedom, The offer – does anyone else have anything he'd like to present. So That makes it very easy if there's something any board member wants To bring up to be included.*
>
> One board member reported that the agenda was a standard one.
>
> *It's a standard agenda of financial data. A pretty standard agenda.*

Some board members were more specific about how the agenda for their regional hospital board meeting were developed and how they would go about suggesting an item be added to the agenda.

The agenda is developed between the hospital administrator and the System. And then if we local board members have something that we want on the agenda, Father _____ is the chairman and he can add whatever he wants.

How would you add something to the agenda?

I would call Father _____ first and then he or I would call the Administrator to get it on the agenda. If it were some sort of local issue, I wouldn't want to go into it without Father _____ knowing what was coming.

Three of the four Board Chairs interviewed indicated that the hospital administrator assumed primary responsibility for agenda development. They appeared to be satisfied with this approach and reported feeling secure in the knowledge that any item they personally wanted on the agenda would be discussed.

The agenda for board meetings are developed by the administrator. Usually I receive it a day or two before the meeting. We talk about it over the telephone. If I wanted something on the agenda I'm sure I'd call the administrator and just tell him I'd like to discuss whatever it is.

The agenda are developed right here by the President of _____ Regional Hospital. I'm sure with information submitted by the System. And if I want something on the agenda of course I just call up and say I'd like to have it on the agenda but I don't develop the agenda.

The hospital administrator usually calls me and says "Is there anything you want to talk about?" and if not it's a pretty standard format. I get a copy of the agenda before the meeting. They ask for my approval before we go in. There have been a few instances where the Board maybe brought something up (at the meeting) *but it's been pretty rare, few and far between.*

One board chair was not pleased with the way the board agenda for his regional hospital were developed but had not felt strongly enough to complain.

I am not consulted. I think the hospital administrator confers with the System regional manager. I think they confer and kind of make an agenda.

Do you think you should be consulted?

Well, I would think that yeah.

Have you asked to be consulted?

I haven't really made a point of it. It hasn't been that urgent. And I think I could get things on the agenda but usually I'm so preoccupied with everything I really haven't given a whole lot of thought to it until I get the packet that afternoon.

The regional hospital administrators were very detailed in their descriptions of the process for board agenda development.

My board meetings are quarterly. I develop the agenda based upon operational and strategic issues that are growing apparent at that time and by what I call routine issues that are mandated by various sources. The routine issues would be Joint Commission type things such as personnel reporting, safety code reporting, quality improvement – those sort of things you see on every agenda. The strategic initiatives I coordinate with the regional vice-president. The local and tactical I coordinate through my local administrative staff. Prior to the board meeting I sit down with the Board Chairman and we go over the agenda to make sure that everything is in there that he feels appropriate. The Board Chairman has the authority to override the agenda or to modify the agenda as he wishes.

I do that. We take issues that have come up since the last meeting and include information on those in the agenda. We take requests that require board action to those meetings, approval for purchasing equipment of major significance, human resource issues, professional quality issues are reviewed. All these things are included as appropriate for the Board to review.

Essentially the agenda is developed by the administration office – which includes myself, the chief financial officer and the chief operating officer. Any corporate actions or resolutions that need to be approved by the local board come under the corporate section of the board agenda. If the Chairman of the Board has any issues, or if local board members do, then those are added to the agenda. Once the agenda for the meeting is developed it is sent over to the System. And if they want or need anything added as a result of issues or resolutions that need to be passed on a corporate level through this Board then these are added. Then the agenda is sent out to the board members along with the board packet.

A second interview question on board responsibilities addressed board member efforts to stay current on healthcare issues and trends. Responses ranged from those who didn't think they did stay current to those who relied on management to keep them informed.

We don't keep current very well.

I don't keep up with it mostly. I learn about it at board meetings and in conversations with the administrator of the hospital. It is far too complex even for professionals to keep up with. We non-professionals, volunteers, you really can't keep up with the complexities of that, I don't think. I don't have time to do it.

Basically through our administrator and the management company.

Well, mostly from management. We do get some literature from the System. Frankly, I don't have time to read much of it. Most of what I get comes from administration at board meetings and I don't pretend to understand very much of it either.

Several board members reported that they learned about many of the key issues from fellow board members, particularly those with System experience, and from various board workshops, seminars and retreats.

The two fellows on our board from the System often times share with us things that they have learned from their other involvement – the Balanced Budget Amendment, for example, and how it affects healthcare costs. That is helpful information to me.

I guess just being aware of the things that are going on and in my case I've learned a lot from other people that I've associated with at the meetings and seminars and training sessions. Other board members from other parts of the country and other parts of our state – many of whom are in rural settings with very similar problems. The exchange of ideas has been good for me. I feel like I've learned more from that than some of the courses.

I know that the System has retreats – I've gone to the retreats and to at least three different meetings where we talked about some of the issues.

Most board members recognized that they needed to be knowledgeable about healthcare issues and trends but some doubted that they possessed the time or the ability to fully comprehend such complex information.

> *You've got to know what the conditions are to know which way to fly the plane or steer the boat. You've got to live by what's coming down the pike or you can't survive. You've got to take the steps but you'd damn well better have the information.*

> *Just being honest, I think in all the years that I've been a trustee that the healthcare industry is very complicated and is continuously changing. And there are just a lot of things I don't think we have a real grasp on. And it's not anyone's fault. I think it's just as lay people we have limited exposure. There are just some things we are not going to understand. Reimbursements and regulations, those things are complex and they are changing constantly. I think we are all guilty of relying on the medical staff and administration. We need to be able to trust them that they're keeping us informed and that their recommendations are right.*

One board chair felt strongly that at his regional hospital they were not able to keep board members current on healthcare issues. He explained:

> *I don't think board members are current. I don't think our Board keeps current and I'll tell you why. I don't think they are given time to. I get those guys and if I keep them an hour and a half that means we've really accomplished a lot. I think they depend on the experts. I know most of the stuff that comes into my office is just trashed and I would suspect the same of the other people here. I get so much mail in my business anyway that after awhile it's just too much.*

Regional hospital administrators have a somewhat different perspective on the mechanisms whereby board members stay current on healthcare issues.

> *There's two primary ways. They get the newsletters and correspondence that I think all board members get through the System and state hospital association and then every month at our board meetings we have what we call the System Report where someone addresses the board members on issues that are more specific to this facility.*

> *We try to give them information and get them data on it. They are routinely part of the System mailing list for all the stuff that comes*

from the System. There are trustee and physician updates which take into account national issues and things like that. We go over them verbally.

We do it several ways. Quorum provides twice annual trustee programs on current issues. The System provides at least two annual continuing education or strategic planning sessions involving the trustees. As well as the fact the last section of our board packet is called Board Continuing Education. We usually take current topics and put those in the board packets. So for those who are not able to get to some of the meetings at least they're getting the information. Currently the Balanced Budget Act is the biggest thing affecting rural hospitals and we just put that as one section of the board agenda and packet and they have access to that information.

The reasons why administrators would go to such lengths to keep board members current was explained this way by one regional hospital administrator:

The more they know about the constraints that we suffer under, makes some difficult decisions easier for them, or understand without questioning some of the reasons you need to do something. They are more aware of the underlying issues that force you to make tough decisions.

Section Four: Board Relationships

The survey by questionnaire solicited data concerning three distinct sets of board relationships: community relationships, board-management relationships and board member relationships. The fourteen questions addressing community relationships sought to understand board member opinions of the hospital's representation of, and interaction with, the local community. Six questions explored board member relationships with hospital administration, with the final five questions in this part of the questionnaire designed to understand board member perceptions of relationships with their fellow board members.

Three interview questions sought to expand on survey responses by soliciting additional information on whether board members and hospital administrators thought it important that regional hospital boards be connected to their local communities, how boards became aware of community health issues and how such community health issues are addressed at board meetings.

Community Relationships

Represent Opinions: When asked whether the hospital reasonably represented the influential opinions of the community, thirteen board members responded that it almost always did, twenty-two said it usually did and one replied that it occasionally did. One board member acknowledged not knowing. The majority of administrators, six, reported that the hospital usually represented the opinions of the community.

Services to Uninsured: Twenty one board members responded that the hospital almost always provided services to the uninsured, with fifteen board members indicating the hospital usually did. Seven administrators reported that the hospital almost always provided services to the uninsured.

Long Range Health Needs: Twenty-three board members perceived that the hospital was almost always or usually fulfilling the community's long range health needs. Three believed it occasionally did. Administrator responses supported board member perceptions.

Understand Managed Care: Board members did not think the hospital was educating the community to understand managed care. Twenty-eight board members believed it occasionally or almost never did. Seven felt it usually did, with only one

board member reporting it almost always did. Administrators appeared to think the hospital was doing a better job of managed care education, with six responding that it usually or almost always did.

Educational Programs: Thirty-one board members reported that the hospital occasionally or usually offered educational programs to the community consistent with community health needs. Administrators agreed with that assessment, with seven of the eight administrators responding in the same categories.

Health Needs: Three questions asked about how the hospital learned about community health needs. Specifically, did it learn about local healthcare needs from healthcare professionals, its board or community organizations.

The majority of board members thought such information came to the hospital either through healthcare professionals or community organizations. Board members did not see themselves as strong providers of information on community health needs. Thirty-four board members reported healthcare professionals supplied this knowledge, while thirty-one responded that community organizations were a likely source. Eleven board members said board members almost never provided such information, with seventeen reporting the board occasionally did. Administrative responses supported board member perceptions.

Community Surveys: Board members were unclear about whether or not the hospital conducted community surveys on a regular basis. Several board members responded with question marks or marked unknown. Of those that did respond, eight reported that the hospital almost never conducted community surveys to address needs, with thirteen saying they were almost never conducted on a regular basis. Eighteen

thought surveys were occasionally conducted, with sixteen saying not on a regular basis. One hospital administrator responded that his hospital almost always conducted community surveys on a regular basis, two responded that they usually did. The remaining six administrators indicated community surveys were occasionally conducted.

Health Needs Not Addressed: Administrators were unanimous in saying that there were occasionally community health needs, which the hospital had not addressed. Board members viewed the situation more positively, with eight saying there were almost never any community health issues, which were not addressed. Twenty-four board members were not so definite, reporting that usually or occasionally there were health issues that were not addressed.

Solutions for Community Health Problems: This question also received mixed responses. The majority of board members, thirty-two, reported that they almost always, usually or occasionally devoted their personal time to developing solutions for community health problems. Five reported that they never did.

Raise Money for Worthy Programs: Eleven board members responded that they almost never helped the hospital raise money for worthy programs, twenty-four said they sometimes did.

Serve as an Advocate: Most board members, thirty one, were willing to serve as an advocate for the hospital in helping the community understand the healthcare changes affecting regional hospitals. All but five board members reported that they almost always, usually or occasionally served as advocates. Five said they almost never did.

Few interview questions were responded to as emotionally as the question soliciting board opinion as to whether or not it was important for regional hospitals to be connected to their local communities. Board members felt strongly that it was crucial.

> *Oh, it's extremely important. The hospital does not exist to serve the System, it exists to serve the community.*
>
> *Oh, that seems essential to me. From my point of view it's all service and we're here for service. If you don't keep an ear to the ground of what the public wants or demands then you're not providing much of a service. What you want to try to do is to listen to what people want and if you can provide it, provide it.*
>
> *I think it is extremely important to be connected to the community. I see the board as a bridge between the hospital and the community.*
>
> *Oh, I think it definitely is. As hospital trustees we're charged to oversee the counties' interests and provide healthcare for the citizens of the county. So I think it should be local people serving as trustees for the local entity. It just makes sense.*

Board members provided differing perspectives on why they thought it was important for the hospital to be connected to the community, citing public image, community representation and service promotion as rationales.

> *Oh, I think it is very important. It is very important for the boards to be connected to the local community. In the same way that Wal-Mart, huge corporation, does local things, local projects. Locally-owned motels are more welcomed in the community.*
>
> *I think it's important. I think part of it has to do with the sense of community feeling that they have access to somebody who can present their views to the entire board. In my case, I'm here – I'm visible in the community. People can call me, people can stop me on the street, in the store and share things that they are thinking.*
>
> *Definitely so. I think that the System has to be responsive to the particular needs within the community. If they aren't, they're not going to be utilized.*

Because there's such an incredible, competitive environment. There are hospital and facilities just over the horizon in any direction and they all want your patients. They all provide adequate equal services. So the best thing that a regional hospital can have going for it is the loyalty of its population. If you don't have that loyalty, you're in big trouble.

Well, I think definitely it's important. You bet. Because that's where most of our patients come from.

One board member felt so strongly about this issue that he returned to the topic at the conclusion of the interview and shared this:

I think that it's real important to understand how important the healthcare facility is to a rural community. With more and more people moving to the outlying areas around the city, there's gonna be more and more need for community services in the outlying areas. And particularly healthcare. So often you have medical emergencies that just couldn't wait to go all the way into the city. They have to be taken care of on the spot. And then there are a lot of cases that need to be taken care of on a local basis from the standpoint of cost and family and patient convenience. People do not generally move to communities where there is not a healthcare facility. They just don't. It is an essential community service. So it's very, very important.

One of the board chairs returned to community relationships at the end of his interview and stressed the importance of the role of a regional hospital within the community.

I think the most important thing is commitment to the community – that you don't lose sight of commitment to what you're really trying to accomplish. Because of the critical role that a hospital plays to the community on economic development. When you look at the community benefit of a hospital, it's a big one.

Another perspective repeated several times by board members had to do with local regional hospital board members and perceptions of their ability to represent the community versus that of individuals who had been appointed as hospital board

members by the System and who probably did not live in the community served by the hospital.

> *If you have a local board member they're going to be more concerned about the community. Feeling about the people. It's not that there are not good people in a large organization. The further you are away, the less you care about the people that are there.*

Regional hospital administrators also saw it as important for regional hospital boards to be connected with their communities, but focused more on community representation and board member political support.

> *Yes, it is important. It builds a confidence level within the facility, that people feel it's their facility. The community will feel that way. They feel a connection through their neighbors or friends or someone they know and respect. They know they have some local control that will consider their family's health or their friends or the community's needs. That voice is there.*

> *I think it is absolutely important that if a System wants to integrate with regional facilities that they have representation from the local community. Otherwise the communities really think they have lost one hundred percent control of anything that goes on in their institutions. By having an equal number of board members from the community and from the System the community thinks they have equal representation. Now when we first began, since this was the first hospital in the System, we had four System board members and three local board members. Within the first year that was changed so that the local board members didn't feel that regardless of what they wanted, there were four System board members who could out vote them.*

> *As far as I am concerned it is vital. The board here understands the dynamics and politics of the local community, where the System boards do not, and without that link to the community we'd be fighting all kinds of relationships, battles really. Bottom line is things are different in small communities than they are in big cities. Virtually everyone knows everyone else. We make a mistake here at the hospital and two hours later probably fifty percent of the community knows what's going on. Everybody around here has a scanner and they listen to the ambulance and the police channels.*

when they hear something, they pick up the phone and call their neighbor.

Yes, I believe it is. And the reason I think it is important is that it is my firm belief that healthcare in this country is delivered on a regional basis. In order for the continuity of care to be effectively served in each locality, it is necessary that there be a governance voice in each one of these local areas. And that can only be accomplished through local participation on a regional hospital board.

With both board members and administrators convinced it was crucial that regional hospitals be connected to their communities, it became important to determine how hospital boards learned about community healthcare issues. Board members offered the following perspectives:

Conversation. Personal relationships . . . . with community people.

Just living here. Through contact with the local people.

Well, they generally come up through the board members. The board members are the hotline from the community to the board.

I feel like that the way we find out about it is through the doctors, through the nurses, through other people in the community.

I think most of it comes from being a trustee over a period of time. Probably our association with local doctors, with our local administrator. And then you get feedback from the citizens who know you are on the board.

I guess there's just an underlying awareness of what people are talking about and thinking about. There have been some surveys attempted, I think.

Here at this hospital we have surveys that we do. It's hard to get a large percentage of them back but at least the information we do get is helpful.

Board chairs mentioned both local citizens and healthcare professionals as channels of communication on community healthcare issues. Two of the board chairs reported that their hospital conducted regular community surveys. One long-tenured

board chair shared that he did not feel the same level of responsibility to be as knowledgeable about things now that the System had taken over the running of the hospital.

> *We survey the community. It's done randomly, I think. Keep in mind my ear is not as close to the ground since the System took over the hospital. As it was when the city ran it. Because we had the ultimate responsibility when I was elected to work for this hospital and now I'm a volunteer.*

So you don't feel the need to be as involved or to be as knowledgeable?

> *No. If you take the administrator of the hospital and work that on up to the talent that's in the System, they don't need to rely on us for those type of things. But we make decisions. We set policy. We watch the finances. When I was on the City Commission we had the P & L responsibility for this hospital. It was up to us to keep this thing open. That burden has been removed from us and has been moved to the System.*

While hospital administrators cited community members as a key source of community health information, they clearly valued the data provided by area physicians and community surveys. Two administrators reported fairly extensive data gathering processes.

> *You get a lot of feedback from your local physicians. The kind of patients they're seeing, the kind of equipment they will need to treat those particular illnesses, the supplies, the drugs. It gives you insight into the kind of patients they're seeing. Not only the high volume cases, but also the changes they're seeing. For example, a different flu strain.*

> *Boards get most of their information from hospital staff. We do at least a biannual community survey which asks questions relating to the hospital and how we're doing, but also what does the community perceive we are not providing. And then we also have a focus group that meets probably twice yearly that has representation from a cross-section of the community. A summary report is put together outlining what business is leaving the community and why. A perfect example is that local physicians do not feel we need a pediatrician because seventy percent of*

the medical staff are family practitioners. They treat the whole family. You go out and ask the community and they want a pediatrician and so therefore they go out of town to seek that service. The physicians didn't know that these people were going out of town because those patients never came to them in the first place. We can then take this information to our board and medical staff.

Boards have two main mechanisms to learn about local health issues. They fall into what I call the hard data sources and the soft data sources. The hard data sources are the demographics which are developed and presented to the internal and external sources. Internal sources being the administrative staff. External sources being public bodies, such as the health department. Soft data is public perception. It is much more difficult to quantify this data but it is just as important. It is the responsibility of the administrative staff to make this information available to the board.

Once a community health issue has been identified, both board members and administrators reported that it would be discussed at a board meeting. Depending on the nature and scope of the issue, board members indicated they might request the hospital administrator and his staff to conduct further research to be presented to the board at a future date. Based on research results the project financials would be developed and a board decision made as to whether to proceed with the project.

Board members cited several examples of community health issues that had received board consideration. In one case there was community concern about the potential for elevated lead levels in the blood of employees of a local smelting plant. The hospital assisted the city and the Environmental Protection Agency in providing testing. Another board member indicated that the need for healthcare in some of the small towns surrounding the regional hospital led to the development of satellite clinics. According to one of the hospital administrators, a diabetes support group was formed when the local health department and a patient's family member approached the

hospital board about the problems of securing care for area diabetics. In each of the previous examples, the health issue became known to the board, was discussed by the board and action was taken. Examples were also provided of projects which, for various reasons, board approval to proceed was not granted. Establishment of an oncology unit and creation of a dialysis center being mentioned as worthy community projects not deemed economically feasible by their hospital boards.

Board–Management Relationships

Six survey questions addressed board perceptions concerning hospital administration's efforts to keep them adequately informed and provided with sufficient background data to enable them to appropriately fulfil their board responsibilities.

The first three questions dealing with the provision of information received complete board member support, whereas responses to the latter three questions on response to board input, communication of community health needs to the System and, resource allocation received only qualified support. Administrator responses paralleled board member feedback, demonstrating an apparent acknowledgement that there might be room for improvement in certain areas.

Informed of Performance Against Goals: Thirty-three board members reported that hospital administration almost always or usually kept them informed of hospital performance against goals. One board member said administration occasionally kept them informed, with two reporting administration almost never did. Seven administrators responded that they almost always provided such information, one reporting that he usually did.

Informed of Key Healthcare Trends: Most board members, thirty-two, felt administration almost always or usually kept them updated on key healthcare trends. Two reported it occurred only occasionally, another two saying it almost never happened. Again, seven of the eight administrators responded that they almost always kept the board informed, one felt he usually did.

Provision of Background Information: Thirty-four board members believed administration almost always or usually provided clear background information to support decision-making on proposed programs and services. Two board members reported administration almost never provided such information. Six administrators were confident that they almost always provided information to support decision-making, two felt they usually did.

Response to Board Input: Sixteen board members believed that administration almost always responded appropriately to board input concerning community health issues. Eighteen board members felt administration usually did. One board member reported administration almost never responded appropriately to board input. Four administrators believed they responded appropriately, four said they usually did.

Community Needs Communicated to the System: In answer to the question "are local community health needs communicated to the System board?", eleven board members reported that needs almost always were communicated. Eighteen responded that they usually were, three said they occasionally were and three board members said they almost never were. One administrator believed he almost always communicated local needs to the System, six felt they usually did, and one acknowledged he only occasionally did.

Discuss Resource Allocation Issues: Six board members believed their board almost always discussed resource allocation issues in cases where organizational and community interests competed. Twenty-three board members felt it usually happened, four said it occasionally did, with one board member reporting his or her board almost never conducted such discussions. One board member indicated they weren't sure either way. The majority of administrators, six, believed their board discussed allocation issues when the need arose.

In this section of the questionnaire, one or two board members consistently responded negatively. These individuals were board members at the same regional hospital and their responses very likely reflected their relationship with the hospital administrator.

Board Member Relationships

Board member perceptions of their relationships with fellow board members and the nature of the their board meeting discussions were the focus for the portion of the survey entitled Board Member Relationships. Responses suggest that board members believed the environment in their board meetings to be such that they felt free to openly discuss issues and that they were appreciative of the contributions of others serving on the board.

Board Dialogue: When asked whether at board meetings board members engaged in dialogue among themselves concerning key issues, board members clearly indicated they felt very comfortable discussing issues with their peers. Nineteen board members responded that they almost always engaged in dialogue, fifteen replied that

they usually did, with two saying they often did. Administrative responses supported board member perceptions, with seven reporting this almost always or usually occurred.

Other Board Member Skills: Twenty-nine board members believed that other board members almost always or usually possessed skills which they lacked and which were helpful in decision-making. Six indicated this was occasionally the case, with one board member believing firmly in his or her superiority and responding that this was almost never the case. Possibly due to their healthcare background and experience, only one administrator reported board members almost always possessed skills they lacked, two indicated they usually did, with five acknowledging they occasionally did.

Effects of Decisions: All thirty-six board members indicated they almost always or usually were aware of the effects that their decisions have on the community. Administrators were in equal agreement with this perception.

Speak Freely: Thirty-three board members reported that they almost always felt free to speak their minds about issues affecting the community. Three board members indicated they usually did. Once again, all eight administrators concurred with this opinion.

Raise Community Health Issues: When asked whether board members raised community health issues, nine board members felt this occurred, eighteen indicated board members usually raised community health issues, with six reporting it occasionally happened. Two board members felt board members almost never raised community health issues. One board member was not sure whether it happened or not. Administrators indicated board members most certainly raised community health issues at board meetings.

Section Five: Board Accountability

Seven questions in the survey by questionnaire sought to understand to what degree board members held themselves accountable to the community members they represented. Both board member and administrator responses suggested that in some instances boards were being appropriately accountable, in other instances this was not the case.

Boards did request feedback about programs provided for the community benefit and were fairly proactive in addressing community health issues. It appeared that most boards only infrequently reviewed community health data and were only occasionally being educated on community health measures. Little board education was reported and board member responses suggest community health issues were not consistently passed on to the System board for their information.

Specific information on community health programs that the regional hospitals had initiated was sought during the in-depth interviews. Another interview question solicited input on how boards determine which community health issues to address given limited financial resources. A third question on board accountability explored what board members felt they needed in the way of board education and what was being offered to them.

Feedback on Community Programs: The majority, 28, board members reported that the board almost always or usually requested feedback about programs provided for the community benefit. Six believed the board occasionally did, while two board members from the same regional hospital responded that their board almost never requested such feedback. The administrators agreed with board members, with two

reporting that their board almost never requested program feedback and the remaining six indicating that their boards almost always or usually asked for updates.

Proactive in Addressing Community Issues: Twenty-seven board members reported that their board was almost always or usually proactive in addressing community issues. Six responded that their board occasionally was. Three board members, each from separate hospitals indicated their board was almost never proactive in addressing community health issues. Each administrator saw his board as generally proactive.

Board Education: Board members and administrators disagreed on provision of board education. Ten board members representing five separate hospitals reported that their hospital almost never provided formal education for board members. Thirteen board members, each hospital having one or two representatives, said their board occasionally provided such education, with twelve reporting that their board almost always or usually did. Only one administrator acknowledged not providing formal board education, with the remaining seven administrators indicating they did on occasion.

Community Health Data: Seven board members from five separate hospitals reported their board almost never reviewed community health data. Twenty indicated their board occasionally did, with only eight reporting they almost always or usually looked at community health data. Feedback from administrators supported these responses. The majority, five, said their board occasionally or usually reviewed community health data. Three reported their board almost never did.

Education on Community Health Measures: Six board members from four hospitals indicated their board almost never received education on community health measures. Fourteen board members reported their board occasionally was educated, with thirteen saying it usually was. Only three board members reported their board almost always received such education. Administrators were split with half, four, reporting they usually educated their board on community health measures and the other half saying it occurred occasionally.

Community Health Issues Passed on to the System: The question "are community health issues passed on to the system level board members for their information and consideration?" received widely mixed responses. Seven board members believed such issues were almost always passed on to the System, eighteen felt they usually were and six reported that issues were occasionally passed on. Four board members, three from one hospital and one from another, thought community health issues were almost never communicated to the System. Administrator responses were equally varied. One reported issues were almost never passed on to the System, three said issues occasionally were, three indicated they usually were and one reported they almost always were communicated.

Board Evaluation: Twenty-eight board members, with at least two board members from each hospital, reported that there was no process for evaluating the board's performance. Five board members said they believed there was such a process in place. Three board members acknowledged they did not know. Three hospital administrators reported that a board evaluation process was in place at their hospital; the remaining five said their hospital did not conduct board evaluation.

During the interviews board members and administrators were asked to describe some of the community health programs their hospital was offering to the community. Administrators were far more readily able to cite examples than were board members, who struggled to recall specific programs. In a few instances board members were personally responsible for surfacing the program idea and in these cases the individual was extremely articulate and provided extensive information.

Board members provided the following program examples:

> *Well, it's an acute care tertiary hospital, so it responds to the need for emergency care and inpatient and outpatient care as far as its capabilities can go. There's a cardiac clinic.*
>
> *We have a health fair once a year where various screenings are offered. Other than that, I don't know.*
>
> *We do a number of screenings throughout the year. We have a urologist that comes down and does several tests. The turnouts are just unbelievable. We offer discount mammograms.*
>
> *There's a blood pressure check. Then there's a community-wide Old Timer's Day with health screenings. And screenings at local schools.*
>
> *I think the specialist clinics are very important. And the mobile CAT scan. There's some other mobile unit that comes down here but I can't think of it.*

When a board member participated in the program development and subsequent implementation of a community project, he or she was very knowledgeable about the program.

> *We have an Oncology Unit. Some people felt like we had a rather high rate of cancer in the area. Our thinking was to try to serve the needs locally rather than having to transport our people to the city sixty-five miles away. We started out thinking there may be some dollar value to it, some income generation. And after a rather intensive year we saw it was not going to be any kind of savior from an economic standpoint but it was gonna provide a*

valuable service. And if it did that and we could make it a break-even proposition then we felt like it was something that needed to be done.

Well, we have a project underway to build a new emergency room facility. What you have in little rural communities is folks that can't pay for health services and so they wait for the weekend and come through the emergency room knowing that you're going to take them in. The most that we are able to get reimbursed from Medicaid is six or eight dollars a call. Well, Medicaid has a program where if you have an emergency clinic then you can get reimbursed fifty or sixty dollars, so we designed our new emergency room around that reimbursement code.

We have satellite clinics and a renal dialysis clinic. We have had the renal dialysis clinic for a number of years. It's been well received by a small minority. So you have something that is a tremendous benefit but it doesn't really impact the whole community. It impacts a small segment, but it's still a wonderful thing.

Several board members reported that the financial situation at their hospital had been so severe that there just weren't any spare resources to allocate to new programs.

So much of what I've done since I've been on the board was just simple survival. There never has been very much consideration of what we can offer. We want to keep the hospital open because especially the emergency room was needed and we have to have inpatient beds in order to qualify to keep the emergency room open. It's just been survival so much.

I don't know if it's in response to community need. So much of it is in response to trying to find something that will just at least break even. That's what it has been prior to our joining the System. The System has given us added strength.

Administrators provided far more detailed information on program offerings than board members did. Examples of programs included a wide variety of satellite clinics where specialist physicians from the city visited the regional hospitals periodically to see local patients. Urology, orthopedics, cardiology, ophthalmology and obstetrics/gynecology were mentioned. Weight loss classes, smoking cessation

programs, a sexual assault nurse examiner program for rape victims, CPR training, and various health screenings were also cited.

One administrator reported that his board had raised several perceived community health needs over a three to four month period. He recommended to the board that a community survey be conducted.

> *The survey asked specific questions as far as the services that the community thought they needed and would support and from that we developed our current specialty clinic program, which now includes six different specialty clinics. They're going extremely well.*

A former hospital administrator, who was now serving as a board member for her regional hospital, shared her, somewhat different, perspective on community surveys.

> *I don't know that doing a survey would make a lot of difference. I'll tell you what it would surface here. It would surface teenage pregnancy, drug abuse, alcohol abuse, nicotine abuse, and overeating. And of those I don't know how much a hospital could do. It's very difficult in a small town to stand up and begin to try to have a program to tell other people how to live. It's not well received.*

Few regional hospitals can address all the community issues the board feels are important. Generally there are insufficient resources. Decisions must be made what programs to pursue and which to put to one side for the present. Board members indicated relying heavily on their hospital administrator to help them through this decision-making process.

> *We would rely on information provided us by the administration. We'd definitely be dependent on that. We're counting on their medical expertise. We'd look at the economics of it. We'd look at what it does locally . . . . and probably throw in a little local politics too.*

Usually we get advice from management – the pros and cons – and of course most of the time what they tell us is right. We may question them but we don't try to override their judgement.

I guess we all have to draw on our own resources. The board is made up of a diverse background of people and a mixture of ideas generally helps to get us to a place we need to be. I think the support we've had through the System has helped, gives us a lot more expertise to fall back on.

I've always thought my function on the board was simply one of providing whatever wisdom I could. Obviously, I don't understand all the healthcare industry. My function is to provide some wisdom – another point of view than people that are tied up in the System.

Board chairs provided different perspectives on how their board decided among community needs:

I suspect it's intuition as much as anything. Just board intuition. What they think will work and what won't work. And you have to remember none of us are specialists, we're not physicians, We're lay people and we just have to use general knowledge and general ideas.

Well, I think we would first of all try to understand what is being proposed. Then, especially those of us in the community, would try to reflect and see how that benefit would be received – good or bad.

One board chair, the chair of the regional hospital which had been the first to join the System, did not feel that final program decisions lay within the scope of accountability of his board.

We really don't make those choices here. That's made at the System. They know what's best for the community based on what's been best for the communities in the past. And of course with what we tell them. I think they give a lot of credence to what we say or recommend.

Regional administrators agreed that their board members depended on management to provide them with the necessary data to support decision-making.

> *The board pretty well leaves those decisions up to the management of the hospital. We have pretty much weighed out what will work and what won't before taking it to the board. We do the homework and bring it to the board.*

> *It's primarily based on the financials that are developed. A lot of times the community's perception of their needs are well intended, but as you get into those types of programs you find out that there's no way the hospital can financially support a particular program unless the community themselves decides to put money into the project and very rarely do they want to do that.*

When faced with having to go back to the community and tell them a project is not feasible, one administrator indicated he may communicate directly with those bringing the issue forward or he may solicit board member assistance in explaining the situation to the community.

> *I give them the research information and let them know that it's not feasible to carry forward with that program. About ninety-five percent of the people understand. You show them you've done the due diligence, researched the problems, and run the proformas. as long as they feel you've made a serious, concerted effort, they're OK with it.*

If an accountability of board members is to support hospital management in explaining why programs are not feasible and to help the local community understand current healthcare issues, then engaging board members in a board development program would better prepare them for such assignments.

One interview question addressed board development directly. Responses suggest that while some board members would value board development efforts, others

reported that time was a limiting factor. Board members indicated that little board development occurred.

> *I would say no board development happens on an organized basis.*
>
> *There has not been any to this point. I think that is a weakness. I kind of floundered for a while when I began on the board. There was so much to be done so quickly, we were just kind of doing what we had to do and hoping we could catch on soon. It's also taken a while to understand what my responsibility is other than just appear, read the reports, and vote. I think all of us are probably willing to do what we need to do but we don't always know what that is.*
>
> *We have only recently made efforts to develop the board. It's really an aged board. We want to start attending some seminars.*
>
> *The System has given us a manual. I think I still know where it is. I have not studied it carefully. I'm sure we need to be aware of the System because we're part of that now. I'm not sure how it all fits together. It's kind of like here's the System and here's the community and we're between them. I guess we need to understand both directions to do our job here.*
>
> *Everyone on our board is encouraged to take part in seminars by the administrator. And it's probably like every other kind of board – the offerings are taken advantage of by some people and not by others. Finding time to leave your everyday tasks and take off for a couple of days becomes kind of difficult.*

Board chairs were more articulate about the importance of board education from their perspective.

> *Board education is the preparation of the person for board responsibility. I think that is very important. I didn't feel like I had the background to just walk in. There has to be some kind of training. I didn't know exactly what to ask for, I just know that I didn't feel very qualified when I started.*
>
> *The time I felt best about being on a hospital board was when I attended one of the conventions of hospital board members a few years ago. That's when I really understood integrated healthcare and that it was possible for hospitals to work together. That you could take the resources available, mainly the doctors, the hospitals, the nursing homes, and integrate them into a system that would really benefit all the people.*

I'm a very conscientious type person and when I do a job I like to feel that I'm doing it the right way. That I can do some good in what I'm doing and not just be a body sitting there when we have board meetings.

Several board members wanted to discuss issues that were indirectly related to board development but which were currently problematic from their standpoint.

One of the big problems in a small town is that the same people get called upon for all kinds of voluntary work and these people get tired after a few years and some inertia sets in. If there's a way, we need to get younger people interested in doing work like this. Then there would be replacements for those who tire of what they're doing.

I think it's important that the board be carefully chosen. And that it's not just a sloughed off thing just for formality. You need to have people who have both intelligence and what I think of as the heart and fortitude that one needs to be successful in healthcare. In my years in healthcare I was really impressed by the quality of the people who were the leaders. I do think that they are more concerned with the welfare of the human population than leaders in other business fields.

The other board members, I have not had opportunity to really get acquainted with them outside the board meetings. Maybe if each board member received a brief biographical sketch of the other board members, it would be helpful. Just two or three sentences about . . . . . this person is the manager of this department, he's married and has three kids, and he likes to fish. Just little personal things of that kind. It would be helpful.

While many of the individuals interviewed confessed to finding healthcare confusing and complex at times, one board member expressed his views more candidly:

I'd be interested in when you've completed your interviews with people in the same position I am, if they're all honest enough to say that they are completely in over their heads most of the time in terms of the details of medical services. As local business men we're just lay people overseeing an entity that specializes in healthcare. We're doing the best we can but we're limited. And we do rely on the staff pretty heavily.

Regional hospital administrators acknowledged that board development was

lacking. They alluded to the fact that most of their board members were very busy people who found getting away from work difficult. Once they were successful in persuading a board member to attend a seminar or workshop, administrators reported the person frequently returned with a heightened appreciation of healthcare issues.

> *If a board's going to function, they have to know what their requirements are and the best way to do that is through a continuous training program. It's difficult sometimes. Most of the sessions are out of town and you have to badger people to go. One board member who went came back just glowing. He said it was wonderful. They meet other people and exchange ideas which is very important. I've had them come back and say "do you know what this hospital in Florida is doing, . . .".*

One administrator talked about the problems he had experienced recruiting board members.

> *If we have a weak spot, board development is probably it. In the past there's not been a great deal of orientation and development. what we've found in the smaller community is that it's extremely difficult just to find someone that will serve on the board. Usually what happens if you find somebody that says "yes", you pluck them off the street, set them behind the chair and you start having meetings.*

Why is it hard to find somebody to serve on the Board?

> *It's a real political issue in small communities. Board members have to answer for what the hospital does or doesn't do for the community. We sometimes have to make some basic structural changes–cutting employee hours, laying people off – that causes unrest in the community. People pick up the phone and call a board member. There's been a lot of long time friendships that have been tested because of these types of issues.*

Issues of politics in small communities was a theme that was repeated in almost every interview. Both board members and administrators reported that it affected not only board selection but also program development and service provision. Managing

these dynamics was seen as part of ongoing public relations, and an accountability of board members and administration alike.

Section Six: Content Analysis of Board Agenda and Minutes

Regional hospital board agenda and minutes of board meetings were gathered and analyzed. Data covered a reporting period of approximately sixteen months from January, 1998 through April, 1999. Data was received from seven of the eight hospitals participating in the study. The goal of this section of the research was to describe those aspects of community health care issues being raised for consideration at the board level.

Board Agenda Analyses

An initial review of the agenda format was conducted. Key agenda topics were noted, together with changes to the agenda format during the review period.

The majority of regional hospitals followed a standardized agenda format, which was utilized at each meeting. A typical agenda format included:

Call to Order
Approval of Minutes
Corporate Board Action
Medical Staff Report
Financial Report
Reports:
- CEO
- Quality Council

Board Continuing Education
Other Business
Adjournment

Other agenda items appearing on hospital board agenda included: establishment of quorum, capital projects, committee reports, operational report, human resources report, public relations report, administrative policy, community service programs, foundation, and announcements. Agenda items such as Election of Officers and Annual Budget Review appeared on the agenda at those times of the year board action was necessary.

All but two regional hospitals kept the same agenda format for the entire review period. Agenda changes for the two hospitals appeared to be the result of System intervention. In each case the previous hospital agenda had lacked a firm structure, with items being listed based on the topics needing to come before the board at that specific meeting. Both hospitals adopted a standard agenda bearing striking similarity to those of the other regional hospitals.

Board Minute Analyses

A total of sixty-two sets of minutes were reviewed. Two of the seven regional hospitals conducted monthly board meetings, five held board meetings on a quarterly basis. A coding system was utilized to log items being discussed by the board. Items were classified as governance, operations, finance, physician and community representation. Community representation issues included board discussion about the community's general health, discussion of equipment that might benefit the community, discussion about programs being proposed or considered for development, discussion about programs which were to be scaled back or dropped, and discussion about recruiting new physicians into the area.

Community representation issues were consequently segmented into five categories: general community issues, equipment need issues, program development issues, program scaling back or closure issues, and physician recruitment issues. Logs were maintained denoting whether a board member or administration raised a community health care issue for discussion.

A total of 793 issues were recorded. A breakdown of results is shown below:

Category	# of Issues	% of Total Issues
Governance	94	11.9 %
Operations	240	30.2 %
Finance	152	19.2 %
Physicians	88	11.1 %
Community Representation	219	27.6 %

A detailed summary of each hospital's data is presented in the following table. A breakdown of community representation issues show the number of issues raised by board members, 90, and those raised by administration, 129.

Summary Table 1: Content Analysis of Board Minutes

Hospital		Schedule	#Mtgs.	Gov.	Oper.	Fin.	Phys.	Comm. R.	Comm. R B	Comm. R A
Hospital		Q	6	12	29	7	10	12	4	8
Hospital	B	M	15	23	64	27	19	62	20	42
Hospital	C	-	-	-	-	-		-	-	-
Hospital		Q	6	6	38	19		39	6	33
Hospital	E	Q	7	12	10	8		15	5	10
Hospital	F	Q	7	14	49	25		35	19	16
Hospital		Q	7	6	29	22		23	11	12
Hospital		M	14	21	21	44		33	25	8
Totals			62	94	240	152		219	90	129

An analysis of the 219 community representation issues reflected in the board minutes revealed that new program discussion accounted for 32.5 % of the issues, general community health discussion constituted 29.7 % of the issues, physician recruitment discussion accounted for 18.3 % of the issues, equipment discussion was 12.4 % of the issues, while program scaling back or closure represented just 7.1 % of the issues. A tabulation of these results is presented below:

Summary Table 2: Community Representation Issues Reflected in Board Minutes

Hospital	Community Issues	Equipment +	Programs -	Programs	Physicians
Hospital A	1	3	3	1	4
Hospital B	23	13	18	3	5
Hospital C	-	-	-	-	-
Hospital D	13	2	16	-	8
Hospital E	-	7	2	3	3
Hospital F	15	2	16	-	2
Hospital G	6	-	8	-	9
Hospital H	7	-	8	9	9
Totals	65	27	71	16	40
	29.7%	12.4%	32.5%	7.1%	18.3%

Board members raised 41 % of the community representation issues, whereas administration raised 59 %.

The analysis of board minutes revealed that board members appear to spend quite some time at their meetings discussing new program ideas or needs and potential program implementation. Discussion of issues pertaining to the general health of the

community also scored highly. The number of times physician recruitment was mentioned suggested that the board recognized the value of physicians to the community, potentially both from a community health standpoint and from an economic standpoint. Hospitals not infrequently need to replace old or worn equipment or may be seeking to upgrade their capabilities, and the number of times equipment was discussed appeared customary. Discussions concerning program scaling back or closure were almost uniformly connected to home health programs. Recent reimbursement changes have led many hospitals to reconsider the scope of their existing home health programs, with many programs closing completely.

Section Seven: System Integration

Two open-ended questions in the survey by questionnaire asked board members and administrators what were the key advantages, and disadvantages, for regional hospitals in joining a healthcare system. Four interview questions also sought to understand the rationale behind the decision on the part of the board and management to seek affiliation with an integrated delivery system, what perceptions of the advantages and disadvantages were at this stage in the relationship, and what integration efforts were being implemented.

Why Regional Hospitals Seek System Affiliation

Board chairs, board members and administrators were very explicit about why their regional hospital sought affiliation with an integrated delivery system. The majority of those interviewed, fifteen, indicated that the hospital's continued survival

was dependent on access to additional financial resources. When asked why regional hospitals sought to become part of an integrated delivery system, board members responded:

> *Because they can't exist on their own. With government regulation and the shrinking of that kind of financial resource, all the cutbacks, the small, rural hospital can't keep their doors open. There's just not enough dollars.*
>
> *Because we were broke. The financial reality of it is we just couldn't make it. We didn't have the patient load, we didn't have the reimbursement and we didn't have the money to do it. We couldn't do it on our own.*
>
> *Well, it's strictly numbers. I don't think in this day and time you can survive unless you're part of an integrated system. I don't think there's any choice. It's just a matter of which one.*
>
> *I guess they're all looking for a security blanket.*
>
> *We, as trustees, felt like rural hospitals were going to continue to face challenges that would make it difficult to remain independent.*

Board chairs were also concerned about the finances, but they also emphasized needing access to a higher level of expertise.

> *The era of the stand-alone rural hospital is gone. We don't have the depth of resource that we need to survive. We've got two big hospitals twenty miles away that would suck the life out of us and we simply would not be able to grow and develop.*
>
> *Well, we don't know how to run a hospital. So it's a matter of knowledge, expertise, and financial help.*
>
> *Survival.*
>
> *There's a recognition that they need professional help. If you look at the resumes of the administrators of small town hospitals who have not been affiliated with a larger group it would give you an idea of what I'm talking about. In the small towns it's just hard to find people who are professionally expert at all the things one needs to be to manage a hospital. Most of these regional hospitals*

are staffed with local people who get promoted because they were good at entry level jobs.

Responses from the regional hospital administrators also stressed survival, the need for access to capital and to economies of scale. One regional administrator clearly acknowledged that he needed help in the form of additional expertise:

As an independent community hospital there are not enough tools available to make the changes necessary to keep up with all the changes in the federal program, such as the Balanced Budget Act. If you affiliate with a system you gain the resources and the infrastructure and the knowledge to be able to make those changes. In other words it's like you're out on the end of a limb and you're sawing the limb off behind you. That's kind of where you're at with an independent hospital, except that the government's the one that sawing the limb. In the System you have so many different resources to draw on and, if nothing else, that information allows you to get on the other side of where the sawing occurs.

Not all regional hospitals made the decision to join an integrated system to avail themselves of additional financial resources. The administrator of the first regional hospital to join the System depicted in the case study described his board's thinking this way:

When _____ Hospital made the decision to join the System it was at a time that they were at the best financial position the hospital had experienced in the previous ten years. They felt it would be much better to align with the System when they had some strength and were in a better position to create a win-win for the community and the board than if it was at a time when they were struggling and then it would be like the tiger against the lamb. The Board felt joining a system was necessary because of all the managed care that was coming into play and that it would be better to associate with an organization able to contract on a global basis.

Advantages for Regional Hospitals in

Joining a Healthcare System

Board members responding to the survey listed the following key advantages to their regional hospital in joining a healthcare system, many advantages appearing multiple times:

Survival	Managed care contracting
Economics	Enhanced financial expertise.
Management	Referrals of patients
Capital access.	Centralized purchasing & supplies
Recruiting	Economies of scale
Guidance	Financial relief
System strength	Known business partner
Expert advice	Financial and operational support
Physician services	Shared risk
Benchmarks	Diversity of programs and services
Cost control	Strength provided by a strong system
Referral sources	Physician network for contracting
Hiring	Improved management information systems

Some board members chose to elaborate beyond a word or a phrase as their survey response.

> *Greater access to quality healthcare for the community through availability of medical expertise, better resources and quality control – thereby providing convenient services and quality outcomes.*

> *The challenges facing rural hospitals can be overwhelming. A healthcare system offers expertise, financial support and leadership to help meet these challenges.*

> *Regional hospitals are heavily dependent on Medicare and Medicaid, which do not reimburse adequately. Rural hospitals do not have a great deal of insurance and private pay insurance.*

> *Support, not just financially, but for knowledge re current legal, regulatory and industry trends, as well as depth in such areas as strategic planning, information systems, etc.*

Better informed about different issues. Stay on top of all issues, such as community health issues, government regulations, managed healthcare, etc.

During interviews with board members many of the advantages outlined in the survey responses were echoed. It was apparent that, in addition to the access to capital and financial expertise offered by the System, board members believed considerable economies of scale could be realized through group purchasing arrangements, that some of their hiring difficulties would be eased as a result of System affiliation, and that System expertise would help them straighten out weak or faulty management systems.

We wanted some stability in the management, buying power, organization. Being able to get price breaks because of group purchase. Management help. The healthcare industry is just so complex and so rapidly changing. Somebody in Washington decides to do something different and you've got thirty thousand changes come out of that and it's just almost impossible for small hospitals to keep up with all that.

Being related to a large organization gave us first of all stability. second of all the appearance of stability, which really, really, helped our hiring good people. We could say we're part of the System and we're here for the long haul.

In the two plus years since we joined the System, I think they've had to come in and almost scrap existing systems and start from scratch. The computer system at the hospital, the billing system in the clinic, receivables – it just had to be redone.

A board chair expressed it this way:

We needed somebody to do exactly what they did. To take the hospital over. To run it and I'll tell you they have run it quite successfully. This hospital has been very profitable and I can only give thanks to the System for that because we weren't doing it prior to that.

Hospital administrators also reported access to financing and management expertise as primary benefits to joining the System from their perspective. One described being part of the System as giving him access to a huge knowledge base, with specific people for each area.

A less obvious benefit to joining the System was shared by the administrator of one of the regional hospitals. His hospital had been struggling due to the negative effects of local politics for quite some time.

> *One thing that the hospital gained in this instance was the ability to cut loose from local political pressures that may be inappropriate. I'm talking about where local officials basically have control of the hospital and try to use political patronage, for instance appointing friends or relatives to the board and similar favoritism for employment at the hospital.*

Using the power and leverage of the System was not only beneficial in helping control local politics, it was also attractive to one regional hospital board looking to replace their hospital administrator.

> *The board wanted to make a change in administration but they didn't have a clue about how to do it. They had been so blocked off from information and routine data. A big part of what they wanted to do was to make very sure this place was cut loose from that administrator.*

Disadvantages for Regional Hospitals in Joining a Healthcare System

While there were many advantages to joining a healthcare system outlined, there were also aspects board members and administrators gave up in the process. Three key disadvantages for regional hospitals in joining a healthcare system were cited repeatedly by board members responding to the survey: reduced community influence, loss of

local control and autonomy, and bureaucracy. Other disadvantages mentioned by board members included:

Reduced control over operations

Lack of communication from the System

Rural communities move at a different speed than corporate.

We are constantly pressed to cut budgets.

We are no longer aware of our true financial status.

Do not feel we are part of a team.

Some loss of autonomy.

"Just another pebble on the beach" syndrome

Not being "large" enough to be important

Cycle time for decision-making

Potential loss of local identity

Some decisions are transferred out of the community

Two fears for the future also became apparent, as the following board member survey comments indicated:

> *Fear that the healthcare system will be tempted to reduce services and facilities at the community hospital in order to funnel that business to the healthcare system.*

> *There is always the possibility that such hospitals may become 1) too dependent, and 2) become expendable to the parent group and 3) be closed.*

An interview question explored perceptions concerning what regional hospitals gave up, if anything, to become part of an integrated delivery system. Responses varied from board members who felt that nothing was given up, to those who seemed to feel

the exchange had been quite costly. The two board members and one board chair who reported that nothing was given up described the relationship as follows:

> *It's a win-win. There's nothing to give up. That was the big challenge when the community and the corporate board had to approve the affiliation. That was the big challenge to get them to understand. There's nothing to give up. It doesn't happen very often that you can do something like this without having to give up anything.*
>
> *I don't think we gave up anything.*
>
> *I don't think we've given up a thing. I think it may be because we had some prior experience with the System and because we found them to be honest people. They always did what they said they'd do and we felt quite comfortable with them.*

The remaining nine board members and board chairs were not so positive.

> *I think there were some people in the community that thought we were giving up local control of the hospital when it became part of the System.*
>
> *Well, we gave up some local control, of course. But that wasn't much to lose at the time. We were at the point of closing the hospital. We were out of options.*
>
> *The ability to make a decision based on local needs.*
>
> *Direct control of day-to-day operations. I feel like we're there for local input and they do listen to us but the final decision is theirs. We have input but we've given up the control we had.*
>
> *They give up their autonomy. They really give up their decision-making in almost every instance. I think it's a trade – a known trade–to get the help they need. But I think it's known they will give it up.*

While loss of local control was reported frequently by board members as something the regional hospital gave up upon joining the System, other issues were also important to administrators.

You do give up some of your autonomy, but you also give up the ability to make quick decisions. The System bureaucracy is the worst part of it. There is a tremendous increase in the amount of paperwork and reports that have to be generated for the System. It puts a tremendous strain on management. we don't have the information systems or the staff.

The slowness of getting something approved. Something that we think ought to be able to be completed and approved in thirty days could take ninety to one hundred and eighty days to get through the System.

I was an employee here and now I'm part of the System. I'm just a tiny, little cog in a wheel where before I was a medium sized cog. You're a little fish in a big pond, my voice isn't heard.

During the course of responding to this question, two additional issues were raised concerning relationships between the regional hospital and the System. One issue, raised by a board chair, dealt with board composition and his concerns that there was unequal representation of local versus System board representatives.

The inability to make a decision based on local needs. Just as that one board meeting where the three of them came and said we're closing the hospital. What could we do? We were outnumbered and they want it that way. They need to be in control.

The board chair went on to explain, in detail, that, as a result of his intervention, the decision to close the hospital was rescinded and that the hospital was given additional months to demonstrate its ability to be financially successful.

The second issue was raised by a hospital administrator concerned about the effects of System decisions on the regional hospitals.

One of the things that the System is learning is the fact that lots of times they don't take into consideration the effect that a decision made at the System level will have on the regional facilities.

How is the System learning that?

They're mainly learning it through the stubbornness of some of us rural administrators. The fact that we just tell them no or that's not going to work.

The final interview question on system integration sought to assess the degree to which integration had occurred following the regional hospitals' affiliation with the System. The question asked how the priorities of the regional hospital and those of the System were integrated. Several board members, 4, were confused by this question. They appeared uncertain of what integration was, how it might occur and seemed somewhat reticent to even consider that the System might seek to influence what they wanted to do locally.

I'm not absolutely sure I'm understanding what you're asking.

If I understand your question, when you're talking about us and the System you're talking about like we're a part of the System? I don't think there has been any. I mean we've tried to hang on to everything we could handle.

We feel a part of the System even though we also feel independent.

Other board members cited examples of how they saw their local needs being met by the System, providing evidence of early integration attempts.

Let me just give an example. The present CEO of _____ hospital is also now the CEO of _____ hospital. So, yeah, I think you'd have to say there's a lot of integration there.
Our laundry is done at _____, another hospital in the System. And then purchasing. We can purchase together much more economically than we can each hospital doing their own thing.

Yet other board members, one a physician board member, described more sophisticated integration efforts and shared details of patient transfer arrangements which had been organized.

I would say that still needs some work. The integration comes, really, in patient care because patients who can't be treated at

our hospital because of personnel and equipment limitations are generally transferred to the System.

The biggest way we've been integrated is when you're in a rural area there are certain limitations to technology. So we wind up having to refer patients to a tertiary care center. From a physician standpoint the biggest issue was how can I get a patient to where they need to be, to the expertise and to the technology that this patient needs. One of the earliest things we did with the System was to establish a transfer agreement, which made it so much easier for us to move a patient from here to there, especially in an emergency. Before that you might have to go for hours trying to find a doctor to accept the patient. I feel like that's been a great benefit to the patients.

Board chair responses demonstrated the same wide variation in level of understanding of integration and how it might potentially benefit the regional hospital.

I probably don't know all the ways. I think there are quite a few, but there's always room for improvement.

Would it seem ridiculous if I said, don't know, don't care? I am not concerned about system. I understand why we need to be in a system and I understand the advantages of being in a system–purchasing, management and operating systems – but I don't really care what the System is doing at _____ regional hospital or at _____ regional hospital or even in the city to be honest with you.

Well, I'd have to go back to when we first talked to the System about affiliation. We had a plan for integrating and growth. That plan was reduced to writing and that plan has been pretty well followed.

In describing the integration plan which had been developed and implemented by his regional hospital and the System, the board chair went on to explain how they had envisioned establishing relationships with several other regional hospitals in their area in order to develop mutually beneficial programs and services and minimize the need to duplicate costly programs at each facility. He described how several of the

hospitals originally outlined in the plan were now part of the System and program and service coordination was underway.

Each of the four administrators interviewed identified the planning process, at both the regional hospital and System levels, as the primary mechanism for integration.

> *Historically those priorities are determined through linkages at the board levels and through administrative planning sessions.*

> *There's a blueprint, so to speak, a strategic plan. It includes some of the objectives of the System in your (regional hospital) strategic plan. Each entity within the System has it's own strategic plan that addresses issues of their community and their hospital, and the System plans for the region. That's primarily your blueprint.*

> *The System has developed a three year strategic plan and the regional three year plan is developed essentially off the System plan so that all our goals and objectives are in alignment with those of the System. Now that doesn't mean there can't be other goals, but at least we're all headed in the same direction.*

While agreeing that planning helps integration efforts, two administrators of the four interviewed expressed concerns that the rapid growth of the System was causing less integration between the city-based hospitals and those in the region. One administrator explained it this way:

> *Probably one of my biggest concerns is that as the System grows there is less integration between the metro part of the System and the region. Perfect example, the first year this hospital joined the System I got a lot of help from the System but as the System grew it was like the metro divisions had their own priorities and they were in the middle of cutting costs. They were downsizing and had financial restraints. So, the region became the last of their concerns and now it is almost impossible to get the help you need. As a regional administrator I am an employee with very little authority to make any type of decisions. Since the System has grown so big, decisions are sent down to the regional level without any input and without any understanding that a lot of the decisions made at the System level just will not work out in the region at all.*

System integration efforts were frequently compounded by marked differences between System representatives and local board members in skills, knowledge, attitudes, and perceptions, as the table on the following page illustrates:

Section Eight: Future Governance Challenges

The final question on the survey by questionnaire and the concluding question during the in-depth interviews sought to understand the future governance challenges for regional hospital boards from the perspectives of those involved in the case study and to gain insight into how such governance challenges might be addressed.

A number of future governance challenges appeared repeatedly in survey responses completed by board members. Among them were continued financial viability, lower reimbursement, increasing government regulation and determining the appropriate model of healthcare delivery in rural areas. Other future governance challenges mentioned included:

To support administration in its efforts to meet community needs
Keeping finances in line
Better supervision of employed physicians
Maintaining high level of quality healthcare in community
Unfunded mandates from government and insurance agencies
Meeting community health needs under the constraint of lower reimbursement
Communication with similar boards and up the chain
Managing a rapidly changing and high exposure industry
Keeping abreast of patient needs at a cost effective pace
Allocating scarce resources while preserving community access to medical services
Access to qualified medical and support staff
An increasingly difficult and complex regulatory environment
Balanced Budget Act
Keeping a top grade regional hospital
Autonomy to respond to local issues without losing sight of System goals

Table 3. Comparison of System and Local Board Members on Regional Hospital Board

	System	Local
Governance		
Understanding of governance structure	5	2
Knowledge of system governance	5	2
Composition		
Live in region served by hospital	1	5
Politically influential in community	1	4
Involved in community or civic affairs	1	4
Financial Skills	5	2
Business acumen	5	2
Community leader	1	4
Board experience	5	2
Health care expertise	5	1
Responsibilities		
Important to establish policies	5	2
Important to provide equipment/facilities	2	5
Important to ensure financial viability	3	5
Important to access community resources	5	2
Important to represent community	3	5
Important to select medical staff	3	5
Important to be informed of healthcare trends	5	2
Relationships		
Ability to represent community opinions	1	5
Ability to educate community on managed care	5	2
Important to conduct community surveys	4	3
Need for administrative update on performance	5	5
Need for clear background information on decisions	1	5
Need to have clear background information on decisions	2	5
Need to have local needs communicated to System	2	5
Need to discuss resource allocation issues	2	5
Need to raise community health issues	2	5
Accountability		
Important to receive community program feedback	2	5
Important to review community health data	5	2
Important to educate System on community health	2	5

Key: 1 = None, 2 = Weak, 3 = Moderate, 4 = Strong, and 5 = All

> Keeping up with technical knowledge
> Giving the best of services for our people
> Attracting qualified professionals to render care
> Three board members expressed themselves more fully.
>
> *Government intervention and regulation continues to be devastating to the operation of hospital boards, as well as being costly.*
>
> *Creating and maintaining healthcare delivery for the millennium – progressive care with appropriate quality control.*
>
> *Establishing identifiable niches to fill in the changing healthcare world, then selling themselves to the community, our political decision-makers (state and federal) and parent company.*

Regional hospital administrators shared board member perspectives, also citing the need to stay financially viable and the need to find the appropriate services to fit community needs. Two additional prospective governance challenges reported included obtaining the necessary resources from corporate to develop community programs and developing the atmosphere to obtain physician commitment to the local hospital.

How can regional hospital boards best address these challenges? According to board members, through board education, staying current about healthcare trends, maintaining open communication and soliciting community input.

> *Governing board education around the need for change across the state and nation, supported by open and candid dialogue between administration, board, medical staff, and corporate leadership.*
>
> *Hospital boards can better meet challenges by trying to keep well-informed about community health needs and informed about ongoing changes in the healthcare system – ready to adapt to changes and adjust accordingly.*
>
> *Listening to patients, doctors and the community.*

In apparent acknowledgment of the complex nature of the relationship between the regional hospital and the System, one board chair wrote his perspective on how to address future governance challenges:

> *Do what you think works best for your community and try to make as few waves as possible upstream.*

During the interviews, board members focused almost exclusively on the need to keep their regional hospital viable as the primary future governance challenge they faced.

> *Well, immediately we have this sort of gentleman's agreement with the System that we have until December to prove that the changes we put into place are actually going to turn things around and we're not going to have such a deep river of red, if not into the black. If we get through December maybe we can get on to building something rather than just hanging on by our fingernails.*
>
> *The only thing that I know to do is that we have to improve our services in order to generate more income.*
>
> *I would say finding a way to achieve enough revenue to cover the fixed expenses of running a hospital.*
>
> *I would hope that we wouldn't have to cut back. I would like to see some more services added. That's the tension between dollars and desires.*
>
> *Well, it all comes down to money. I think all of our challenges will be to increase the use of the hospital in order to break even.*
>
> *We're going to have to raise some money. I see that very clear. We're going to have to raise some money to pay for some of the improvements that we need in order to bring more business to this hospital.*
>
> *We're in the third year of a fifteen year operating agreement and I guess I have confidence that the System will eventually get things running very smoothly here. That all these changes they've had to implement will finally get us to a level that they were hoping they would.*

One board member added a broader perspective that went beyond the usual financial concerns:

> *Our governance challenges will be primarily trying to keep up with the changes in healthcare. I'm starting to get the feeling that we're going to start seeing more alternative healthcare. People are going to want privileges. Chiropractors and acupuncturists, for example. Somebody that has not traditionally been on staff – and the board is going to have to deal with that. There may be another run at nationalization. Then I think the board is going to have to look at demographics – the aging of America . And the overall community economics – what industries are going to be here in five to ten years.*

Board chairs were blunt in their assessment that they saw hospital survival as the biggest governance challenge facing regional hospital boards:

> *I think the biggest thing is going to be survival. I really do.*
>
> *Regional hospitals are going to face problems. It will mean more regional hospitals will close.*
>
> *Well, I would hope we could get past the financial problems.*
>
> *The number one challenge we're going to face is the one we've faced all along – government tightening of the reins. What concerns me most is how you get the message across to the general population about what's taking place. I don't think they realize it until it's too late. You can go to some communities where the hospital's closed and they realize it now.*

One of the board chairs expounded at some length about his frustration over his hospital's inability to help the community understand about government reimbursement reductions:

> *Just how much can the government shift to the local community? I think they will continue to shift responsibility until one of two things happens – either it is paid for locally or the hospital goes out of business. How do you get the message out to the community about what's taking place? We've tried several times with articles. What you get is people on Medicare and let's say they go to the*

emergency room with suspected pneumonia. They're x-rayed and have tests and sure enough up to the hospital they go because they have pneumonia. And then they get out in three or four days and say "look at that hospital bill for seven, nine or twelve thousand dollars for three days in there. And the doctor bill was extra." You try to explain to them what the hospital's really going to be paid but you just can't get it across to some of the older people. They just don't buy it.

The regional hospital administrators were equally concerned about the future.

Again the challenges are being able to find the support mechanisms for survival – meaning that as the federal government changes the rules and regulations, such as the Balanced Budget Amendment of 1997, it's a challenge to the local boards to find what services the local community can and will support. We may have to completely change directions. But it all boils down to finding your niche in the ecosystem that allows you to provide the top of the line as far as the quality of healthcare that the community can and will support. that is the challenge of the board.

Service issues versus reimbursement. We're going to do less well with our high level of Medicare and Medicaid patients. The board is going to have to face that revenues are decreasing while their demands for expenditures are increasing.

One administrator chose to focus on the board structure explaining that he believed the model put in place by the System may need revising.

The biggest governance challenge is going to be defining the structure. What is going to be the structure under which boards will be able to develop? Is that structure going to be a centralized decision-making board or is it going to be a diffused board? The System hasn't made up its mind and is trying to have it's cake and eat it too. A basic underlying trustee responsibility is to assure that the healthcare needs of the community are met. But they can't do that until they define their structure. My concern with the current structure is that if you read the bylaws of this hospital's board you'd say this is a judiciary board. If you look at the organizational structure and the corporate culture you'd say this is an advisory board.

What do you think the structure should be?

I think it should be a centralized board made up of representatives from as many of the regional hospitals as possible. However, I think the

board should be very small. It should be centralized but should have the ability to make decisions quickly. I would not be at all opposed to a paid board – as a matter of fact, I think that's the way we should go. The board of directors should be compensated for what they do based upon the skills that you're looking for and the ability. But they have to make sure the needs of those individual communities are met.

What you are describing in some ways is the structure of the regional Liaison Board that acts as an intermediary board between the local hospital boards and the System board.

Yes, but I don't think they should be an intermediary. One, I don't think there should be an intermediary. And two, there is no representative from this hospital on the Liaison Board.

At the conclusion of the interview with one regional administrator, he talked about the development of integrated delivery systems and highlighted one of the governance challenges from his standpoint.

We have to remember there is no proven model - because integrated delivery systems are developing, because healthcare is fragmented, because the needs of each region and the needs of each community are different. There is no proven model.

Section Nine: Regional Liaison Board

The System Board created a regional Liaison Board as part of its efforts to build an effective governance structure and provide a linking mechanism between the regional hospital boards and the System board.

In order to understand the purpose and function of this segment of the governance structure an interview was conducted with the Chair of the regional Liaison Board. The Liaison Board Chair also served as board chair for one of the regional hospitals in the System.

At the beginning of the interview, the Liaison Board Chair explained how he had come to serve in this role.

> *Well, I was appointed to the System Board in February, 1998. shortly after that the System CEO called me and asked me if I would serve as Chairman of the Liaison Board, which was going to be made up of board members from regional hospitals, as well as regional executives from the System.*

He confessed to being somewhat unsure about the purpose of the Board when it was first formed.

> *Of course, I was at a loss as to really what the goals and desires were for the Liaison Board. I visited with the System CEO a little about this. At the beginning it was my understanding that it was to be more of a communication tool for the regional hospitals and a way to introduce information. For instance, we knew very little about each other's hospitals. So to begin with we've had each one of the regional administrators come in and present information on their hospital, its plans, history and so on. It's been very educational for all of us.*

The Liaison Board included representatives from the regional hospital boards. Not all regional facilities were represented. Three of the regional facilities were not: one was a very recent addition to the System, one was the furthest away from System headquarters, and one was very small and financially fragile. The Chairman of the System Board and one other System board member were also appointed as Liaison Board members.

The Liaison Board met monthly and reported directly to the System Board. minutes of the Liaison Board meetings were kept and included in the board packet for the System Board. There was an expectation that the Liaison Board Chair would briefly report on the Liaison Board meetings during the System Board meeting to keep System board members appraised of activities in the region.

The Liaison Board chair reported that he did not develop the agenda for the meetings. He indicated that System executives responsible for the region developed the agenda. Although the agenda followed a standard format each month, the Chair confirmed that:

> *All the basic decisions about the regional hospitals are run through the Liaison Board. For instance, we talked about the regional hospital in _____ and how the System was working with the community to keep some kind of healthcare there. But after they got in there and tried they just couldn't pull things out. It was not a profitable situation. So we discussed how we could best ease out of that as well as help them maintain some sort of emergency services. We've done the same thing on a couple of other hospitals. All those kind of things are basically approved by our Board. And it's my duty to pass that information on to the System Board.*

The Chairman described the Liaison Board meetings as open and candid in discussing sensitive issues such as potential hospital closures.

> *I feel like we ask some pretty pointed questions.*

The Liaison Board Chair reported, from his perspective, the board was still in a learning phase and that he still remained hesitant about whether it was serving its purpose.

> *I talked with the System CEO after our last meeting and asked if he felt that the Liaison Board was performing and doing the exact things we needed to be doing – that we're serving our purpose. And he said, "yes, I feel like we are". I still felt a little unsure of what he was wanting us to accomplish.*

Not hesitant to offer his ideas, the Liaison Board Chair had shared with the System CEO that he thought it might be helpful to invite one of the regional hospital administrators on a quarterly basis.

> *I thought that if I had my administrator from _____ hospital and whoever from the other regional hospitals that it would*

help the communication flow a little better. Particularly when we're talking about one of the regional hospitals not meeting its budget. Most of us board members don't have the hands-on to comment. I felt like maybe having the administrator there it would let them have their input, because we've made some pretty tough decisions. Being a banker, I'm always thinking of the numbers, but the administrators are always pointing out and protecting customer needs.

One of the interview questions addressed customer needs and whether he thought it important for Liaison Board members to understand their communities and know what the community wanted.

Oh, definitely. And I feel like each one of the board members that are on the Liaison Board are very involved with their community, know the pulse of the community. We're all from small communities. We understand that a hospital is an economic portion of that rural community. Probably in almost all the rural communities, the hospital is probably the first, second or third largest employer. And then there's the physicians. Only a local person in a small community knows the emotional makeup of these physicians. Yes, the System expects us to know our communities, to know the feeling and all the little political agendas that go on between individuals that sometimes don't go on in larger communities.

The Liaison Board chair reported that the System CEO had sought the counsel and guidance of the Liaison Board on sensitive regional matters on a number of different occasions.

He always asks for our input before he goes into a situation.

The Liaison Board had been asked to make difficult decisions, such a the decision to close a rural hospital, on more than one occasion. In response to a question soliciting his opinion as to whether or not he was provided with sufficient background information to make an informed decision, the Chair replied:

Well, yes, very definitely. This was not normally done in one or two meetings. The regional executive does an excellent job of keeping us

informed. He never misled anybody. These things go on over a two or three month period.

Discussions were occasionally held about what kinds of services the regional hospitals should be providing.

Rural hospitals can't be specialist in everything. So what we've tried to do is to help assist each other, to do the things we can do best. The other discussions have been about making sure that the communities had emergency type coverage and were educated, for instance, that if you have critical care situations where would be the next best place to ship the patient.

In response to a question about how the priorities of regional hospital and the System are integrated, the Chair replied:

Through the activities of the people that are instrumental in it. And I think that comes back to the administrators, board members and the regional executives in communication and working together. Communication is the only way the System is going to work.

Recognizing that the challenges ahead were going to be difficult for regional hospitals and the System, the Chair offered these comments on what he felt would help facilitate the process:

I just feel like the regional Liaison Board is a step in the right direction. I feel like it just needs to grow a little bit more, age a little bit more I guess you could say.

Chapter Summary

The purpose of this study was to describe the governance practices of regional hospital boards of an integrated healthcare delivery system in advocating the healthcare needs of their communities. In order to accomplish that goal a case study utilizing three separate research approaches was conducted. An integrated delivery system in the

Southwest was selected for the case study. The eight regional hospitals within the System were the primary focus of the study. First fifty-six board members and administrators of the regional hospitals were surveyed by questionnaire. Next seventeen in-depth interviews were conducted with selected board members, board chairs, administrators and the chair of the regional hospital liaison board. Finally a review of historical data consisting of board agenda and minutes was completed. Questions asked throughout the research process sought to disclose the role of regional boards in functioning as community representatives, explore the potential of community representation as a vehicle for enhanced system integration, and investigate governance and board strategies to enhance community representation. An analysis of the data gathered during the case study constituted the findings of this study and has been presented here in this chapter.

Study findings were presented in nine sections: Section One presented an overview of the regional hospitals in the study and described the characteristics of participating board members and administrators; Section Two presented the governance structures and processes in place; Section Three presented board responsibilities; Section Four presented board relationships; Section Five presented perspectives on board accountability; Section Six presented content analysis of board agenda and minutes; Section Seven presented the rationale for regional hospitals joining an integrated delivery system; Section Eight presented future governance challenges for regional hospitals; and, Section Nine presented an overview of the regional Liaison Board.

Eight regional hospitals participated in the study. Geographically spread and varying in bed-size from 20–99 beds, all facilities provided in-patient and emergency room services to communities ranging in size from 1,950 to 10,000 residents.

Thirty-six board members and eight regional hospital administrators participated in the survey. Two-thirds of the board members lived in the community served by the hospital, with the majority, 16, having resided there longer than fifteen years. Administrative tenure ranged from six months to sixteen years.

Governance changes were made necessary as a result System affiliation. Seven of the eight hospitals had been independent prior to joining the System, one was part of a competing healthcare system. All but one of the hospitals had, and continued to maintain, ownership or tax relationships with their local city.

Survey responses on governance revealed widespread confusion as to the exact nature of the governance structure and relationships following System affiliation. Twenty-five board members stated that the hospital had a legally constituted governing board, which bore ultimate responsibility for the affairs of the organization, eleven board members said it did not. System efforts to integrate new board members into established governance processes generated further confusion as respondents provided widely disparate information on how many of their board members had been asked to serve on System boards and committees.

Subject perceptions on fourteen areas of board responsibility were sought. Concern for the continued financial viability of the hospital received the strongest support, with ensuring professional standards in the care of the sick, and selecting and

maintaining a qualified medical staff also scoring highly as important areas of board responsibility.

Responsibility for board agenda development was unclear to most board members. Board members reported being uncertain how the agendas for their board meetings were developed but felt reasonably confident about their ability to have an item listed on the agenda should they so desire. Administrators reported that they developed the agenda with System review.

Board members acknowledged that they found the board responsibility to stay current on healthcare issues and trends difficult, with many relying on management to keep them informed. Administrators shared examples of how they try to help board members keep up with the constantly changing healthcare world but admitted it was not easy.

Board relationships with the community, between the board and management, and among board members were explored. In commenting on community relationships, board members were satisfied that the long-range health needs of the community were being fulfilled and that appropriate services to the uninsured were being provided. They did not feel the hospital was adequately educating the community about managed care. Board members did not see themselves as being strong sources of information on community health needs, believing that data came from health professionals. Board members were unclear about whether or not their hospital conducted community surveys.

Few interview questions elicited as emotional a response as the question whether or not it was important for regional hospitals to be connected to their

communities. Board members voiced strong opinions that it was critical, and stressed the important role of the hospital in the community. Local board members were seen as being better able than System board members are to represent community needs.

Hospital administration was seen as being very supportive in providing board members with the information they needed to fulfil their responsibilities, whereas only qualified support was given to administrator responsiveness to board input, communication of community health needs to the System and discussion of resource allocation issues. Administrator responses paralleled board member feedback suggesting room for improvement.

Board member to board member relationships were seen as good, with the environment in board meetings seen as open and candid. Board members expressed appreciation of the skills and contributions of others serving on the board. Most board members, 18, reported that community health issues were raised by board members in their meetings.

Board accountability was at appropriate levels in some instances and lacking for others. Boards did request feedback about programs provided for the community benefit and appeared proactive in addressing community health needs. It appeared that most boards only infrequently reviewed community health data and were only occasionally being educated on community health measures. Little board education was reported and board member responses suggest community health issues were not consistently passed on to the System board for their consideration.

Board members struggled when asked to describe programs and services their hospital had implemented for community benefit. The exceptions were those board

members personally involved in specific program development. Administrators were far better able to cite examples such as specialist clinics, health fairs and mobile CAT scan and mammogram units. Feedback indicated that few regional hospitals were able to address all the community issues the board felt were important due to limited financial resources.

Board members reported relying heavily on hospital management to provide them with sufficient information to enable appropriate program decisions to be made.

Board education was seen as lacking. Responses suggest that while some board members would value board development efforts, others reported time was a limiting factor.

A content analysis of regional hospital board agenda and minutes revealed use of a standard agenda format. All but two hospitals followed this format for the entire sixteen-month review period. Two hospital boards met monthly, the remainder met on a quarterly basis. Sixty-two sets of minutes were reviewed, with 793 discussion items categorized into governance, operations, finance, physicians and community representation topics. Operational topics, 30.2%, and community representation issues, 27.6%, were discussed most frequently. A breakdown of community representation issues revealed that of the 129 total, board members raised 90 issues, with administration raising 129. Discussions concerning new programs constituted 32.5% of community representation issues.

Data showed that regional hospitals sought to affiliate with integrated delivery systems primarily for survival reasons. All but one of the eight hospitals were

experiencing financial pressures. Access to management expertise and the economies of scale available through group purchase programs were also cited.

Reduced community influence, loss of local autonomy, and bureaucracy were viewed as the key disadvantages. Two board members and one board chair reported that nothing was given up to join the System, the remaining nine board members and board chairs believed that loss of autonomy and the ability to make timely decisions based on local needs were costs of System affiliation.

Board members were either openly confused by questions concerning system integration or had difficulty providing examples. They appeared uncertain of what integration meant and how it might occur. Familiar with this example because of his professional role, one physician board member saw the establishment of patient transfer agreements as demonstrating system integration. Hospital administrators viewed both the regional hospital and System strategic plans as being the blueprints for system integration efforts.

A number of future governance challenges appeared repeatedly in board member survey responses. Among them were continued financial viability, lower reimbursement, increasing government regulation and determining the appropriate model of healthcare delivery in rural areas. Regional administrators shared these perspectives emphasizing financial viability and the need to find appropriate services to fit community needs.

Board education was seen as one way regional hospital boards could best address future governance challenges. The need to stay current about healthcare trends, maintaining open communication, and soliciting community input were also reported.

Board chairs focused almost exclusively on hospital survival and expressed concern that financial shortfalls would lead to hospital closures.

A Regional Liaison Board was created by the System to provide a governance linking mechanism between the regional hospital boards and the System board. The chair of one of the regional hospitals was appointed Chair of the Liaison Board. The Chair acknowledged that he was uncertain as to the board's purpose when first appointed. All basic decisions about the regional hospitals were run through the Liaison Board, including decisions to downsize or close a hospital. The Chair indicated he remained unsure as to whether the Liaison Board was fully serving its purpose, believing the board to be a step in the right direction but that the board was not fully matured.

The findings revealed answers to the basic questions embodied in this study. Many of the answers were consistent with existing concepts of governance and the development of organized delivery systems. Other answers have provided new perspectives on community representation in organized delivery systems. Chapter Five presents a summary of the study conclusions, recommendations for further research, recommendations for future practice, and the implications of the study.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

This study sought to describe the governance practices of regional hospital boards of an integrated delivery system in advocating the healthcare needs of their local communities.

A literature review encompassing work on the development of integrated delivery systems, governance of integrated delivery systems, board roles and responsibilities, resource dependence theory and case study methodology was conducted.

The development of integrated healthcare delivery systems is an emerging field of study. The literature contains few empirical studies addressing the topic. Research about the role of governance in integrated delivery systems is especially lacking. Shortell conducted much of the early research on integrated delivery systems. He defined this new organizational model as "a network of organizations that provides, or arranges to provide, a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and health status of the population served" (Shortell, Morrison & Friedman, 1992).

The literature suggests that governance can serve as an important facilitator of, or barrier to, successful healthcare integration (Alexander et al., 1995; Shortell et al., 1996). Governance is defined as the making or not making of important decisions and

the related distribution of authority and legitimacy to make decisions (Kovner, 1990). Pointer and Ewell identify the important challenges facing healthcare boards in the 1990s as integration, competition and financial viability.

The literature suggests that the board role of community steward deserves attention (Delbecq & Gill, 1988; Shortell & Gillies et al., 1996), with hospitals being rewarded for commitment to a community. Pointer and Ewell (1994) defined board responsibilities as the specific matters a board must attend to in order to fulfil its responsibilities to the organization's stakeholders.

Resource dependence theory is presented as a theoretical underpinning describing the relationship between hospitals and the communities they serve. Pfeffer and Salancik observed that the resource dependence perspective views organizations as needing to strike relationships with individuals, groups and organizations in their environment to acquire the resources to survive. Foundational theoretical work applying this perspective to governance was conducted by Zald (1969).

The case study method has been an important form of research in the social sciences and management (Denzin & Lincoln, 1998). Yin (1989) believes major strengths of the case study method are that it measures and records behavior, and uses both qualitative and quantitative data. Eisenhardt (1989) argues that the case study method is particularly well suited to situations where little is known about a phenomenon or where current perspectives have little empirical substantiation. Limitations are seen as observer bias and lack of generalizability (Eisenhardt, 1989; Yin, 1989).

A case study of an integrated delivery system in the Southwest was undertaken. Three separate research approaches were incorporated into the case study: a survey by questionnaire, in-depth interviews, and content analysis of historical data.
The board chairs, board members and administrators of eight regional hospitals were asked to describe governance practices concerning community representation. Questions asked during the research process sought to disclose the role of regional boards in functioning as community representatives, explore the potential of community representation as a vehicle for enhanced system integration, and investigate governance and board strategies to enhance community representation. Answers to these questions, together with content analysis of board agenda and minutes, were analyzed using qualitative methods. Chapter V summarizes the conclusions that emerged from the analysis of the data. These conclusions are applicable only to the integrated healthcare delivery system in the study, and are offered to guide further research on the development of healthcare systems. Recommendations for future research, and recommendations for future practice follow the conclusions. The final section of this chapter draws attention to the implications of the study.

Conclusions

The descriptions of roles and relationships embedded in the data that were collected in this study demonstrate the central role that relationship management plays in the development of integrated healthcare delivery systems. They further support Pfeffer and Salancik's (1978) resource dependence concepts and Zald's (1969) foundational work on governance.

While the importance of relationship management and the dependencies it creates have long been assumed, the actual benefits and costs were unclear until Pfeffer and Salancik's recent work. Early resource dependence research was done by Selznick (1949), who found that opposing groups were neutralized when their representatives were included on the governing board. Zald (1969) built on Selznick's work by applying this perspective to governance. Zald saw boards as having two functions: internal control and external control. The first involves overseeing internal functioning, while the second deals with developing linkages with stakeholders. These linkages allow the organization to acquire the resources that it needs to be successful. Pfeffer and Salancik's (1978) comprehensive work on resource dependence views organizations as needing to strike relationships with individuals, groups and organizations in their environments to acquire the resources to survive. Such relationships create dependencies which organizations attempt to either minimize or manage. The results of this study support Pfeffer and Salancik's views regarding the importance of relationship management in healthcare governance.

Role of Regional Boards in Functioning as Community Representatives

The first research question sought to determine what regional board members understand about their roles as community representatives. Study results confirm that board members take the role of representing their local communities extremely seriously. They believe the regional hospital exists to serve the community and that, as board members, they are charged with overseeing appropriate provision of healthcare

for the citizens of the area. The regional hospital board is seen as the bridge between the hospital and the community.

- Regional hospital boards consider community representation a critical board member role.

Historically hospital boards have been composed of members who were explicitly or implicitly chosen to "represent" specific constituencies. While recognizing the need for changes in board composition to allow System representation, local board members strongly emphasized the importance of boards remaining connected to the community they represented. Board members believe this can best be accomplished through local board representation. The value of the contribution that could be made by someone familiar with the community was stressed repeatedly. The perception being that the community ought to have representatives who could present their views to the board. Local board members indicate that they are the only ones who can fulfil this role and see an integral part of their role being to listen to and relay information back to the hospital administrator or the board for information and action.

- Local regional hospital board members believe they are uniquely qualified to represent the community, whereas board members representing the integrated delivery system are not.

In addition to community representation, public image and service promotion were seen as important reasons why regional hospitals should be connected to their communities. Board members clearly want their local communities to be proud of their hospital and believe that one way to build such pride is for the hospital to undertake local projects with the support and assistance of the organized delivery system. It is believed that by demonstrating their commitment to, and willingness to invest in, the local community the new healthcare partnership will be viewed favorably by those

living in the area. Comparisons were made to large corporations, such as Wal-Mart, and the contributions that they make locally.

Service promotion was seen as being critical for the hospital to remain financially viable, with board members believing that unless the hospital provided the services needed and valued by the community, patients would go elsewhere. Building community loyalty was seen as one of the best strategies a hospital could undertake.

- Integrated delivery systems can build community loyalty by engaging in community related projects with their regional hospitals.

In recent years the majority of communities throughout the United States have seen organizational changes with respect to healthcare, many involving their local hospital and other providers. Often larger organizations, such as healthcare systems, have been created. The public's analysis of why these changes occur is consistent and straightforward; they believe the motive is profit. (AHA, 1998). The public believes that the larger and more powerful healthcare organizations become, like larger banks, the less they are focused on the needs and concerns of individuals. An American Hospital Association study (1998) found that in situations where a local hospital had affiliated with a larger institution, system or chain the community experienced a sense of loss and a fear that care would diminish in quality and availability.

Regional hospital board members see themselves as the guardians of their communities and would respond to locally expressed fears that services would lessen in their role as advocates of their communities. Such concern may have prompted the vehement support board members showed in regard to the importance of community representation.

- Regional hospital boards considering affiliation with an integrated delivery system should anticipate local community reaction to be concern over potential reduction of healthcare services.

The need for the continued survival of the hospital in the community is seen as critical. Board members and administrators alike view the local hospital as essential to the growth and development of the community. Survival is seen as being synonymous with ongoing financial viability. Concern over hospital finances was a primary driver in all but one of the regional hospitals in the case study seeking affiliation with an integrated delivery system. The financial challenges posed by the Balanced Budget Act and other reimbursement cuts are well recognized by both board members and administrators. Board members will go to great lengths to ensure their community retains appropriate access to healthcare and will not easily be persuaded by administrators or System executives to consider service reductions.

- Local board members will fiercely protect community beneficial healthcare services.

Hospital administrators recognize the importance of the role that local board members play in helping them maintain close relationships with the community. Local board member efforts at community representation are valued and their contributions at board meetings are respected. Ideas and suggestions are researched and findings reported back to the board. In direct contrast, administrators do not believe System board representatives possess a full appreciation for community needs and are not able to represent local citizens in the same way that local board members can.

- Individuals selected as integrated delivery system representative board members on regional hospital boards will not be viewed as community representatives.

Administrators talk positively about how the community describes the hospital as theirs and believe this perception builds a confidence level in the quality of care provided by hospital staff. The smaller the community the more positive the perception was believed to be and the stronger the sense of community ownership. The members of small communities know each other and most know people who work at the hospital. Community trust in the hospital is seen as building over time through various experiences, some personal and some word of mouth. Administrators rely on their local board members to help them build a positive public image of the hospital through interactions with their neighbors and business associates.

- Local regional hospital board members can facilitate building a positive public image of integrated delivery affiliation.

The Potential for Community Representation As a Vehicle for Enhanced System Integration

Successful integrated healthcare organizations have a community rather than a membership orientation (Conrad & Shortell, 1997). They seek to deliver a broad array of services to a defined population across the continuum of care in a cost-effective manner. In order for an integrated delivery system to reap the full benefits of integration, the organization must find ways to pool knowledge capital and apply best practices across the continuum of care.

Regional hospital board members acknowledge that the era of the stand-alone rural hospital is gone. They know they need the knowledge, expertise and financial help that healthcare systems can offer. Assistance with financial and operational management, physician recruitment, managed care contracting, and management

information systems is urgently needed. In exchange for providing such affiliation benefits, an integrated system expects to gain access to the communities surrounding the regional hospital and assist them meet their healthcare needs.

Early integration efforts with the regional hospitals in the case study included several strategies designed to enhance community relations. New programs and services were discussed and incorporated into strategic and operational plans. Community need for specialist services was evaluated and arrangements made to have specialist physicians from the metropolitan area conduct regional clinics. Physician needs were identified and recruitment plans initiated. Managed care experts reviewed the insurance and physician networks to which the regional hospital belonged and worked to negotiate broader participation in health plans. Such efforts were welcomed and appreciated by both hospital board members and administrators.

- Early integration efforts are welcomed by regional hospitals.

In the case study, integration efforts often did not move quickly enough to satisfy the regional hospitals. Board members and administrators speculated that the System was growing too quickly, adding more and more regional hospitals to its portfolio, and was finding it increasingly more difficult to allocate the resources, human and financial, to the regional hospitals.

- Rapid growth of an integrated delivery system may limit its ability to initiate integration strategies.

Once a part of the System, local board members would begin to raise community issues they perceived needed addressing. New program ideas would be discussed in board meetings. Community health concerns seen as worthy of consideration for the establishment of new services would be reviewed. New or

replacement equipment would be requested. The need for additional physicians in the community would be reviewed. For quite some months after affiliation the new relationship between the regional hospital and the System will be continually tested to see if it held all the promise for the community the regional board members hoped for.

- Regional hospitals will seek early benefits of system integration.

For the System this can be a time of tremendous opportunity. The potential exists to not only meet community needs, but exceed expectations, while integrating services into the continuum of care provided by the System. Local area physicians can be networked with metropolitan physicians, referrals to both regional and metropolitan System specialist physicians can be facilitated. Patient transfer agreements can be established. Local physicians can be encouraged to join System-sponsored or supported networks and health plans. Protocols of care can be shared. Relationships between, and amongst, the System and its regional hospitals can be built.

Regional hospitals, board members and administrators alike, are eager to see these kind of progressive changes occur. They are willing to give up local control of their hospital to gain the experience the System offers, but the window of opportunity is narrow for the System to demonstrate it can produce the desired benefits. A state of psychological readiness exists immediately, and for some time, after affiliation. Administrators, board members and physicians are open to changes they perceive will benefit themselves, the hospital and the community. Creation of a collaborative culture among the local and System board members on the regional hospital board can enhance system integration efforts.

- Integration opportunities are best initiated early in the affiliation relationship.

The creation of a new and different board culture is an integral part of system affiliation. The newly formed boards are asked to operate within a new governance structure and to learn new processes of decision-making.

Both board members and administrators acknowledge that little board development occurred. While some board members clearly valued board development efforts, others emphasized that their professional lives kept them too busy to devote the needed time. Board members admit feeling unprepared for their board responsibilities and are openly confused over the complexities of modern healthcare. Most board members rely heavily on their regional hospital administrator and on System board representatives to educate them on issues as they arise. Many board members lack a full appreciation of what an integrated delivery system is and how what the system seeks to accomplish might benefit their local community.

- Regional board members find healthcare complex and confusing.
- Regional board members should understand and appreciate the mission of the integrated delivery system to which they are affiliated.
- Organized delivery systems will face integration difficulties unless regional hospital boards recognize that the interests of their community will be best served if the system as a whole pursues and achieves its mission.

Two research questions addressed the identification of community health needs. One question sought to determine how regional board members identified the healthcare needs of their local communities. A second question sought to uncover how regional board members applied what they learned about community health needs.

Few regional hospitals have developed effective processes to learn about unmet community health needs. Board members do not see themselves as reliable sources of

community health information, although administrators believe differently. Board members consistently raise community health issues for discussion at board meetings and demand updates on existing community health programs. Only one of the regional hospitals in the study conducts a community survey on a regular basis and utilizes the data to plan services and programs. The communities surrounding the regional hospitals in the study were very different and could reasonably be expected to have varying health needs. Regularly conducted community surveys provide both board members and administrators with the data needed to effectively represent their communities' health needs.

- Community health needs vary by community.
- Regularly conducted community surveys can enhance community representation.
- Data from community surveys can enhance system integration efforts.

Affiliation with an integrated delivery system brings management and operational changes for the regional hospital. While there are acknowledged benefits to system affiliation, there can also be significant disadvantages. The establishment of trust is a prerequisite for building the new relationship. Maintaining trust necessitates that each party honor its promises. For the system this equates to providing the needed management and operational assistance the regional hospital seeks. System integration efforts were enhanced when the regional hospital felt it was part of a trusting relationship and was receiving the benefits it sought in a timely fashion. Things fell apart when the needed help was slow in coming, causing the regional hospital to doubt the spirit of the affiliation.

- System integration efforts are most effective when a relationship of trust exists between the regional hospital and the system.
- Slow system response to perceived regional hospital needs erodes trust.
- System bureaucracy minimizes the likelihood of successful system integration.

Governance and Board Strategies to Enhance Community Representation

The fourth research question sought to understand how System corporate board members identify the healthcare needs of the communities surrounding member hospitals. While System governance structures are still evolving, and processes to ensure appropriate information flow both up and down the rapidly developing organization in their infancy, the answers to this research question appear be twofold. First, systems thinking will enhance the potential for information flow throughout the healthcare system. Second, the creation of the Liaison Board provides a formal governance vehicle for discussion of issues important to the regional hospitals. These conclusions are discussed more fully later in this section.

Early in the development of the integrated delivery system in the case study, consideration was given to the desired form of governance. Cognizant that representational governance was the model used by regional hospitals, the System sought to preserve local representation in designing system governance processes. It was also broadly acknowledged that board members could be instrumental in helping the System become better acquainted with, and be accepted by, the local community.

Upon affiliation with the System the bylaws of the regional hospital were rewritten to reflect the new governance structures. Many of the regional hospitals in the case study had complicated ownership relationships, with the System leasing and/or managing the facility. Local board members found the new governance confusing. They were unclear about the exact nature of the relationship changes upon affiliation. This confusion led to uncertainty regarding their roles and responsibilities as board members, and levels of authority.

- Developing integrated delivery systems should anticipate the need to educate regional hospital board members on board roles and responsibilities following system affiliation.

Prior to the decision to become part of a larger healthcare system, the regional hospital boards were made up of purely local citizens. Affiliation to the organized delivery system brought about changes in the governance structure and in the composition of the board. Local citizens now constituted approximately 50% of the total board membership, the remaining membership being individuals chosen primarily to represent the System and it's interests.

These changes in the composition of the hospital boards are being met with some resistance by local board members. They fear a shift in the balance of power and that their efforts to represent the community will be outvoted by System board members. Recognition of these concerns led the System to amend early governance efforts at board composition, which attempted to appoint more System representatives than local board members.

- Board composition changes following affiliation with an integrated delivery system enhance concerns regarding the potential of future community representation.

- Equal numbers of local and system board representatives facilitates the building of trust.

The local board members selected by the System to be appointed to the new board were seasoned community members. Known and respected in their local communities, the majority had served on the hospital board for some years prior to System affiliation. Several individuals were physicians who served the local community. Many had prior board experience on community boards. They were mature individuals, who held responsible positions in a wide variety of local businesses. Having lived in the community for many years, these local board members were knowledgeable of community issues and concerns.

- Selection of respected community members for regional hospital board appointment enhances community perceptions of representation.
- Greater physician involvement in governance will enhance system integration.

Few working governance models for integrated delivery systems existed when the System began implementing its integration strategy. Development of the governance structure became a work-in-progress. In addition to the desire to retain some form of representational governance, the System saw it as advantageous to move towards standardization of regional hospital board meetings, including agenda development and board minute reporting. These changes were being implemented gradually, with hospitals being at various stages of compliance at the time of the case study. Board meetings were seen as vehicles for gathering information, decision-making, and sharing information. Agenda development was initiated by the hospital administrator, generally with input by the hospital board chair. Agenda were reviewed by the System in advance of the meeting to allow System executives the opportunity to

evaluate items proposed for discussion and decision-making and to recommend changes they felt were warranted. Efforts were made by the System to fully discuss all aspects of board business with both the board chair and the administrator. These discussions provided an opportunity for the System to educate the administrator and the board chair on current healthcare issues and to learn regional perspectives on items being proposed for board consideration. Most regional hospitals appreciated the structure that this process brought and considered their board meetings more productive.

In situations where relationships with the regional hospital were strained, the System attempted to exert greater control over board affairs. Local board chairs generally realized this was occurring and did not appreciate being excluded from the process. Unless effective communication links were reestablished, the relationship between the regional hospital and the System continued to deteriorate.

- Effective boards control how they spend their time.
- Standardization of board meeting agenda enhances governance effectiveness.
- System involvement of regional hospital board chairs facilitates system integration.
- Lack of regional hospital board chair involvement promotes distrust of the system.

As part of System initiatives to integrate regional board members into the System governance structure, various regional hospital, locally based board chairs and board members were invited to participate on System boards and committees. Also serving as a board development process, local board members were exposed to corporate level governance and to the complex world of a rapidly developing integrated delivery system. Board members shared what they learned with their regional hospital

boards back home and in return provided the System with regional perspectives. While most regional board members were aware that some of their colleagues were serving on boards at the System level, there was great confusion about who and how many were serving in such roles.

- Involvement in integrated delivery system governance processes promotes systems thinking on the part of regional board members.
- Representation of local board members in system level governance enhances community representation.

The increasing number of regional hospitals becoming part of the System gave rise to development of the regional Liaison Board. Made up of representatives from the regional hospital boards and the System, the Liaison Board addresses regional integration issues, passing key items on to the System board for information and final approval. A potentially valuable governance integration mechanism, this board is in the early stages of development and appears to be still determining its role and function.

- Development of a joint regional board at the system level may facilitate the transition from institutional governance to system governance.
- System boards may lose touch with the unique circumstances and needs of system member organizations.
- Representational governance at the system level may cause system board members to focus on the best interests of component parts of the system rather than on the best interests of the system as a whole.

Recommendations

Recommendations for Future Research

This study was designed to identify the aspects of governance which facilitate effective community representation in integrated healthcare delivery systems. It has successfully produced a number of relevant conclusions, each of which represents an issue for further research. While the inductive qualitative approach in this study has been useful in developing study conclusions, a more focused deductive approach is recommended for future exploration of their validity.

Of particular interest is research into effective system governance models and how such models address community representation. This study has presented one governance model adopted by an organized delivery system early in its development. Research comparing governance models adopted by mature organized delivery systems would offer further insight into how such healthcare organizations incorporate community representation.

Identifying community health needs proved challenging to the regional hospitals in the study. Further research into how to most effectively capture and analyze community health data would provide regional hospitals with mechanisms that would allow them to better target community service and program provision given limited resources.

Healthcare appears to be on a path toward redefining itself as a more responsible and vital service to both individuals and the community as a whole. This transformation will involve a greater reliance on scientific knowledge and a greater

need for shared knowledge among healthcare professionals. Further research into the processes whereby organized delivery systems assume responsibility for the health status of the communities they serve will greatly benefit this transformation.

Recommendations for Future Practice

If the conclusions presented in this study are found to be reflective of patterns of community representation behavior demonstrated when regional hospitals join integrated delivery systems, then persons involved in the planning of integrated delivery system integration or persons involved in evaluating regional hospital affiliation to a healthcare system should consider the following recommendations.

Governance Transition: As regional hospitals merge with integrated delivery systems their boards will need to transition from representational governance to the broader, mission-based form of governance employed by systems. Board members will need to become system thinkers.

Systems Thinking: Individual regional hospitals that successfully join together to form a new integrated delivery system must transform themselves in the process. They will need to appreciate that what might be good for one part of the organization might not be good for the organization as a whole and that working together to reach a common goal is the best strategy in the long run.

Systems-Oriented Governance: Newly developing integrated delivery systems should design governance structures and process that will ultimately lead to an integrated, systems-oriented form of governance. Regional hospital boards will ultimately be subordinate to a system board. Reconciling this reduction in authority and

clarification of roles and responsibilities between the regional hospital boards and the system board are crucial to achieving effective system governance.

Assumption of Accountability: Integrated delivery systems must recognize that they are accountable for the health status of all the communities surrounding their regional hospitals. Activities should be directed toward identifying the health needs of specific communities and promoting health and prevention rather than merely treating injury and illness. Community surveys should be conducted on a regular basis, with results reported back both to the regional hospital board and to the system. All other sources of community health data should be identified and researched for use in program planning.

Accessible Continuum of Care: A continuum of care should be established that encompasses decentralized primary care provider locations, and smooth and efficient access to specialty care, hospital care, and ancillary services. Regional healthcare professionals must be sufficiently knowledgeable about the continuum of care to guide community residents requiring care.

Best Practices: Individuals and entities that provide similar levels of care should be integrated through best practices. Healthcare professionals should be encouraged to share best practices with their system colleagues to promote high quality, cost-effective care.

Physician Integration: Key players in the development of integrated delivery systems, physicians must be integrated into all aspects of the system, particularly into governance processes. Physicians should be integrated at all levels of leadership structures and planning activities.

Board Development: Effective preparation of regional board members for system involvement and leadership requires a formal program of board development. Conducted both at the regional hospital and system levels, focus should be on culture development, systems thinking, board roles and responsibilities, system mission, system planning and community representation.

Change is the one constant in today's complex healthcare environment. System governance issues will continue to emerge as systems themselves grow and develop. Many healthcare systems are struggling with how best to continue gaining representation from the various constituencies served by the system. While most boards are community-minded, they are still very much on the learning curve in terms of thinking and acting from a system standpoint. Those involved in assisting integrated delivery systems determine appropriate system integration strategies and those working with regional hospitals new to system affiliation should appreciate the process of change is often unpredictable. It may be slow and gradual, or fast and dynamic. Only by understanding the nature of human response to change and by managing the complex web of relationships can professionals best facilitate the development of integrated delivery systems.

Implications of the Study

Whether or not the integrated delivery system emerges as a dominant healthcare model, huge changes are ahead for hospitals. As health resources become scarcer and more tightly controlled, hospitals will have to integrate their services with those of other providers for resource efficiency. Integration involves the coordination of functions and

activities across operating units so as to maximize the value of services delivered (Gillies et al., 1996). The promises of integration are clear: greater continuity of care, greater control over quality and costs, increased efficiency, and better service to the community.

Hospital governance, as it has traditionally been, will not survive unchanged. As new forms of health care organizations emerge, new forms of governance will be required to lead them. Although many boards have gone through some form of transition, a quantum leap to the next form of governance is required.

Overseeing and managing the incredibly complex networks of relationships that are integrated delivery systems will necessitate new and very different forms of governance. Although vital, its relationship to the community is but one of the many relationships that the organized delivery system must manage. Care must be taken to ensure that the valuable contributions made by local board members on behalf of their communities are not sacrificed to streamlined governance.

Effective management of relationships is crucial to the future success of integrated healthcare delivery systems. By working together, the multiple partners who comprise an integrated delivery system can fulfil the promises of integration and enhance healthcare for communities throughout the country.

BIBLIOGRAPHY

Advisory Board Company. 1993. The grand alliance: Vertical integration strategies for physicians and health systems. Washington, DC.: Advisory Board Company.

Alexander, J. A., & Fennell, M. A. 1986. Patterns of decision making in multihospital systems. Journal of Health and Social Behavior 27: 14-27.

Alexander, J. A., Vaughn, T., Burns, L.R., Zuckerman, H.S., Andersen, R.M., Torrens, P., & Hilberman, D. W. 1996. Organizational approaches to integrated health care delivery: a taxonomic analysis of physician-organization arrangements. In Medical Care Research and Review, Vol.53:1. Sage Publications.

Alexander, J.A., Zuckerman, H.S. & Pointer, D.D. 1995. The challenges of governing integrated health systems. Health Care Management Review, 20:4, 69-81.

Allison, G. T. 1971. Essence of decision-making: Explaining the Cuban Missile Crisis. Boston: Little Brown Book.

American Hospital Association. 1982. Guidelines: Roles and functions of the hospital governing board. Chicago: American Hospital Association.

American Hospital Association. 1993. Assessing health status: A five phase model. Hospitals and Health Networks 67 (24): 29.

American Hospital Association. 1993. Transforming healthcare delivery: Toward community care networks. Chicago: American Hospital Association.

American Hospital Association. 1998. Reality Check II: More public perceptions of healthcare, change and hospitals. Chicago: American Hospital Association.

Anderson, P. C. 1983. Decision-making by objection and the Cuban missile crisis. Administrative Science Quarterly, 28:201-222.

Appleby, C. 1995. Market Reform: The middle no more. Hospitals and Health Networks, 69 (11).

Bergman, R. 1994. Making the grade. Hospital and Health Networks (5 January): 34-36.

Blau, P. M. 1955. The dynamics of bureaucracy: A study of interpersonal relations in two government agencies. Chicago: University of Chicago Press.

Boeker, W. & Goodstein, J. 1991. Organizational performance and adaptation: Effects of environment and performance on changes in board composition. Academy of Management Journal, 34:805-826.

Borg, W. R. & Gall, M. D. 1983. Educational research: an introduction. Longman, New York, NY.

Burda, D. 1993. Study–Mergers cut costs, services, increase profits. Modern Healthcare 23 (6): 4

Campbell, A. 1995. Vertical integration: Synergy or seduction? Long Range Planning 28 (2): 126-128.

Campbell, D. T. 1975. Degrees of freedom and case study. Comparative Political Studies, 8: 178-193.

Carpenter, R. N. 1988a. Cooperative governance, Part I: As a corporation. Management Quarterly, 29,1: 3-6.

Carpenter, R. N. 1988b. Cooperative governance, Part II: Director's responsibilities. Management Quarterly, 29,3: 3-6.

Carver, J. 1991. Boards that make a difference: A new design for leadership in Nonprofit and public organizations. San Francisco: Jossey-Bass.

Carver, J. 1994. To focus on shaping the future, many hospital boards might require A radical overhaul. The Baxter Foundation's Health Management Quarterly 16 (1): 7.

Charns, M. P. & Tewksbury, L. J. S. 1993. Collaborative management in health care: Implementing the integrative organization. Jossey-Bass, San Francisco.

Coddington, D. C., & Bendrick, B. J. 1994. Integrated health care: Case studies. Englewood, CO: Center for Research on Health Care Administration.

Coddington, D. C., Moore, K. D., & Fischer, E. A. 1994. Integrated health care: Recognizing the physician, hospital and health plan relationship. Englewood, CO: Center for Research in Ambulatory Health Care Administration.

Coile, R. C. 1995. Age wave: Organizing integrated care networks for an aging Society. Health Trends 7 (6): 1-8.

Conrad, D. A. 1993. Coordinating patient care services in regional health systems: The challenge of clinical integration. Hospitals and Health Services Administration 38 (4): 491-507.

Conrad, D. & Shortell, S. 1997. Integrated health systems: Promise and performance. Frontiers of Health Services Management, 13 (1): 3-37.

Daft, R. L. 1980. The evolution of organizational analysis in ASQ: 1959-1979. Administrative Science Quarterly, 25,4: 623-636.

Delbecq, A. L. & Gill, S. L. 1988. Developing strategic directions for governing Boards. Hospital & Health Services Administration, 33: 25-35.

Denzin, N. & Lincoln, Y. 1998. The landscape of qualitative research: Theories and issues. Thousand Oaks, CA.: Sage Publications.

Denzin, N. & Lincoln, Y. 1998. Strategies of qualitative inquiry. Thousand Oaks, CA.: Sage Publications.

Denzin, N. & Lincoln, Y. 1998. Collecting and interpreting qualitative materials. Thousand Oaks, CA.: Sage Publications.

Devers, K. J., Shortell, S. M., Gillies, R. R., Anderson, D. A., Mitchell, J. B., Morgan, Erickson, K. L. 1994. Implementing organized delivery systems: An integration scorecard. Health Care Management Review 19 (3): 7-20.

Drake, D. F. 1994. Reforming the health care system: An interpretive economic history. Washington, DC.: Georgetown University Press.

Dukerich, J. M., Golden, B.R., & Shortell, S. M. 1995. The antecedents and consequences of organizational identification in vertically integrated health delivery systems. Working paper presented at the meeting of the Academy of Management, Vancouver, B. C., Canada.

Dyer, G. & Wilkins, A. 1991. Better stories; not better constructs to generate better theory: A rejoinder to Eisenhardt. Academy of Management Review, 16, 3:613-619.

Eisenhardt, K. M. 1989. Building theories from case study reassert. Academy of Management Review, 14:4, 532-550.

Emerson, R. M. 1983. Contemporary Field Research: A collection of readings. Prospect Heights, IL: Waveland Press Inc.

Fehrenbacher, H. L., Owens, T. R. & Huenn, J. F. 1978. The use of student case study methodology in program evaluation. Research Evaluation Development Paper Series No. 10, Northwest Regional Educational Laboratory. Portland, OR.

Fickenscher, K., & Lagerwey-Voorman, M. 1992. An overview of rural health care. In S. M. Shortell and U. E. Reinhardt (eds.), Improving Health Policy and Management: Nine Critical Research Issues for the 1990s. Ann Arbor, Mich.: Health Administration Press.

Fox, W. 1989. Vertical integration strategies: More promising than diversification. Health Care Management Review, 14: 49-56.

Gay, L. R. 1992. Educational research: competencies for analysis and application. (4th Ed.) Macmillan Publishing Company, New York, NY.

Gersick, C. 1988. Time and transition in work teams: Toward a new model of group development. Academy of Management Journal, 31:9-41.

Gillies, R. R. et al. 1993. Conceptualizing and measuring integration: findings from the health systems integration study. Hospital and Health Services Administration. 38 (4): 467-489.

Ginn, G. O., Young, G. J., & Beekun. 1995. Business strategy and financial structure: An empirical analysis of acute care hospitals. Hospital and Health Services Administration 40 (2): 191-209.

Goldsmith, J. C. 1994. The illusive logic of integration. Health Care Forum Journal 37 (5): 26-31.

Gordon, L. A. et al. 1992. The challenge of governing for value. Directors and Boards, 16,3: 13-17.

Gouldner, A. W. 1954a. Patterns of industrial bureaucracy. New York: Free Press.

Gouldner, A. W. 1954b. Wildcat Strike: A study in worker-management relationships. New York: Harper & Row.

Gregory, D. 1992. Strategic Alliances between physicians and hospitals in multihospital systems. Hospital and Health Services Administration 37 (2): 247-258.

Griffith, J. R. 1992. The well managed community hospital. Ann Arbor, MI: Health Administration Press.

Griffith, J. R. 1996. Managing the transition to integrated healthcare organizations. Frontiers of Health Services Management, 12:4, 4-50.

Griffith, J. R. 1994. Re-engineering Health Care: Management systems for Survivors. Hospital and Health Services Administration, 39 (4): 451-470.

Griffith, J. R. 1995. The well-managed health care organization, 3rd ed. Ann Arbor: Health Administration Press.

Griffith, J. R. 1995. The infrastructure of integrated delivery systems. Healthcare Executive, May/June: 12-17.

Griffith, J. R., Sahney, V. K. & Mohr, R. A. 1995. Reengineering Health Care: Building on CQI. Chicago: Health Administration Press.

Hageman, W. M. & Umbdenstock, R. J. 1990. Organizing and focusing the board's Work: Keys to effectiveness. Frontiers of Health Services Management, 6,3: 29-46.

Harris, S. & Sutton, R. 1986. Functions of parting ceremonies in dying Organizations. Academy of Management Journal, 29:5-30.

HCIA. 1995. The comparative performance of U.S. hospitals. The Sourcebook. Baltimore, MD: HCIA and Deloitte and Touche.

Healthcare Forum. 1993. What creates health? Individuals in communities respond. A national study conducted by Dyg, Inc., for the Healthcare Forum. San Francisco: Healthcare Forum.

Herzlinger, R. E. 1994. Effective oversight: a guide for nonprofit directors. Harvard Business Review 72 (4): 53.

Hofstede, G. 1991. Cultures and organizations. New York: McGraw-Hill.

Holland, T. P., Ritvo, R. A. & Kovner, A. R. 1997. Improving board effectiveness: Practical lessons for non-profit health care organizations. American Hospital Publishing Inc., Chicago.

Hospital Association of Pennsylvania. 1993. A guide for assessing and improving health Status. Harrisburg, Penn.: Policy Research Department, Hospital Association of Pennsylvania.

Houle, C. O. 1989. Governing boards: Their nature and nurture. San Francisco: Jossey-Bass.

Huber, G. P., & Glick, W. H. 1993. Organizational change and redesign: Ideas and Insights for improving performance. New York: Oxford University Press.

Hurley, R. E. 1993. Towards a seamless health care delivery system. Frontiers of Health Services Management, Summer: 5-35.

Iglehart, J.K. 1993. The American health care system: Community hospitals. The New England Journal of Medicine, 329 (5): 372-376.

Institute for the Future. 1993. Integrated medical systems: the next generation of managed care. Unpublished report. Menlo Park, CA.

Integrated Health Care Report. 1994. How can hospitals survive? Integrated Health Care Report, July: 2.

Issac, S. and Michael, W. B. 1971. Handbook in research and evaluation. Edits Publisher, San Diego, CA.

Jones, W. J., & Mayerhofer, J. J. 1994. Regional health care systems: Implications for health care reform. Managed Care Quarterly, 2 (1): 31-44.

Jordan, L. R. 1990. Strong, effective boards: A necessity for the 90's. Frontiers of Health Services Management, 6,3: 34-37.

Kahneman, D. & Tversky, A. 1973. On the psychology of prediction. Psychological Review, 80:237-251.

Kaluzny, A. D., Zuckerman, H. S. & Ricketts, T. C. 1995. Partners for the dance: Forming strategic alliances in health care. Chicago: Health Administration Press.

Kanter, R. M. 1989. Becoming pals: Pooling, aligning and linking across Companies. Academy of Management Executive, August, 3: 183-193.

Kaufman, K., et al. 1979. The effect of board composition and structure on Hospital performance. Hospital and Health Service Administration, 24 (Winter): 37-62.

Kidder, T. 1982. The soul of a new machine. New York: Avon.

Kotler, P., & Clarke, R. N. 1987. Marketing for health care organizations. Englewood Cliffs, NJ: Prentice-Hall.

Kovner, A. R. 1974. Hospital board members as policy-makers: Role, priorities and qualifications. Medical Care, 12,4: 971-982.

Lathrop, P. 1993. Restructuring health care: A patient-focused paradigm. San Francisco: Jossey-Bass.

Levi-Strauss, C. 1966. The Savage Mind. (2nd Ed.) Chicago: University of Chicago Press.

Lloyd, J. S., & Hadelman, J. M. 1995. Retaining good leaders before and after Mergers. Trustee 48 (1): 18.

Luke, R. D. 1992. Local hospital systems: Forerunners of regional systems? Frontiers of Health Services Management 9 (2): 3-51.

McKnight, J. 1992. Two tools for well being: Health systems and communities. Paper presented at the Conference on Medicine for the 21st Century, American Medical Association, Annenberg, Washington Program, U.S. Environmental Protection Agency, and W. K. Kellogg Foundation.

McNerney, W. J. 1995. Community health initiatives are widespread, challenging our sense of civic obligation. Frontiers of Health Services Management, Summer: 39-44.

Miles, M. & Huberman, A. M. 1984. Qualitative data analysis. Beverly Hills, CA: Sage Publications.

Miller, R. H. 1996. Health system integration: a means to an end. Health Affairs. Vol. 15: 2, 92-106.

Miller, W. L. & Crabtree, B. F. 1992. Primary care research: A multi-method typology and qualitative roadmap. In B.F. Crabtree & W.L. Miller (Eds.), Doing Qualitative Research. Newbury Park, CA: Sage Publications.

Molinari, C., Alexander, J., Morlock, L., & Lyles, C. A. 1995. Does the hospital Board need a doctor? The influence of physician board participation on hospital Financial performance. Medical Care, 33 (2): 170-185.

Morlock, L, & Alexander, J. 1986. Models of governance in multihospital systems. Medical Care, 24 (12): 1118-1135.

Moscovice, I., Christianson, J., Kralewski J., & Manning, W. 1995. Building rural Hospital networks. Ann Arbor, MI.: Health Administration Press.

Nelson, C., Treichler, P. A., & Grossberg, L. 1992. Cultural Studies. In L. Grossberg, C. Nelson, & P.A. Treichler (Eds.), Cultural Studies: 1-16. New York: Routledge.

Nisbett R. & Ross, L. 1980. Human inference: Strategies and shortcomings of of social judgment. Englewood Cliffs, NJ: Prentice-Hall.

Orlikoff, J. E. & Totten, M. K. 1993. An action plan for boards: leading your Organization into healthcare reform. Health Governance Digest 3 (5): 1-6.

Pettigrew, A. 1988. Longitudinal field research on change: Theory and practice. Paper presented at the National Science Foundation Conference on Longitudinal Research Methods in Organizations, Austin.

Pfeffer, J. 1972. Size and composition of corporate boards of directors: the organization and its environment. Administrative Science Quarterly, 17: 218-228.

Pfeffer, J. 1973. Size, composition and function of hospital boards of directors: a study of organization-environment linkage. Administrative Science Quarterly, 18: 349-364.

Pfeffer, J. 1992. Managing with power: Politics and influence in organizations. Boston: Harvard Business School Press.

Pfeffer, J & Salancik, G. 1978. The external control of organizations: a resource dependence perspective. New York, Harper and Row.

Pinfield, L. 1986. A field evaluation of perspectives on organizational decision-making. Administrative Science Quarterly, 31: 365-388.

Pointer, D. D., & Ewell, C. M. 1994. Governance fingerprints. Trustee 47 (May): 44-47.

Pointer, D. D. & Ewell, C. M. 1994. Really governing: How health system and hospital boards can make more of a difference. New York: Delmar Publishers.

Pointer, D. D., Alexander, J. A., & Zuckerman, H. S. 1995. The governance challenge: Preserving community mission with integrated health care systems. Frontiers of Health Services Management 11 (3): 6

Pointer, D. D., Alexander, J. A. & Zuckerman, H. S. 1995. Loosening the Gordian knot of governance in integrated health care delivery systems. Frontiers of Health Services Management 11 (3): 20.

Provan, K. G. 1988. Organizational and decisional unit characteristics and board influence in independent versus multihospital system-affiliated hospitals. Journal of Health and Social Behavior, 29:239-252.

Prybil, L. D. & Starkweather, D. B. 1976. Current perspectives of hospital governance. Hospital and Health Services Administration, 3,2: 67-75.

Risk, R. R., & Francis, C. P. 1994. Transforming a hospital facility company into an integrated medical care organization. Managed Care Quarterly, 2 (4): 12-23.

Roberts, C. C. 1996. Redefining the healthcare paradigm: a proposal for successful provider integration. Hospital Topics. Vol. 74:2.

Ross, A., & Fenster, L. F. 1995. The dilemma of managing value. Frontiers of Health Services Management 12 (2): 3-32.

Salmon, W. J. 1993. Crisis prevention: How to gear up your board. Harvard Business Review 71 (1): 68-75.

Selznick, P. 1949. TVA and the grass roots. Berkeley, CA: University of California Press.

Sheldon, A., & Windham, S. 1984. Competitive strategies for health care organizations. Homewood, Illinois: Richard D. Irwin.

Sherman, V. C. 1993. Creating the new American hospital: A time for greatness. San Francisco: Jossey-Bass.

Shortell, S. M. 1988. The evolution of hospital systems: unfulfilled promises and self- fulfilling prophesies. Medical Care Review, 45:2, 177-214.

Shortell, S. M. 1991. Effective hospital-physician relationships. Ann Arbor, Mich.: Health Administration Press.

Shortell, S. M., et al. 1993. The holographic organization. Healthcare Forum Journal 36 (2): 20-26.

Shortell, S. M, Gillies, R. R., Anderson, D. A., Mitchell, J. B., & Morgan, K. L. 1993. Creating organized delivery systems: The barriers and facilitators. Hospitals & Health Services Administration, 38:4, 447-466.

Shortell, S. M., Gillies, R. R. & Anderson, D. A. 1994. The new world of managed care: Creating organized delivery systems. Health Affairs, 13:5, 46-64.

Shortell, S. M., Gillies, R. R. & Devers, K. J. 1995. Reinventing the American Hospital. The Milbank Quarterly, 73:2, 131-160.

Shortell, S. M., Morrison, E. M. & Friedman, B. 1992. Strategic choices for America's hospitals: Managing change in turbulent times. San Francisco, CA.: Jossey-Bass.

Shortell, S., Gillies, R., Anderson, D., Erickson, K. & Mitchell, J. 1996. Remaking healthcare in America: Building organized delivery systems. San Francisco, CA: Jossey-Bass.

Shortell, S. M., Anderson, D. A., et al. 1993. The Holographic organization. Healthcare Forum Journal, March/April, 20-26.

Shortell, S. M., Gillies, R. R., et al. 1993. Creating organized delivery systems: The barriers and facilitators. Hospital & Health Services Administration, 38:4, 447-466.

Sigmond, R. J. 1995. Collaboration in a competitive environment: The pursuit of community health. Frontiers of Health Services Management 11 (4): 5-36.

Sigmond, R. J. 1995. Back to the future: Partnerships and coordination for community Health benefit. Frontiers of Health Services Management, Summer: 5-36.

Southwick, K. 1994. Case study: Putting the pieces in place for regional integration. Strategies for Healthcare Excellence, 7 (1): 1-7.

Spirer, J. 1980. The case study method: guidelines, practices and applications for vocational education. Columbus, OH: The National Center for Research in Vocational Education, The Ohio State University.

Stake, R. 1978. The case study method in social inquiry. Educational Researcher, Vol. 7, pp 5-8.

Starkweather, D. 1988. Hospital board power. Health Services Management Research. 1: 74-86.

Stevens, R. 1989. In sickness and in wealth: American hospitals in the Twentieth Century. New York: Basic Books.

Strauss, A. & Corbin, J. 1990. Basics of Qualitative Research: Grounded theory procedures and techniques. Beverly Hills, CA: Sage Publications.

Stablein, R. 1996. Data in Organization Studies. In Handbook of Organization Studies. Editors: Clegg, S.R., Hardy, C & Nord, W.R. Sage Publications, London.

The Governance Institute. 1995. Governance trends and practices in health systems: 1995 panel survey of system boards. La Jolla, CA: The Governance Institute.

Toomey, R. E. & Toomey, R. K. 1993. The role of governing boards in multihospital systems. Healthcare Management Review, 18 (1), 23-30.

Umbdenstock, R. J. et al. 1990. The five critical areas for effective hospital governance of not-for-profit hospitals. Hospitals and Health Service Administration, 35,4:481-492

Van Dalen, D. B. 1962. Understanding educational research. McGraw Hill, Berkeley, CA.

Van Maanen, J. 1988. Tales of the field: On writing ethnography. Chicago: The University of Chicago Press.

Voluntary Hospitals of America. 1994. Integration: Market forces and critical success factors. Irving, Texas: Voluntary Hospitals of America.

Walston, S., Kimberly, J., & Burns, L. 1996. Owned vertical integration and health care: Promise and performance. Health Care Management Review 21 (1)::: 83-92.

Walter, W. P. 1990. Neither market nor hierarchy: Network forms of organization. In B. Staw & L. Cummings (eds.), Research in Organization Behavior (vol. 12). Greenwich, Conn.: JAI Press.

Webster's Ninth New Collegiate Dictionary. 1990. Springfield, Mass.: Merriam-Webster.

Weiner, B. J., & Alexander, J. A. 1993. Corporate and philanthropic models of hospital governance: A taxonomic evaluation. Health Services Research 28 (3): 325-355.

Whyte, W. F. 1955/1943. Street corner society: The social structure of an Italian slum. Chicago: University of Chicago Press.

Williams, J. B. 1992. Guidelines for managing integration. Health Care Forum Journal, March/April: 39-47.

Yin, R. 1981. The case study crisis: Some answers. Administrative Science Quarterly, 26, 58-65.

Yin, R. 1984/1989. Case study research: Design and methods. Beverly Hills, CA: Sage Publications.

Yin, R. 1993. Applications of case study research. Beverly Hills, CA: Sage Publications.

Zald, M. N, 1969. The power and function of boards of directors: A theoretical synthesis. American Journal of Sociology, 75: 97-111.

Zuckerman, H. S., & D'Aunno, T. A. 1990. Hospital alliances: Cooperative strategy in a competitive environment. Health Care Management Review 15 (2): 21-30.

Zuckerman, H. S., & Kalzuny, A. D. 1991. The management of strategic alliances in health service. Frontiers in Health Services Management 7 (Spring): 3-23.

Zuckerman, H. S., & Kalzuny, A. D. 1991. Strategic alliances in health care: The challenge of cooperation. Frontiers of Health Services Management 7(3): 3-23.

APPENDICES

APPENDIX A

HEALTHCARE GOVERNANCE SURVEY

Please circle or check one answer for each of the following questions.

Section A: Governance

1. Does the hospital have a legally constituted governing board which bears ultimate responsibility for the affairs of the organization? Yes No

   a. If no, does it have an advisory board that provides advice, counsel or recommendations to the management or board of a system? Yes No

2. To which higher board or authority is the hospital board legally responsible?

   a. board or management of a health care system? Yes No
   or b. a unit of state, county or local government? Yes No
   or c. other - please specify _____

   d. the hospital board is not responsible to a higher board or authority _____

3. How many of your hospital board members serve on system boards or committees? _____

Section B: Composition

4. Please supply the following information about your board:

   a. do you serve as a board member? Yes No

   or b. do you serve as an administrator? Yes No

   c. how many years have you held this position at this hospital? _____

   d. if a board member, is your position a voting position? Yes No N/A

   e. are you male or female? Male Female

   f. what is the year of your birth? _____

   g. do you live in the region served by the hospital? Yes No

      a. if Yes, what year did you move to the community? _____

   h. would you describe yourself as politically influential within the community? Yes No

   i. would you describe yourself as involved in community or civic affairs? Yes No

j. would you describe yourself as having financial skills? Yes No

k. would you describe yourself as a business person? Yes No

l. would you describe yourself as a community leader? Yes No

m. have you had previous board experience? Yes No N/A

n. please provide your professional job title:

Section C: Responsibilities

Please circle one of the following responses for this section:
VI= Extremely Important, I= Rather Important, SI= Somewhat Important, NI= Not Important

5. Over the next three years, please indicate how important it is for your board to change or improve performance concerning the following board responsibilities:

a. establish the policies of the hospital in relation to community needs EI RI SI NI

b. provide equipment and facilities consistent with community needs EI RI SI NI

c. ensure that proper professional standards are maintained in the care of the sick EI RI SI NI

d. coordinate physician interests with administrative, financial and community needs EI RI SI NI

e. provide for the hospital's long-term financial viability EI RI SI NI

f. gain access to key resources from the community EI RI SI NI

g. represent those served by the hospital EI RI SI NI

h. serve as a resource to top management EI RI SI NI

i.. establish corporate goals EI RI SI NI

j. ensure that plans and programs are developed and implemented to accomplish corporate goals EI RI SI NI

k. select and maintain a qualified medical staff EI RI SI NI

l. ensure that the community is well informed about the hospital's goals and performance EI RI SI NI

m. serve as an advocate for the hospital EI RI SI NI

n. be informed about current healthcare trends EI RI SI NI

Section D: Relationships

Please circle one of the following responses for the remaining three sections:
AA= Almost Always, U= Usually, O= Occasionally, AN= Almost never

Community relationships:

6. Does the hospital reasonably represent the influential opinions of the community? AA U O AN

7. Does the hospital provide services to the uninsured? AA U O AN

8. Is the hospital fulfilling the community's long-range health needs? AA U O AN

9. Is the hospital educating the community to understand managed care? AA U O AN

10. Does the hospital offer educational programs to the community consistent with community health needs? AA U O AN

11. Does the hospital learn about community health needs through healthcare professionals? AA U O AN

12. Does the hospital learn about community health needs through its board? AA U O AN

13. Does the hospital learn about community health needs through community organizations? AA U O AN

14. Does the hospital conduct community surveys to assess needs? AA U O AN

15. Is a community survey conducted on a regular basis? AA U O AN

16. Are there key community health issues which the hospital has not addressed? AA U O AN

17. Do you, personally, devote time to developing solutions for community health problems? AA U O AN

18. Do you, personally, help the hospital raise money for worthy programs? AA U O AN

19. Do you serve as an advocate for the hospital in helping the community understand the healthcare changes affecting regional hospitals? AA U O AN

Board-Management Relationships:

20. Does hospital administration keep the board informed of hospital performance against goals? AA U O AN

21. Does hospital administration keep the board informed of key healthcare trends? AA U O AN

22. Does hospital administration provide clear background information to support decision-making on proposed programs or services? AA U O AN

23. Does hospital administration respond appropriately to board input concerning community health issues? AA U O AN

24. Are local community health needs communicated to the system board? AA U O AN

25. Does the board discuss resource allocation issues in cases where organizational and community interests compete? AA U O AN

Board Member Relationships:

26. At board meetings, do board members engage in dialogue among themselves concerning key issues? AA U O AN

27. Do board members possess knowledge or skills which you lack and which are helpful in decision-making? AA U O AN

28. Are board members aware of the effects that their decisions have on the community? AA U O AN

29. Are board members free to speak their minds about issues affecting the community? AA U O AN

30. Do board members raise community health issues? AA U O AN

Section E: Accountability

31. Does the board request feedback about the programs provided for community benefit? AA U O AN

32. Is the board proactive in addressing community health issues? AA U O AN

33. Does the hospital provide formal education for board members? AA U O AN

34. Does the board regularly review community health data? AA U O AN

35. Is the board educated concerning community health measures? AA U O AN

36. Are community health issues passed on to system level board members for their information and consideration? AA U O AN

37. Is there a formal process for evaluating the board's performance? Yes No

38. What are the key advantages for regional hospitals in joining a healthcare system?

39. What are the key disadvantages for regional hospitals in joining a healthcare system?

40. What are the future governance challenges for regional hospital boards?

41. How can these challenges be addressed?

Thank you for your participation.

APPENDIX B

INTERVIEW SCHEDULE

Regional Hospital Board Members (8)
Regional Hospital board chairs (4)
Regional hospital administrators (4)
Liaison board chair (1)

- Define terms *regional hospital and regional hospital board*

1. Please tell me a little about your role. How long have you held this position?
2. To which body are regional boards accountable? Please explain the relationship and how it works.
3. How are agenda for regional hospital board meetings developed?
4. Is it important for regional hospital boards to be connected with their Communities?
5. How do regional hospital boards learn about community health issues?
6. How are community health issues addressed at regional hospital board meetings?
7. What programs are offered in response to community needs?
8. How do regional hospital boards determine which community needs to address?
9. How are regional hospital boards kept informed about current healthcare issues?
10. How does regional hospital board development occur?
11. How are regional hospital priorities and system priorities integrated?
12. Why do regional hospitals seek to become part of integrated systems?
13. What do regional hospitals gain to become part of an integrated system?
14. What do regional hospitals give up to become part of an integrated system?
15. What are the future governance challenges for regional hospital boards?

Additional questions may be asked to explore issues raised in survey responses.

Thank participant for his/her time and information.

APPENDIX C

LETTER FROM HEALTHCARE SYSTEM CEO

Letter from Healthcare System CEO to regional board members and regional administrators soliciting their participation in questionnaire

Date

Addressee name & address

Dear Board Member or Administrator,

Re: Healthcare Governance

As part of an effort to learn more about hospital and healthcare system governance, I am writing to ask you to participate in a governance survey being conducted by Oklahoma State University.

The questionnaire, which you will receive shortly in the mail, solicits your input on the composition, responsibilities, relationships and accountabilities of your hospital's board of trustees. Survey results will assist us better understand governance within an integrated healthcare system.

Thank you in advance for your participation in this important study.

Sincerely,

Name
Title

APPENDIX D

LETTER FROM SURVEY RESEARCHERS

Letter from survey researchers to regional hospital board members and regional hospital administrators soliciting participation in the study.

Date

Addressee name & address

Dear Board Member or Administrator,

Re: Healthcare Governance

As part of an effort to learn more about hospital and healthcare system governance, we are writing to ask you to participate in the attached Governance Survey. Conducted by Oklahoma State University, the survey asks for your feedback about the composition, responsibilities, relationships and accountabilities of your hospital's board of trustees. Your knowledge will be used to further understanding of governance in an integrated healthcare system.

The questionnaire is designed to be completed in approximately 20 minutes. Survey responses will be kept strictly confidential, with surveys reviewed solely by us. Survey findings will be reported in a group format only to assure that individual identity is protected. Your name is shown on the survey to allow us to track responses and to conduct follow-up if necessary.

We recognize that governing boards vary in structure and composition and that some of the survey questions may be more relevant to your board than others. Please direct questions regarding the content of the survey to Jenny Auger Maw at 584-8961. Completed surveys should be returned in the enclosed postage paid envelope by Friday, February 12th, 1999.

The healthcare industry has much to learn about the development of integrated healthcare systems. As a regional hospital board member or administrator in a rapidly growing healthcare system, you are uniquely positioned to contribute to this understanding. Thank you in advance for your participation in this important study.

Sincerely,

William Venable, Ph.D.
Associate Professor

Jenny Auger Maw
Doctoral Candidate

APPENDIX E

CONSENT FORM

Informed Consent Form for In-depth Interviews

I, _____, hereby authorize Jenifer M. Auger Maw to

tape record the interview she conducted with me on _____, 1999

concerning healthcare governance.

It is my understanding that information gathered during the interview will be used as part
of an investigation entitled "Governance Practices of Regional Hospitals in an Integrated Healthcare Delivery System".

It is further my understanding that all notes and tapes concerning this interview will be used solely for the purpose of this research project, that they will be secured in the researcher's office and erased upon completion of the research study.

It is also my understanding that comments and observations made during this interview may be referenced in the study report to explain events or perceptions in support of study conclusions. For confidentiality purposes, the study will identify individuals by position only. Neither the rural hospitals or the healthcare system participating in the study will be identified by name.

The purpose of the study is to further understanding of the role of regional hospital boards in functioning as community representatives within an integrated healthcare delivery system setting.

I understand that participation is voluntary, that there is no penalty for refusal to participate, and that I am free to withdraw my consent and participation in this project at any time without penalty after notifying the project director.

I may contact Jenny Auger Maw at telephone number: (918) 584 8961.
I may also contact Gay Clarkson, IRB Executive Secretary, 203 Whitehurst, Oklahoma State University, Stillwater, OK 74078; telephone number: (405) 744 5700.

I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

Date: _____ Time: _____ am/pm

Signed: _____

I certify that I have personally explained all elements of this form to the subject before requesting the subject to sign it.

Signed: _____

APPENDIX F

INSTITUTIONAL REVIEW BOARD (IRB)

APPROVAL FORM

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD

DATE: 01-06-99 **IRB #: ED-99-065**

Proposal Title: THE BOARD-COMMUNITY CONNECTION: HOW REGIONAL HOSPITAL GOVERNANCE MAINTAINS THE LINK

Principal Investigator(s): William R. Venable, Jenifer M. Auger Maw

Reviewed and Processed as: Exempt

Approval Status Recommended by Reviewer(s): Approved

Signature: Carol Olson Date: January 22, 1999

Carol Olson, Director of University Research Compliance
cc: Jenifer M. Auger Maw

Approvals are valid for one calendar year, after which time a request for continuation must be submitted. Any modification to the research project approved by the IRB must be submitted for approval. Approved projects are subject to monitoring by the IRB. Expedited and exempt projects may be reviewed by the full Institutional Review Board.

VITA

Jenifer M. Auger Maw

Candidate for the Degree of

Doctor of Education

Thesis: GOVERNANCE PRACTICES OF REGIONAL HOSPITALS IN AN INTEGRATED HEALTHCARE DELIVERY SYSTEM

Major Field: Occupational and Adult Education

Area of Specialization: Human Resource Development

Biographical:

Personal Data: Born in London, England, on July 16, 1949, the daughter of Francis Thomas Baxter Burdett and Daphne Dalton Scott. Married to Gilbert M. Maw, M.D. Two sons, Paul and Marc Auger.

Education: Graduated from Wallington Grammar School for Girls, London, England, in July 1965; received Bachelor of Science degree in Business Administration from the University of Tulsa in 1990; received Master of Arts in Industrial/Organizational Psychology from the University of Tulsa, in December 1992; completed requirements for the Doctor of Education degree at Oklahoma State University in May, 2000.

Professional Experience: Executive Assistant and Human Resources Representative at Amoco (U.K.) Exploration Company from 1967 to 1971; Business Manager of Okmulgee Radiology Inc. from 1976-1979; held the following positions with Hillcrest Healthcare System, Tulsa: Coordinator of Management Development, 1979-1985, Director, Management Development, 1985-1987, Administrative Director at Hillcrest Healthcare System, Tulsa; Administrative Director, Kaiser Rehabilitation Center, 1987-1988; Vice President, Human Resources, 1988 to 1993; Vice President, Organization Development, 1993-1997; served as consultant and Senior Vice President, Organization Development at Hillcrest Healthcare System, 1997 to 1999.