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Governance Models among California Public Hospitals

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by

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I. Executive Summary

PUBLIC HOSPITALS ARE AN ESSENTIAL PART of the health care system. They serve as the safety-net providers for many communities, providing a significant portion of care to the underinsured and uninsured.

Public hospitals are also among those that are the most affected by changes to the health care environment. The recent economic downturn promises to swell the rolls of the underinsured and uninsured, the very patients who turn to these safety-net hospitals in times of need. At the same time, reductions in federal and state budgets have cut reimbursement to these hospitals even as demand is rising—a situation that puts tremendous strain on hospital resources and often delays capital investment in programs and infrastructure.

In light of these challenges, public hospitals across the country have explored options meant to improve their competitive and financial position in their local markets. These options have included a wide variety of governance and organizational restructuring efforts. In California, public hospitals are in various stages of reconsidering and revising their governance structure.

This report identifies the models of governance that exist among California's public hospitals, pinpoints the challenges faced by these hospitals because of their governance structures, and highlights the efforts of four nationally known public hospitals to improve the speed and quality of decision making through changes to their governance structures.

The findings suggest that changing the governance model alone doesn't improve a hospital's nimbleness, but the process of change, which allows strong leaders to reinvent the hospital, can have an effect. Through the restructuring process, four basic components of the governance function—management oversight, board composition, level of public involvement, and hospital bylaws—can be adjusted to customize the response hospitals need to react to a changing market.

II. Background

EVERY YEAR, MORE THAN 10 MILLION PEOPLE in the United States receive care from public hospitals and public health systems.¹ Nearly 20 percent of the country's hospitals can be categorized as public, nonfederal, acute care hospitals—the majority have fewer than 200 beds, serve small rural settings, and are owned by county governments.² Among their common characteristics:

- They are the safety-net providers for many communities, providing a significant portion of care to the underinsured and uninsured;
- Most function as the local trauma and burn centers, making them essential in times of catastrophic events (e.g., natural or manmade disasters, bioterrorism, etc.);
- They serve as major training sites for physicians, nurses, and other health care professionals; and
- They are often a crucial part of the local economy, and represent important sources of direct and indirect employment for their local communities.

The public hospitals in California share many of the functional characteristics mentioned in this list, but their scale and scope of services are typically larger than those serving rural areas around the country.

There are 19 public hospitals recognized as the major safety-net providers in California (see Figure 1 on page 4). Though they make up only 6 percent of all California hospitals statewide, these public hospitals represent 10.5 percent of the total beds in

the state, and provide nearly 45 percent of all hospital care to the state's 6.5 million uninsured.³

These public hospitals are also tremendously complex institutions. They account for almost 60 percent of California's Level I trauma and burn centers (i.e., those facilities with personnel and resources required to treat the most critically injured patients) and train 45 percent of the doctors in the state. They are also responsible for providing 60 percent of the state's psychiatric emergency care and delivering nearly 90 percent of the state's outpatient care to the medically indigent, broadly defined as low-income, underinsured, or uninsured people with unmet medical needs.⁴

Nationally, public hospitals are among those that are the most affected by changes to the health care environment. Economic downturns swell the ranks of underinsured and uninsured patients most likely to seek care at safety-net hospitals. Shrinking federal and state budgets cut reimbursement even as demand is rising—straining hospital resources and complicating their ability to invest in new programs and infrastructure. Shifts in compensation models and national shortages in key health care professions (both physician and non-physician) add to the difficulty of recruitment at public hospitals.

Such challenges have spurred public hospitals to look for ways to improve their competitive and financial position in their local markets, including reconsidering and revising their governance structure. The purpose of this paper is to identify the models of governance that exist among California's public hospitals (excluding district hospitals), pinpoint the challenges faced by these hospitals because of their governance structures, and highlight several best

practices (both in-state and nationally) to serve as examples for other public hospitals in their efforts to improve the speed and quality of their institution's

decision-making, or what this analysis refers to as *nimbleness*.

Figure 1. California Association of Public Hospitals and Health Systems, Members by County*



III. Project Objectives and Methodology

THIS PAPER IS FOCUSED ON THREE KEY objectives:

- Develop a high-level understanding of the various governance structures currently in place at public hospitals in California;
- Profile the governance structures for a subset of these hospitals within the state to illustrate the operational challenges that are attributable to these structures; and
- Provide detailed vignettes of a few high-profile public hospitals from around the country that have adapted their governance structures to enable institutional transformation.

The methodology employed to answer these objectives includes a detailed analysis of the governance structures of all 19 public hospitals that are members of the California Association of Public Hospital and Health Systems (CAPH). CAPH hospitals include county hospitals and three University of California (UC) hospitals—those at Davis, Irvine, and San Diego. (A list of CAPH hospitals can be found in Figure 1, as well as in Appendix A.)

The information presented here is based on a collection of qualitative data—obtained by interviewing administrators with years of responsibility in California public hospitals and integrating two decades of health care governance experience accumulated within KSA since the firm first opened its offices in California—as well as quantitative data gathered from a detailed review of publicly available sources.

Detailed case studies were completed for the following hospitals:

- Alameda County Medical Center, Oakland, CA;
- Denver Health, Denver, CO;
- Grady Health System, Atlanta, GA; and
- Westchester Medical Center, Valhalla, NY

Alameda County Medical Center represents a unique governance model currently in place in California. Denver Health, Westchester Medical Center, and Grady Health System represent large, high-profile public hospitals that are in various stages of sweeping changes to their governance structures. Their experiences proved to be very informative regarding the challenges, processes, and outcomes that are associated with extensive governance changes.

This report includes the most up-to-date publicly available information, but there are a few caveats to note:

- Wherever possible, data collected from hospital and county Web sites have been verified. However, recent changes to governance structures and authorities may not be reflected in the available information (e.g., Grady Health System went through a major reorganization during the last six months of 2007 that was not communicated publicly until January 2008, several months after the final structure had been discussed and vetted internally).
- No single, reliable source identifies the models of governance for the 19 California public hospitals, or the roles, authorities, and responsibilities

of their boards. As a result, the research used analyses of board agendas and meeting minutes, in addition to phone calls and local experience, to assess and define the level of public control/autonomy associated with these institutions. Linking multiple data sources was necessary in instances where public hospital governance involves both a public (often county) board of supervisors and a semi-autonomous board of trustees, since the board of trustees typically serves in an advisory role, with the level of control it exerts dependent upon the personal and political dynamics of that particular board.

IV. Categorizing California's Public Hospitals

GOVERNANCE STRUCTURE HAS THE POTENTIAL to influence most aspects of a public hospital, including finance and capital, operations, quality, medical staff and personnel, strategic planning, and philanthropy. As a result, it has a tremendous impact on a hospital's long-term viability.

Two key characteristics distinguish public hospitals from their private counterparts:

- Public hospitals have a reporting relationship to locally elected government; and
- They can access local taxpayer revenues (e.g., property taxes and utility subsidies), regardless of how many people they serve.

Nationally, governance models for public hospitals fall into five basic categories, which are outlined below and summarized in Table 1 on page 9.⁵

Direct Local Government Control

Possibly the most common governance structure for public hospitals, direct local government control entails control by a unit of local government. In these cases, major hospital decisions are made by elected individuals who have broader governance responsibilities than those directly associated with operating a hospital.

In this structure, the local unit of government is responsible for making all major decisions regarding the hospital (such as budget and affiliation), although day-to-day operations may be delegated to a semi-autonomous board of directors or supervisors for whom the hospital is the primary responsibility. As part of local government, hospitals in this structure

have access to tax revenue (typically in the form of an annual line of support), but only if their local unit of government has allocated the money.

Independent Nontaxing Unit of Government

Several high-profile public hospital systems have migrated in the past decade to an independent nontaxing model of governance. (The Health and Hospitals Corporation in New York is one example.) This structure allows hospitals greater autonomy from local government, but, like hospitals under direct local government control, hospitals operating under this structure can access tax revenue only if the local unit of government has allocated the money. The range of allocation mechanisms varies by situation—annual lines of operating support and subsidies associated with the provision of support services (e.g. power, water, sewage)—are among the most common.

For a hospital to adopt an independent nontaxing governance model, there almost always must be a change in legislation to create a new hospital governing body. While the board and the administrative leadership operating within this model still have accountability to elected officials, they are much more insulated from local politics. The two most common forms of this governance structure are hospital authorities and public benefit corporations (PBCs).

Although hospital authorities and PBCs differ in their legal nuances, several characteristics are common to both:

- Civil service and procurement mandates usually apply to hospital authorities and PBCs, although

in some cases the enabling statute has specific provisions that allow the hospital authority or PBC to circumvent these requirements;

- Compared to hospitals under direct local control by government, hospital authorities and PBCs experience less interaction with local units of government regarding day-to-day operations, and the board/administrative leadership have more autonomy when making decisions about control (such as acquisitions and affiliations);
- Only decisions related to large-scale funding typically require direct approval by elected government. The level of influence exerted by local government is almost always correlated to the amount of capital required and the proposed funding mechanism.
- Members of the boards for the hospital authority or PBC are usually nominated by a variety of government units (for example, Westchester Medical Center has a board composed of representatives from the county, the state legislature, and the governor's office); and
- Hospital authorities and PBCs do not have the authority to levy taxes to support operations, but most tend to receive multiple lines of funding from the units of government that appoint members to their boards.

Independent Taxing Health Care Entity

The independent taxing health care entity model is a common governance structure in California, where entities are referred to as “districts.” Hospital systems in this category are under the control of an independent governing body that is elected separately from the local unit of government. Formation of these hospital districts requires authorization by statute, and is often done to free the local unit of

government from the constraints placed on it by the scale of its hospital operations.

Board members for hospital districts are elected by voters within the district and are responsible for the governance and oversight of all aspects of hospital operations and strategy. Under this structure, the district has the authority to go directly to the electorate for funding. For most hospital districts, local civil service and procurement mandates apply.

Third-Party Hospital Management

Third-party hospital management represents a wide range of possibilities. Contracting with a third party is usually pursued when the local unit of government no longer wishes to maintain control over the operations and management of the hospital or hospital system. In these cases, the local unit of government usually shifts to play the role of “landlord,” maintaining control over the physical assets of the institution but contracting with the third party to manage everything else.

Third-party arrangements can occur in any number of forms. They can be made with an existing nonprofit or for-profit entity, or through the development of a newly created nonprofit corporation. They can be formalized through a combination of lease agreements and purchase agreements and/or management contracts. In all cases, management of the hospital or hospital system shifts to the third party, and the third party is given the authority to make almost all decisions affecting the day-to-day operations of the hospital. The only exceptions to this third-party authority include decisions that might alter the value of the physical asset, and decisions that might reduce the community's access to care (e.g. closing clinical programs, new affiliations). In most third party arrangements, employment of the hospital staff shifts from the local unit of government to the third party,

which has its own taxpayer ID and set of financial statements.

State Owned/University Governed

The state owned/university governed model is not identified as one of the basic categories of governance models in the National Public Health and Hospital Institute (NPHHI) report referenced above, but systems such as the University of California often own and/or exert significant control over public hospitals that are embedded within the systems as primary teaching sites. The governance structure of these systems varies on a case-by-case basis and the enabling statutes for these systems differ. Common characteristics include the following:

- Elaborate, well-defined and highly public governance structures;
- Strong support by state sponsors; and
- A breadth of responsibility related to clinical care, research, education, and the community.

The boards of these systems are typically appointed by the very highest levels of state government, and the finances and capital allocations associated with these systems often represent a large portion of states’ budgets.

Note: NPHHI combines hospital authorities and PBCs and does not explicitly recognize academic systems such as the University of California because their governance models differ on a state-by-state basis.

Each of the 19 public hospitals in California can be assigned to one of three categories: direct local government control, independent nontaxing unit of government (hospital authority), or state owned/university governed. Note that hospitals governed under direct local government control can be further subdivided into those hospitals that are directly governed by the county board of supervisors (BOS) and those that have a separate board of trustees (BOT) that serves as the operating or advisory board to the hospital (BOS-BOT).

Table 1. Public Hospital Governance Models

MODELS	LEVEL OF OPERATIONAL CONTROL BY RELEVANT GOVERNMENT BODY	ABILITY TO INFLUENCE REVENUE STREAMS FROM TAXPAYER MONEY	EXAMPLES
Direct Local Government Control (semi-autonomous board within local government)	Varies from High to Moderate	Varies from High to Moderate	Nearly all public hospitals
Independent Nontaxing Unit of Government (hospital authority)	Moderate	Moderate	Alameda County Medical Center (CA)
Independent Nontaxing Unit of Government (public benefit corp)	Varies from Moderate to Low	Varies from Moderate to Low	Westchester Medical Center (NY)
Independent Taxing District	Varies from High to Moderate	High	Harris County Hospital District (TX)
Contract Hospital Management to 3rd Party	Low	Low	Grady Health System (GA)
State Owned/University Governed	Varies by state—both in levels of operational autonomy and external funding		University of California (CA)

Source: National Public Health and Hospital Institute. *Best Practices in Public Hospital Governance*, May 2008.

Of the 19 hospitals, 16 use a direct local government model. Ten of these hospitals are governed directly by the board of supervisors and are organized under the county's health system as either an agency or department. Under this model, the board of supervisors appoints an administrative director to manage the department/agency, including the hospital.⁶ The remaining six hospitals have a separate board of trustees, often appointed or elected by the board of supervisors to oversee the hospital. Only one hospital, Alameda County Medical Center, has an independent nontaxing unit of government

(hospital authority) model, and the three UC hospitals are categorized as state owned/university governed. Table 2 illustrates the governance model for each hospital. A detailed description of each hospital's governance structure is included in Appendix A.

Because of the unique nature of the UC system, the remainder of this paper focuses on the characteristics and challenges of the two most common structures: direct local government board and hospital authority (independent nontaxing unit of government).

Table 2. Categorization of Governance Models for California Public Hospitals

GOVERNANCE MODEL/HOSPITAL	GOVERNANCE MODEL CODE
Direct Local Government Control (semi-autonomous board within local government)	
Arrowhead Regional Medical Center	Board of Supervisors
Contra Costa Regional Medical Center	Board of Supervisors
Harbor/UCLA Medical Center	Board of Supervisors
LAC+USC Medical Center	Board of Supervisors
Olive View/UCLA Medical Center	Board of Supervisors
Rancho Los Amigos National Medical Center	Board of Supervisors
Riverside County Regional Medical Center	Board of Supervisors
San Joaquin General Hospital	Board of Supervisors
Santa Clara Valley Medical Center	Board of Supervisors
Ventura County Medical Center	Board of Supervisors
Kern Medical Center	Separate Board of Trustees
Laguna Honda Hospital/Rehabilitation Center	Separate Board of Trustees
Natividad Medical Center	Separate Board of Trustees
San Francisco General Hospital	Separate Board of Trustees
San Mateo Medical Center	Separate Board of Trustees
Hospital Authority	
Alameda County Medical Center	Hospital Authority
Academic System	
University of California, Davis	State Owned/University Governed
University of California, Irvine	State Owned/University Governed
University of California, San Diego	State Owned/University Governed

Source: KSA analysis.

V. California Public Hospital Governance

Summary of Findings

THE MANAGEMENT DECISION-MAKING process of a public hospital can be helped or hindered by the governance structure under which the institution operates. This structure can particularly influence the speed and quality of decision-making, or nimbleness. The lack of nimbleness can subsequently place public hospitals at a significant disadvantage compared to their private competitors, particularly in the areas of procurement, personnel policies, recruitment, and retention, as well as the level of autonomy they have in making operational and financial decisions as they look to maintain or enhance their ability to serve those who look to them for care.

This study identifies three findings:

- There is no apparent relationship between a public hospital's governance structure and key institutional characteristics—such as its size, patient volumes (discharges and visits), or operating margin.
- There is no “optimal” model of governance for public hospitals—the effectiveness of different models depends on the environment in which the hospital operates and the abilities of key leadership.
- Restructuring provides opportunities for increased nimbleness and the ability to influence four key factors including management oversight, board composition, level of public involvement, and hospital bylaws.

Details of each finding are discussed below.

No Relationship Between Governance and Institutional Characteristics

Table 3 shows a select subset of 2007 hospital statistics for 16 California public hospitals from the Office of Statewide Health Planning and Development (OSHPD).⁷ There appears to be no relationship between the governance structure and any of a range of institutional characteristics, including hospital size (defined as the number of available beds), the number of inpatient discharges or visits (emergency department or outpatient visits), or percent operating margin.

An interesting observation, however, is that the average percent operating margin for hospitals with less direct government control is more favorable compared to those hospitals more closely tied to local government.

Table 3. Snapshot of Key Statistics from OSHPD, 2007⁸

HOSPITAL	GOVERNANCE MODEL CODE*	TOTAL AVAILABLE BEDS [†]	INPATIENT DISCHARGES	EMERGENCY ROOM VISITS	OUTPATIENT VISITS	OPERATING MARGIN [‡]
Arrowhead Regional Medical Center	BOS	373	22,870	105,254	289,573	-8.94%
Contra Costa Regional Medical Ctr	BOS	166	9,670	52,717	427,299	-40.76%
Harbor/UCLA Medical Center	BOS	427	21,534	68,418	351,273	-44.40%
LAC+USC Medical Center	BOS	942	37,918	137,089	731,015	-61.30%
Olive View/UCLA Medical Center	BOS	238	13,973	42,797	215,031	-112.22%
Rancho Los Amigos National Med Ctr	BOS	224	2,255	N/A	33,664	-33.99%
Riverside County Regional Med Ctr	BOS	367	21,296	84,290	228,803	-18.86%
San Joaquin General Hospital	BOS	196	9,305	41,789	207,812	-11.54%
Santa Clara Valley Medical Center	BOS	509	24,325	63,709	775,248	-21.94%
Ventura County Medical Center	BOS	193	12,042	40,835	560,633	-32.84%
Kern Medical Center	BOS – BOT	204	13,472	46,925	147,937	-27.12%
Laguna Honda Hospital/Rehab Center	BOS – BOT	1,147	1,110	N/A	19,590	N/A
Natividad Medical Center	BOS – BOT	172	7,265	30,837	100,743	-13.36%
San Francisco General Hospital	BOS – BOT	598	16,222	56,637	700,305	-19.91%
San Mateo Medical Center	BOS – BOT	453	4,441	29,225	240,745	-0.86%
Alameda County Medical Center	H. AUTH	475	13,479	85,440	316,409	1.39%

*BOS: board of supervisors; BOS-BOT: separate board of trustees; H. AUTH: hospital authority.

†Includes all classifications of beds for the hospital facility per OSHPD reporting—general acute, psychiatric, rehabilitation, long-term care, and chemical dependency/other.

‡Taken directly from 2007 Hospital Annual Financial Pivot Table. Definition of operating margin as defined in the OSHPD dataset “Glossary:” net income from operations divided by total operating revenue (net patient revenue plus other operating revenue). This ratio indicates the percentage of net patient revenue which remains as income after operating expenses have been deducted. Net Income on the Annual Financial Pivot Tables has been adjusted to reflect Medi-Cal DSH funds transferred back to related organizations.

Note: N/A means that data were not available.

Source: Office of Statewide Health Planning and Development. 2007 Hospital Annual Financial Pivot Table, RPE January 1, 2007 to December 31, 2007.

No Optimal Model of Governance

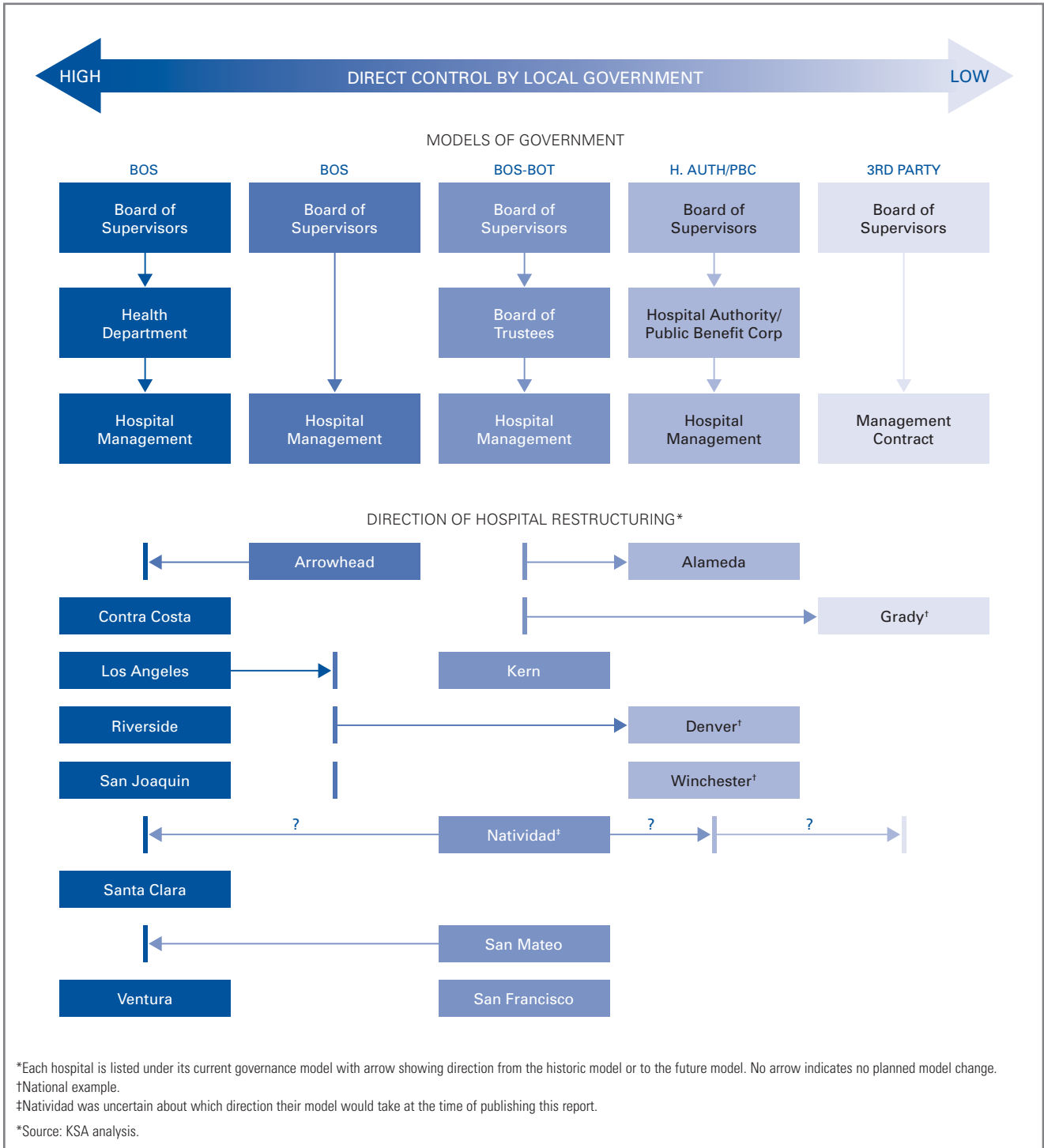
The study found that several hospitals, both nationally and in California, have recently revised or are planning to revise their governance structures. Figure 2 illustrates the historical, current, and future models of governance by hospital.

As shown in Figure 2, most hospitals altering their governance structure have shifted to models that tend to reduce the level of control exerted by local government (i.e., shifting to models to the right of the current model—as illustrated by the arrows above). The exceptions include Arrowhead Regional

Medical Center and San Mateo Medical Center, both of which reorganized such that the hospital and public health services are consolidated under one department—a model typically characterized as having a governance structures with greater local government oversight.

To gain a better understanding of the operational challenges related to an institution’s governance structure and identify whether a change in governance structure led to more operational flexibility, this study assessed four of the more high-profile, public hospital governance changes of the last

Figure 2. Detailed Governance Structures and Current and Historical Trends



decade: Denver Health, Westchester Medical Center, Grady Health System, and Alameda County Medical Center. A brief summary of available information on why the governance models were changed and their outcomes follows. Detailed case studies for each of the four institutions can be found in Appendix B.

Denver Health

Denver Health used to function as a component of Denver's city/county government. Under this structure, the institution faced several challenges, including a lack of purchasing authority, a decentralized system (the hospital and clinics functioned as silos), and a history of operating in the red. In 1997, Denver Health changed from direct local government control to a hospital authority, thereby shifting more autonomy to management. As a result, Denver Health has been able to offer a more competitive, market-based salary structure to physicians and other health care professionals; integrate the hospital and clinics to provide the full continuum of care to Denver residents; improve its financial status through a combination of local, state, and federal funding; and improve decision making on capital investments and the day-to-day operations of the hospital.⁹

Westchester Medical Center

The governing body for Westchester Medical Center (WMC) changed from the county board of supervisors to a public benefit corporation in 1998. The key drivers for the change were twofold: to lighten the legal/regulatory constraints imposed by the local government charter, and to decrease county expenses (WMC accounted for 40 percent of the county budget).¹⁰

The change in governance did not produce any immediate positive effect. Strong political pressure prevented the shift of autonomy to management.

The county not only withdrew funding, but also began to charge the medical center for certain services. During this period, the PBC made significant capital investments in new affiliations and construction of a new children's hospital that reduced its financial flexibility. By 2005, seven years after the restructuring, WMC was no longer financially sustainable. It was not until a new leadership team was installed in early 2006 that management realized what level of operational flexibility was expected when the PBC was created.¹¹ Today, two years after the leadership change, Westchester Medical Center has stabilized its financial situation, with substantial improvements in operating performance and recent approval to update and expand its physical facility.

Grady Health System

From 1941 to 2007, Grady Hospital used a Hospital Authority model. This governance structure proved to be a challenge for Grady. The board was highly politicized, which often led to allegations of corruption and discrimination; there was constant turnover of hospital leadership (five CEOs within three years); and the constraints of civil service laws made it difficult to recruit, retain, and/or dismiss hospital staff.

It was not until the financial viability of the hospital came into question that a recommendation was made to change the legal and governance structure of the hospital. In 2007, the management of the hospital was contracted to a third party, the Grady Memorial Hospital Corporation.¹² Six months later, a new CEO was hired. A year after the change, the financial position of the hospital significantly improved. In 2008 Grady reported bottom line increases of more than \$60M through a series of revenue cycle and supply chain initiatives.¹³

Alameda County Medical Center

The success of Denver Health's change in governance structure inspired Alameda County Medical Center (ACMC) in 1998 to convert to a hospital authority. The results of the change were similar to the outcome at Denver Health: ACMC purchasing is now more cost-effective, the salary structure allows ACMC to compete for new recruits in all health care fields, and management has more autonomy when making capital and operational decisions. As Alameda County's Board of Supervisors, ACMC's Board and Executive Management team continue to adapt to the new structure, management is taking a more proactive approach toward achieving financial autonomy in the near future.¹⁴

Based on these four examples, it seems reasonable to conclude that transitioning away from local government control alone did not necessarily make these hospitals more nimble; reassessing leadership and the needs of the hospitals at the time also played a role.

Restructuring Provides Opportunities for Increased Nimbleness

The previous finding hints at the notion that it is not the model of governance that creates an institution's nimbleness, but the process of restructuring itself that may enable management to better respond to changes in the health care environment. Specifically, governance change (or considering a change) affords the organization an opportunity to revise the following:

- Level of management oversight;
- Board composition;
- Public involvement/education; and
- Hospital bylaws.

Level of Management Oversight

In a well-functioning public hospital, the Board is the key architect of the institution's mission and vision. Board members are entrusted with the responsibility of ensuring that the public hospital meets the health care needs of the community's residents. However, a public hospital board can sometimes impede a hospital's ability to operate efficiently, through either a lack of oversight or too much oversight (such as micromanaging). Decisions about the optimal model of governance are often influenced by the most immediate needs of the county and county hospital, as demonstrated by the restructuring trends of Arrowhead Regional Medical Center, San Mateo Medical Center, the Los Angeles Health Department, and Natividad Medical Center.

While every situation is different, there are some parallels to be drawn from the cases of Arrowhead Regional Medical Center and San Mateo Medical Center. Both are moving toward a consolidated health care model where the medical center is included as a program under the county health department or agency. The intent is to combine all health care services under one umbrella—to improve access and quality of care as well as better allocate resources through the consolidation of like functions into a single department.^{15,16} Under this model, hospitals are traditionally governed by the county Board of Supervisors, which oversees all county departments—not just health services. The Board of Supervisors often appoints a director to oversee the county health department, but this person is also (just like the board) responsible for multiple community programs (e.g., public health, medical center, primary care clinics, etc.). The sheer scope of responsibility entrusted to these individuals often makes it difficult for them to allocate an appropriate amount of time to the oversight and governance of the hospital. Recognizing this, one potential

advantage for San Mateo Medical Center is that it is governed by a separate board of directors, allowing for more autonomy by the board and management. The recent success reported by the medical center—improved operational and financial performance through improved contracting with payers, reduced number of unnecessary hospitalizations among the uninsured, improved scheduling of staff including reduced overtime, etc.—suggests that this structure is working well.¹⁷

There are examples of public hospitals, such as the Los Angeles Health Department and Natividad Medical Center, that have operated in the consolidated department model or with a separate board of trustees for some time. However, in both cases, there has been recent public pressure to shift away from these models. In Los Angeles, the County Board of Supervisors has agreed to separate Public Health from the Department of Health Services. The rationale for the separation is to enable the Department of Health Services to focus on providing hospital and clinical services thereby decreasing the number of programs the department is responsible for overseeing.¹⁸ Natividad Medical Center, which is governed by a separate board of trustees appointed by the Monterey County Board of Supervisors, recently reported plans to establish functional autonomy from Monterey County. Currently, the medical center must adhere to all county policies and procedures for purchasing, human resources, IT, and governance. Under the new plan, the board of trustees and chief executive officer would be given more authority and accountability for the operational and financial performance of the medical center.¹⁹

Board Composition

The composition of the board also influences the level of management autonomy and institutional nimbleness. Public hospital board members are often appointed to the board by elected officials. The advantage of this arrangement is that political leaders are well aware of the capabilities of the individual (e.g., knowledge, level of expertise, integrity, etc.). The disadvantage is that these individuals may be beholden to the elected officials, which could compromise their duties as board members.

San Francisco County has managed to minimize this potential conflict of interest by implementing the San Francisco Health Commission. The commission governs the Department of Public Health, which includes, but is not limited to, San Francisco General Hospital and Laguna Honda Hospitals. Since the mayor of San Francisco has direct oversight for appointing and removing members of the commission, the commission is somewhat insulated from external political pressures.²⁰

The board composition is also critical for making informed decisions. Public hospital governance involves familiarity with areas such as finance, strategic planning, quality and patient safety, legal and regulatory issues, and an understanding of current and projected health care trends.²¹ Having the right mix of competencies on the board is critical to efficiently govern the hospital.

For instance, over the past few years, the Alameda County Board of Supervisors, the Board of Trustees, and hospital leadership have worked collaboratively to ensure the board of trustees has the right mix of competencies to effectively govern the medical center. The board recognizes that a lack of the appropriate qualifications can lead to delayed decision-making, since education and training must take place before informed decisions can be made.²²

Public Involvement/Education

California public hospitals have strict rules regarding the number of Board meetings, and the level of public participation and disclosure required at each. In California, the Brown Act (see Appendix C) attempts to protect both the public, through enforcing transparency, and the board, by allowing the board to meet in closed session where authorized.

²³ However, the legalities and details are often cumbersome and require careful planning of board agendas including topics for discussion.

This level of transparency, while mandated to minimize potential abuse of power by local government or hospital leadership, may also have the effect of preventing frank discussion, and limiting leadership's ability to engage in strategic discussions that require a level of confidentiality. Disclosure of details such as compensation and contract amounts may cause intense (and often negative) public scrutiny, and many public hospitals report a failure to attract exceptional clinical and administrative talent because of this perception. In a similar vein, since public hospitals are often required to hold open meetings before finalizing decisions, leaders at these institutions are often unable to act swiftly to approve fleeting opportunities or quickly intercept threats. These constraints affect the "nimbleness" of the organization. Changing the governance model at a public hospital offers its leaders the latitude to restructure committees and modify meeting logistics to mitigate these issues.

Hospital Bylaws

Hospital bylaws are the written rules and regulations that govern each individual hospital. They often include details on the structure of the hospital board (e.g., composition, accountability to the public, transparency) and the level of autonomy that management has in making decisions (e.g., hiring

and firing employees, strategic planning, operations, etc.). While the bylaws vary from hospital to hospital, they are what enable public hospitals to balance meeting their missions of providing care to the underinsured and uninsured against remaining financially viable.

Another advantage of changing the governance structure of a hospital or health system is the opportunity to revise its bylaws. The increased nimbleness of both Denver Health and Alameda County Medical Center is partly the result of a change in bylaws during the restructuring process. The changes enabled better financial control, especially in the areas of labor and purchasing costs, which in turn allowed hospitals to sustain their services to the underserved.

However, bylaw revision is a cumbersome, highly political process requiring legal expertise and strong leadership. It may be most likely to succeed when it is in the interest of all parties involved. For instance, divesting some responsibility for hospital operations from the county government may not only free the hospital from county oversight, but also allow the county to redeploy limited management resources.

VI. Conclusion

PRESSURES IN THE HEALTH CARE ENVIRONMENT are driving public hospitals to consider changing their governance structures. The findings in this report suggest that changing the governance model alone doesn't improve a hospital's nimbleness; rather it is the process of change itself that allows capable leaders to reinvent the hospital and improve the speed and quality of an institution's decision-making. Through the restructuring process, certain levers, including management oversight, board composition, level of public involvement, and hospitals bylaws can be adjusted to customize the response needed to react to a changing market.

Appendix A: Overview of California Public Hospital Governance Structures

GOVERNANCE MODEL / HOSPITAL	GOVERNANCE STRUCTURE
Hospital Authority	
Alameda County Medical Center (ACMC)	ACMC is a Public Hospital Authority governed by a Board of Trustees. The Board of Trustees is appointed by the County Board of Supervisors and employs the CEO of the medical center.
Direct Local Government Control	
ACADEMIC/TRAINING SYSTEMS	
University of California Hospitals	<ul style="list-style-type: none"> The University of California hospitals are governed by the state through the UC Regents. The Regents operate through ten standing committees, including the committee on health care services, which is responsible for submitting health care related recommendations to the Board on behalf of the universities.
<ul style="list-style-type: none"> UC Davis UC Irvine UC San Diego 	
GOVERNED BY BOARD OF SUPERVISORS	
Arrowhead Regional Medical Center	<ul style="list-style-type: none"> San Bernardino County Board of Supervisors is the governing body for the medical center. The Board of Supervisors appoints a Director of the Hospital who is responsible for communicating and interacting with the Board.
Contra Costa Regional Medical Center (CCRMC)	<ul style="list-style-type: none"> The Contra Costa County Board of Supervisors is the governing body for the hospital and health systems. CCRMC is one of eight divisions under the Contra Costa Health Services. The Division Head/Executive Director of CCRMC is the primary contact for the hospital
Los Angeles County (LAC) Hospitals	<ul style="list-style-type: none"> The Department of Health Services (DHS) oversees the four county hospitals, as well as county ambulatory care centers, health centers, and clinics. The formal governing body of DHS and LAC hospitals is the LAC Board of Supervisors.
<ul style="list-style-type: none"> Harbor/UCLA Medical Center LAC+USC Medical Center Olive View/UCLA Medical Center Rancho Los Amigos National Med Center 	
Riverside County Regional Medical Center (RCRMC)	<ul style="list-style-type: none"> The Riverside County Board of Supervisors governs the medical center. RCRMC is a distinct county agency/department.
San Joaquin General Hospital (SJGH)	<ul style="list-style-type: none"> SJGH is a component of the department of Health Care Services. The Board of Supervisors appoints the Director of the Health Care Services. The Director is responsible for administrative oversight of the hospital, mental health services, public health services, and substance abuse.
Santa Clara Valley Medical Center (SCVMC)	<ul style="list-style-type: none"> SCVMC is part of the Santa Clara Valley Health and Hospital System, a department of the County. The Board of Supervisors appoints the CEO of the Hospital and Health System and the Director of SCVMC.
Ventura County Medical Center (VCMC)	<ul style="list-style-type: none"> Ventura County Health Care Agency is a county department governed by the Board of Supervisors. The Health Care Agency oversees the daily operations of VCMC, Santa Paula Hospital, county clinics, behavioral health, public health, emergency services and the Medical Examiner's Office. The Health Care Agency Director is currently the administrator of VCMC.

Direct Local Government Control, *continued*

SEMI-AUTONOMOUS BOARD WITHIN LOCAL GOVERNMENT

Kern Medical Center	<ul style="list-style-type: none"> • In 1994, the Kern County Board of Supervisors established the Kern Health Systems Board of Directors. • The Board of Directors is a special county health authority. • The Board of Supervisors appoints the Board of Directors.
Natividad Medical Center	<ul style="list-style-type: none"> • A Board of Trustees appointed by the Monterey County Board of Supervisors is responsible for the governance of Natividad Medical Center.
San Francisco Community Health Network <ul style="list-style-type: none"> • Laguna Honda Hospital and Rehabilitation Center • San Francisco General Hospital (SFGH) 	<ul style="list-style-type: none"> • The San Francisco Health Commission governs the Department of Public Health, which includes SFGH and Laguna Honda Hospitals as well as other programs. • The mayor's direct oversight of the commission means that its decisionmaking is somewhat insulated from external political pressure.
San Mateo Medical Center (SMMC)	<ul style="list-style-type: none"> • SMMC has a separate Medical Center Board of Directors that oversees the medical center. • Board members are appointed by the President of the Board who is currently a member of the County Board of Supervisors.

Source: Hospital and county Web sites from Appendix B.

Appendix B: Hospital and County Data Sources

HOSPITAL / WEBSITE	COUNTY WEBSITE
Arrowhead Regional Medical Center www.arrowheadmedcenter.org	www.co.san-bernardino.ca.us
Contra Costa Regional Medical Center www.cchealth.org/medical_center	www.co.contra-costa.ca.us
Harbor/UCLA Medical Center www.harbor-ucla.org	www.lacounty.info
LAC+USC Medical Center www.doctorsofusc.com/locations/lac-usc-medical-center	www.lacounty.info
Olive View/UCLA Medical Center www.uclaoliveview.org/ovmc.html	www.lacounty.info
Rancho Los Amigos National Medical Center www.rancho.org/gi_home.htm	www.lacounty.info
Riverside County Regional Medical Center www.rcrmc.org	www.countyofriverside.us
San Joaquin General Hospital www.sjgeneralhospital.com	www.co.san-joaquin.ca.us
Santa Clara Valley Medical Center www.scvmed.org	www.sccgov.org/portal/site/scc
Ventura County Medical Center www.vchca.org/mc	www.ventura.org
Kern Medical Center www.kernmedicalcenter.com	www.co.kern.ca.us
Laguna Honda Hospital/Rehabilitation Center www.sfdph.org/dph/comupg/oservices/medsvs/lhh	www.sfgov.org
Natividad Medical Center www.natividad.com	www.co.monterey.ca.us
San Francisco General Hospital www.dph.sf.ca.us	www.sfgov.org
San Mateo Medical Center www.co.sanmateo.ca.us/portal/site/smmc	www.co.sanmateo.ca.us
Alameda County Medical Center www.acmedctr.org/index.cfm	www.acgov.org
University of California, Davis www.ucdmc.ucdavis.edu/medicalcenter	www.co.sacramento.ca.us
University of California, Irvine www.healthcare.uci.edu	egov.ocgov.com
University of California, San Diego www.ucsd.edu	sdpublic.sdcounty.ca.gov

Appendix C: Detailed Case Studies

Denver Health

DENVER, COLORADO

History

Founded in the mid-1800s as a public hospital, Denver Health is Colorado's primary safety-net institution. Its 477-bed main hospital houses the only academic Level I trauma center in the region. Last year, Denver Health provided nearly \$300M in uncompensated care.²⁴

Governance Change: Rationale and Implications

For most of its history, Denver Health functioned as a component of city/county government. During this time, the institution faced several challenges that it was unable to rectify:²⁵

- Lack of purchasing authority made it difficult to put capital into technology or physician recruitment;
- The hospital and the 11 community clinics operated in silos, with leadership often lacking authority to improve operations or experience; and
- Year-over-year financial losses polarized the political environment and made it difficult to retain consistent funding.

In 1997, Denver Health became the Denver Health and Hospital Authority, with a governance structure separated from the city but with no change to its mission or responsibilities. This change took approximately four years and required significant political buy-in and infrastructure upgrades. New purchasing and personnel systems separate from the city's civil service system were created, and the new legal entity signed a long-term contract with the city.²⁶ Today, Denver Health's board is made up of nine members, appointed by the city mayor. The board members serve five-year terms and direct all activities pertaining to financial management, education and quality assurance, personnel and compensation, and the Denver Health Medical Plan, Inc.²⁷ The CEO of Denver Health now reports directly to this board.

The change in structure enabled Denver Health to accomplish the following:²⁸

- Develop a competitive, market-based salary structure for physicians and other professionals that improved recruitment, including employment for physicians who still wished to keep academic appointments at the University of Colorado;
- Build an integrated system, linking the hospital to the full continuum of care;
- Integrate county, state, and federal funding into a comprehensive package, and negotiate improved public financing through Disproportionate Share Hospital payments; and
- Enjoy greater operational flexibility and capital flexibility, with the ability to successfully issue its own revenue bonds.

Over the last ten years, Denver Health has delivered more than a billion dollars of unsponsored care, supported \$130 million of capital improvements from operations, and has a positive net margin.²⁹

Westchester Medical Center

VALHALLA, NEW YORK

History

Westchester Medical Center (WMC), built in 1977 to replace the old 1920 Grasslands Hospital, is the largest public hospital serving the Hudson Valley. Operating nearly 900 acute and long-term care beds, WMC includes a Level I trauma center and the 120-bed Maria Fareri Children's Hospital. It is the primary teaching affiliate of the New York Medical College (NYMC), and is one of four public benefit corporation hospitals in the state of New York.³⁰

Governance Change: Rationale and Implications

From 1920 to 1998, WMC was run directly by the Westchester County government. The county attempted

to redefine WMC as a high-end academic medical center affiliated with NYMC in the 1970s, but continued to operate the hospital until 1998 when it vested control of the hospital in the Westchester County Health Care Corporation (WCHCC), a public benefit corporation in the state of New York.

Shifting direct control of WMC away from the county was done to accomplish the following:

- Remove the hospital from the legal/regulatory constraints imposed as part of its local government charter to expedite its growth as an academic medical center.
- Reduce the cost of government. WMC accounted for 45 percent of all county employees and 40 percent of the entire county operating budget in 1998.³¹ The newly elected county executive had promised to cut property taxes by 15 percent.³²

Within seven years of the divestiture, WMC was on the verge of financial collapse. By 2005, WMC had more than \$200M in cumulative losses.³³ The failure, in spite of the governance change that theoretically should have shifted autonomy to the medical center, could be attributed to several factors:

- The divestiture process became so politicized and complex that there ended up being less autonomy given to on-the-ground administration than before (e.g., the new WCHCC Board comprised 15 voting and 4 nonvoting representatives, including representatives from the governor, the senate, the assembly, board of legislators, and the county executive).³⁴
- Westchester County abruptly withdrew its financial support and began to charge for utilities/services that it had previously provided gratis.
- WCHCC added two new affiliates (Ellenville and St. Agnes) and began construction on a new children's hospital. All three projects were not focused on the core mission of the hospital, and all ultimately proved to have negative returns on investment.³⁵

Recent efforts to save WMC have focused entirely on financing and operations, including a new leadership team that has been granted the operational latitude that was originally proposed when WCHCC was first created. Changing WMC's Medicaid classification from academic to public resulted in \$25M more in annual state financing. The county approved an infusion of over \$100M (from tobacco revenues and a property tax levy) to enable the hospital to update its infrastructure.³⁶ The result is that WMC is projected to turn a profit in 2008, with significant cost savings projected for the future.

Grady Health System

ATLANTA, GEORGIA

History

Founded in the 1892, Grady Health is the primary safety-net institution for metro Atlanta. With nearly 1,000 beds, it is the largest hospital in Georgia and one of the largest Level I trauma centers in the country. The Grady Health System relies almost entirely on the Emory and Morehouse Schools of Medicine to provide doctor and resident staffing.³⁷ More than 75 percent of Grady Health's patients last year were either on Medicaid or uninsured, and it has been running a monthly operating deficit of \$8M.³⁸

Governance Change: Rationale and Implications

In 1941, a state charter gave control of Grady Health System to the Fulton/DeKalb Hospital Authority (FDHA).³⁹ While these two counties represent less than half of the metro Atlanta population, they contribute almost all its financial support, which has steadily declined as affluence shifts to the suburbs. FDHA is governed by a ten-member board of trustees, with seven appointed by the Fulton County Board of Commissioners and three appointed by the CEO of DeKalb County government. This structure resulted in several challenges that Grady Health was unable to overcome:

- A highly politicized board left Grady Health vulnerable to reimbursement modifications based on political

expediency, frequent allegations of corruption, and accusations related to race and social class.

- The inability to vest authority in on-the-ground leadership led to constant turnover. Grady Health had five full-time or interim CEOs in a three-year span from 2005 to 2008.
- Civil service limitations made it difficult for Grady Health to recruit and retain talented employees, or let go of those that were unwilling to meet service standards.

With Grady Health's financial situation bordering on insolvency, the "Greater Grady" Task Force (GGTF) was created in 2006 to recommend immediate changes that would re-establish Grady Health as a viable health care entity. Their highest recommendation was to restructure the legal entity and change the governance structure. Under the terms of a new agreement, the Grady Memorial Hospital Corporation (GMHC) was created in 2008 as a 501(c)(3) and composed of 17 members, four of whom would be members of the current board. GMHC would take over the operations of Grady Health System, and would have a 40-year lease agreement with the FDHA, which would retain ownership of the health system assets.⁴⁰

The agreement hinged on the completion of several conditions:⁴¹

- A \$200M, four-year commitment from the Atlanta business community, including \$50M in cash/escrow before the lease agreement was executed;
- A commitment to raise \$100M in philanthropic contributions by 2012; and
- A commitment to retain all health care services deemed vital to the community.

A year after the governance structure was changed (and less than six months after a new CEO, Michael Young, was brought on board),⁴² there was a significant improvement in Grady Health's financial position. Private philanthropic contributions totalled \$50M by mid-

2008, money that was invested in facility and systems infrastructure to improve quality and billing. On the operational side, Grady's new leadership has realized revenue cycle enhancements resulting in a \$42.6M improvement. Similar efforts in the supply chain process have translated to another \$17.2M in savings, all in the first nine months of 2008.⁴³

Alameda County Medical Center

ALAMEDA, CALIFORNIA

History

In 1864, the Alameda County Medical Center (ACMC) admitted its first patient on the Fairmont site in San Leandro. By 1927, the Alameda County Board of Supervisors opened Highland Hospital in Alameda to meet the growing need for acute care services among the indigent. Today, ACMC is a Level II trauma center (meaning they treat most trauma patients with the exception of those with severe head, chest, and burn injuries that are sent to Level I centers) with 475 licensed beds spread across three campuses (Highland Hospital, Fairmont Hospital, and John George Psychiatric Pavilion) and three neighborhood-based ambulatory care sites.⁴⁴

Governance Change: Rationale and Implications

Until the last decade, the governing body for the medical center has been the Alameda County Board of Supervisors.⁴⁵ Like other county hospitals with this model of governance, ACMC was faced with familiar challenges:⁴⁶

- Lack of purchasing authority made it difficult for ACMC to participate in low-cost bidding, further straining the financial position of the hospital.
- Adherence to the county civil service model and salary standards made it difficult to attract and retain new graduates in a market that is highly competitive for physicians, nurses, and other allied health professions. In addition, it was difficult to dismiss staff that did not meet quality and service standards.

- Bylaws presented a challenge to developing a board with a contemporary composition that was attuned to the leadership needs required to govern a hospital.

Inspired by the success of Denver Health, APMC adopted the hospital authority model in 1998. The hospital authority holds the hospital license, appoints the CEO, and engages with county government to ensure the medical center continues to provide care to all county residents. The 11-member board of trustees is now appointed by the board of supervisors by majority vote.

This change in structure enabled Alameda County Medical Center to accomplish the following:⁴⁷

- Build a board based on the competencies of the board members. The bylaws are strong and include a vetting process to screen board members before appointments.
- Create a buffer between the governing body of the hospital and county politics, while maintaining full public transparency demanded by the Brown Act.
- Offer a competitive, market-based salary structure for physicians and other professionals to improve recruitment and attract new graduates in the highly competitive Bay Area market.
- Improve its financial position through better purchasing/procurement laws and using more flexible financial instruments to manage expenses and debts.
- Engage in collective bargaining with labor organizations.
- Improve the hospital's nimbleness by shifting more authority to the CEO (reporting to the board) around management, operational issues, and financial issues.

Despite the continued financial link to the county, APMC was the only county hospital in California in 2007 with a positive operating margin.⁴⁸

Appendix D: Legal/Regulatory Definitions

The Brown Act

The Brown Act (Ralph M. Brown Act – California Government Code sections 54950–54963) is more than 50 years old. It was originally enacted in 1953 by the California State Legislature to ensure that decisions and deliberations made in local government meetings were transparent to the public. The Brown Act applies solely to California city and county government agencies, boards, and councils. It was originally a brief 686-word statute, however, there have been substantial additions to its content over the years to try and limit the ability of local government bodies to conduct covert sessions and avoid public scrutiny of their decisions.

The introduction to the Brown Act describes its purpose and intent:

“The Legislature finds and declares that the public commissions, boards and councils and the other public agencies in this State exist to aid in the conduct of the people’s business. It is the intent of the law that their actions be taken openly and that their deliberations be conducted openly. The people of this State do not yield their sovereignty to the agencies which serve them. The people, in delegating authority, do not give their public servants the right to decide what is good for the people to know and what is not good for them to know. The people insist on remaining informed so that they may retain control over the instruments they have created.”

Source: Official California Legislative Information retrieved from:
www.leginfo.ca.gov/cgi-bin/waisgate?waisdocid=5486161224+2+0+0&waisaction=retrieve

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