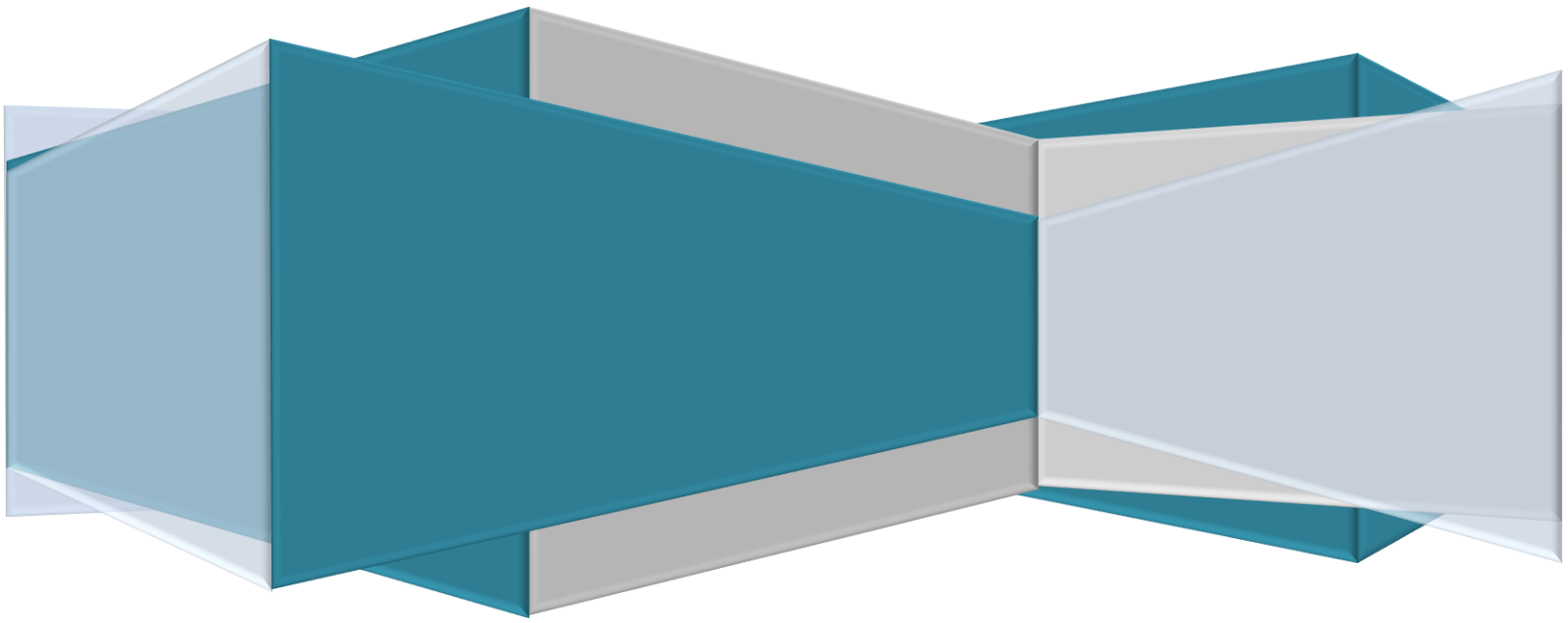
CHATHAM-KENT
Health Alliance

Governance Models and Practices in Ontario's Community Hospital Sector and Rural Hospital Systems



GOVERNANCE MODELS AND PRACTICES IN ONTARIO'S COMMUNITY HOSPITAL SECTOR AND RURAL HOSPITAL SYSTEMS

"The board of trustees of a nonprofit organization has one responsibility: to keep the organization on a straight course for the long-term good of the whole."[i]

BACKGROUND:

Chatham-Kent Health Alliance ("the Alliance") is currently under supervision by the Ontario Government. The Minister of Health and Long-Term Care made this decision following the report by the provincially appointed Investigator who cited, among other things, significant governance and operational issues and shortcomings that had evolved over a number of years. The Alliance, created in 1998, has a governance structure that has remained unchanged since it was created. This structure, is the root cause of the challenges the Alliance has faced. To address these challenges, the Alliance must evaluate and analyze its structure and practices with the goal of developing a governance model that reflects best-practices and enables it to succeed.

Context

The Alliance was created through the work of the Health Services Restructuring Commission in the late 1990's. It serves a population of approximately 110,000 Chatham-Kent residents, as well as residents of South Lambton and Walpole Island. The Alliance is considered a medium sized community hospital, operating both acute (medicine) and sub-acute (complex continuing care) and ancillary services. It also operates a 24/7 Emergency Service at each of its campuses.

The Alliance is in fact three separate hospital corporations, one of which is denominational, operating on two sites with one large campus located in the City of Chatham and a smaller campus located in the town of Wallaceburg. Other than the governance level, all aspects of the organization are integrated including employees, medical staff, patient records and financial records. This relationship is outlined in an Alliance Agreement that was signed in 1998.

Over the 20-year span since the Alliance's creation, healthcare governance has evolved significantly. However, over this same period, the Alliance governance model has remained unchanged. Examples of the significant changes in governance best practices elsewhere include comprehensive skills-based recruitment of board members, and the evolving regulatory environment, which have resulted in changing understandings and expectations of hospitals including fiduciary duty, quality, transparency and clarity of accountability. This necessitates the modernization of governance structures, practices and processes.

In addition, the Alliance Agreement was developed before the creation of Local Health Integration Networks (LHINs) and has not been updated to account for the LHIN role in the health system. The agreement also does not reflect the hospital's responsibilities in relation to

the accountability agreements between the hospital and LHIN, which have been in place for over a decade, or accountabilities under the Excellent Care for All Act. Adding to the complexity, a review of hospital practices over the years, up to and including the governance level, reveal that the terms of the Alliance Agreement have not been followed almost since the Agreement's inception.

The Alliance was created to provide an integrated system of hospital services across Chatham-Kent for the broader community through services across the two sites. While the integration of patient records, staff and physicians across both sites reflected this important direction to create a system of services, the continued separation of the organizations at the governance level led to competing fiduciary duties for the directors and the dysfunction that ultimately led to Provincial intervention.

The outdated Alliance Agreement, coupled with a governance model that does not reflect best practices, resulted in poor alignment and inconsistent decision-making across the three corporations. This led to the appointment of an Investigator in June 2016, followed shortly thereafter by the appointment of a Supervisor in August 2016. With the Supervisor's appointment the Government of Ontario has clearly communicated the need to modernize the governance structure, practices and processes to ensure that the board better serves the hospital, its patients and the community and that the fiduciary duty of all directors is clear, consistent and effectively executed.

It is not surprising that this model struggled over time given that effective governance is achieved by (a) having a common vision regarding strategy, direction, mission, and fiduciary duty and (b) recruiting board members who are aligned with the common vision and whose skills match the board's requirements for advancing the vision and exercising its fiduciary responsibility. It is clear that in the current model there was not a common vision for the Alliance. Interestingly, since the appointment of the Supervisor, the vision of a hospital system anchored by two hospital sites has been made clear by Alliance leadership and with this clear vision, the community has started to see strengthening of patient care services and infrastructure at the Wallaceburg campus such as the recently announced new specialist medical clinics and the investment in a new boiler plant at the campus.

The purpose of this paper is to explore Ontario hospital governance models by (a) conducting a literature search regarding contemporary approaches to governance models, and (b) surveying community hospitals in Ontario with a configuration similar to the Alliance – multi-site, ideally with one larger hospital site in a rural health system.. This is detailed in Part 1.

Part 2 of this discussion paper explores community engagement by (a) conducting a review of current legislation and literature and (b) surveying the same hospitals to identify formalized mechanisms for board-level engagement activities.

Key Learnings from Literature Search

- **Healthcare governance has been studied significantly in Ontario by experts ranging from the Provincial auditor to Hospital Supervisors**
- **Governance issues are most often the root cause for Hospitals placed under supervision by the Ontario Government**
- **Best practices for Boards focus on:**
  - **Skills-based board**
  - **Minimize ex-officio directors**
  - **Skills-based corporations**

PART 1: GOVERNANCE MODELS

"The Minister has made it clear that while independent voluntary hospital governance will be maintained, there will be a significant increase in MOHLTC expectations of hospital boards with respect to accountability, joint planning with other health service providers and service integration."[ii]

Literature Search

Hospital governance has been studied extensively over the years in Ontario. This includes the work done by the Health Services Restructuring Committee, reports commissioned by the Ontario Hospital Association, the Provincial Auditor, provincially appointed Supervisors, all in addition to hospital driven efforts to guide best practices across the sector (See Appendix A). There is also a significant amount of academic literature related to good governance. Consistent across all of the reports and literature are a number of themes that are summarized below.

Skills-Based Boards

Providing governance oversight of a hospital is an increasingly complex responsibility. The accountabilities and responsibilities of hospital directors are significant, as outlined in the report "Role of a Member of a Board of Directors" posted on the Ask CKHA web site[iii].

The Auditor General of Ontario (AGO) studied and reported on hospital governance. In 2010 the AGO recommended to the Ministry of Health and Long-Term Care that hospital boards should consider "incorporating good-governance practices, including those that would facilitate competency-based recruitment and set term limits for directors, into future changes in legislation"[iv]. This recommendation built on the literature that pointed to the need, benefit and importance of skills-based board composition and recruitment.

In reviewing various Supervisors' reports, it is clear that a focus on best practices in governance and specifically skills-based boards, is a key success factor in transforming challenged hospitals. The focus on skills-based governance is now a key part of the mandate of most Supervisors. For example, the Terms of Reference for supervision of the Alliance include reference to establishing boards with appropriate skills and competencies.

Drawing on the expertise of leading governance thinkers, the Ontario Hospital Association (OHA) developed a "Guide to Good Governance" that is recognized as a leading resource for hospital boards. This guide identifies three aspects of board composition that collectively supports effective governance: skills, experience knowledge and diversity and qualities.

> ***Skills:*** The most critical aspect of board composition is a skills-based board. This can be a combination of individuals who possess skills in traditional areas of legal, financial and governance; people with expertise in quality of care; or those with skills to support a local or hospital-specific issue or a time sensitive initiative, such as expertise in building development when working on a capital project (construction).
>
> ***Experience, Knowledge and Diversity:*** This dimension of competency moves beyond specialized skills to broader experience in relevant areas, such as government or healthcare. It also includes individuals that bring both a combination of useful skills and reflect the community's own diversity, such as age, gender, culture, or ethnicity. While important, diversity is secondary to skill.
>
> ***Qualities:*** This element of board composition speaks to board behaviour. All board members should demonstrate integrity, honesty, loyalty and good faith. Other qualities, such as the ability to work in a team, being a strategic thinker and having the ability to provide the time commitment are also important factors. [v]

While skills and competency-based boards are widely accepted as a foundational element of good governance, the challenge in today's healthcare environment is the proper identification and subsequent recruitment of individuals with the right type of skills and experiences to ensure a high-performance board. The Provincial Auditor has highlighted two best practices in the area of board recruitment:

- "Advertise board vacancies and interview potential board members based on skill sets required by the board"
- Use the board member selection process to screen out individuals from single- or special- interest groups who wish to be board members"[vi]

<u>Board Size & Composition</u>

The optimal size of a board of directors has also been studied extensively. As noted in the 2008 Auditor General of Ontario's Annual Report, while there is debate on optimal size, boards must be of a sufficient size to achieve diversity and the competency mix required to effectively achieve their mandate. It is not unusual for hospitals in smaller communities to have fewer people given the smaller total population to draw upon, the general standard appears to be between 12-15 directors. Under the Public Hospital's Act (PHA), hospitals have a specified number of ex-officio non-voting members on their board, specifically: the Chief Executive Officer, Chief of Medical Staff, Chief Nursing Executive and President of the Medical Staff Organization. Ex-officio refers to board members who are part of the board by virtue of the office or role they hold. Some hospitals have historically included additional ex-officio members over and above those identified in the PHA, increasing the size of the board. Over the last decade there has been a trend to limit the number of ex-officio members recognizing the

challenge of achieving the right skills mix on a board and also acknowledging the potential inherent conflict of interest some ex-officio directors may have. Best practice boards limit their ex-officio members to those outlined in legislation.

Membership

In a similar way to the evolution of the role and approach for Directors, the nature of corporate membership has also evolved over the years.

At one time paid or open membership corporations with annual memberships were the predominant model for membership. In this model individuals paid an annual fee to join the hospital corporation and vote at Annual meetings. Over the past 20 years there has been a dramatic shift in Ontario hospitals from paid membership type corporations to skills-based or closed membership corporations in which the directors are also the corporate members. The shift has occurred as skills-based governance has been recognized as a best practice in light of situations resulting in diverging personal interests and attempts to commandeer an organization. Skills-based Corporate membership provides a clear connection between the legislated accountability framework of hospital boards and the Corporations structure.

Survey Results

A survey was undertaken of peer hospital organizations, that is multi-site hospitals in rural Southern Ontario to identify how the structural elements outlined in Part 1 of this discussion document are used in practice. A particular focus of the survey was placed on peer organizations comparable to CKHA, specifically those with multiple sites, ideally with one larger (urban) and at least one smaller (rural) campus and operating budgets of approximately $50M. The six organizations surveyed were: Bluewater Health, Grey Bruce Health Services, Huron Perth Healthcare Alliance Middlesex Health Alliance, Quinte Health Care and South Bruce Grey Health Centre. Presented below is a summary of the findings of this sample.

Key Findings from Survey

- **Skills-based Board Structures**
- **Board size of 12-16**
- **Skills-Based Membership Model**

	Number of Sites	Board Structure	Board Membership	Administration	Corporate structure	Corporate Membership
CKHA	2	Three Boards (Alliance)	16 Elected (July 2016)	Single Chief Executive Officer and staff	Three corporations including one denominational	Paid and Skilled membership
Bluewater Health	2	Single Board	12 Elected		Single corporation	Skilled membership model
Grey Bruce Health Services	6	Single Board	12 Elected; 2 Appointed from org; 2 reciprocal cross appointments		Single corporation	Skilled membership model

Huron Perth Healthcare Alliance	4	Four Boards (Alliance)	11 Elected		Four corporations	Skilled membership model
Middlesex Hospitals Alliance	2	Single Board (Alliance)	11 Elected	Single Chief Executive Officer and leadership	Two corporations	Skilled membership model
Quinte Health Care	4	Single Board	12 Elected	Single Chief Executive Officer and staff	Single corporation	Skilled membership model
South Bruce Grey Health Centre	4	Single Board	7-13 Elected; 1 nominated by GBHS; 1 from partner org		Single corporation	Skilled membership model

Discussion

Number of Corporations

Although the organizations surveyed at one time had multiple sites that were independent organizations, they have evolved in terms of their current corporate structures. It is important to note that CKHA is the only organization in the sample that includes a denominational organization (St Joseph's) coupled with non-denominational organizations (Public General and Sydenham District Hospitals).

All organizations have a single Chief Executive Officer and hospital staff. Similarly, the majority of the organizations have moved to a single corporate organization. The prevalence of one CEO and leadership team in multi-site hospitals reflects the requirement for leadership and organizational alignment in order to achieve operational effectiveness and efficiency.

At Bluewater Health the integration of its original three sites evolved over many years to become amalgamated into a single entity in 2003. The evolution resulted in the number of board directors decreasing from 48 in 1999 to 15 by 2005, and the implementation of a new framework for community accountability with the establishment of the "External Advisory and Accountability Structure."[vii]

Regardless of the number of corporations, the number of elected directors is consistent across all sites examined and reflects best practices in terms of overall size and ex-officio members as discussed in the literatures section of Part 1 of this paper.

Board Size & Composition

> ***"The composition, size, turnover, nomination, and recruitment processes are perhaps some of the most important governance elements and processes that contribute to effective governance."[viii]***

Across the organizations surveyed there is only minor variation on who is eligible to serve on the board, with some organizations having stronger geographic representation requirements in addition to a more clearly articulated skills mix. The inclusion of geography in recruitment is found more often in rural settings and can help to assist the board in strengthening its

relationship with stakeholders, including the communities served by the hospital. However, as the Provincial Auditor General suggests, the challenge is to balance the requirements needed to best serve the organization against other interests. The individual directors, regardless of their ties to the community, collectively must have the skills necessary to competently lead the organization. In some regions, particularly those challenged to find the full complement of skills they need on the board, the organization allows for a portion of their board seats to be filled by people from outside of their own communities.

Membership

Almost all of the hospitals surveyed have a skilled membership model. This is in keeping with the literature on good governance and the recognition that elected directors must act in the best interest of, and fulfill the multiple accountabilities of, the hospital corporation. A further survey of hospitals across South Western Ontario was done to ascertain the prevalence of a paid membership model. Of the 23 hospital organizations contacted, spanning a much larger number of sites, 20 had a skilled based structure. Regardless of size or location, modern and effective boards are built on key principles of best practice. These boards put in place structures and compositions that support the board's legal roles and responsibilities while reducing the potential for special interest influence or conflict of interest from emerging. The evidence, and the hospitals examined, confirm that good governance is grounded in a commitment to the mission and fulfilling the corporations' accountabilities, while also serving the needs of stakeholders.

PART 2: COMMUNITY ENGAGEMENT

Successful governance and leadership of hospitals requires a specific focus on community engagement. This must start at the board level so as to ensure that patient and community engagement is woven into the DNA of the organization and becomes an integral part of how the organization does business.

Legislative Context and Literature Search

> ***"While it is clear that the board of a hospital is solely accountable to the hospital corporation, understanding to whom the hospital is accountable is more challenging. To fully understand hospital accountability, a board must first be knowledgeable of the various relationships between the hospital and its stakeholders."***[ix]

Hospital boards need to continually consider their numerous stakeholders, from patients to providers, funders to other healthcare organizations, and staff to the general public. Boards must also consider the best strategies and mechanisms to manage and develop those relations.

While the concept of community participation has been in place over many decades, the importance of the relationship between hospital's and their stakeholders increased in Ontario's healthcare system about 10 years ago with the Local Health

Key Learnings:

- **Leading boards prioritize patient and community engagement and actively participate in ongoing community conversations**

System Integration Act, 2006 (LHSIA). The Act states that health service providers, including hospitals, "shall engage the community of diverse persons and entities in the area where it provides health services when developing plans and setting priorities for the delivery of health services."[x]

Today, engagement, with a particular focus on patients and families, is gaining even greater relevance and is viewed as a critical success factor in enhancing patient experiences and quality outcomes. This is best reflected in recent changes to the *Excellent Care for All Act* and requirements for patients and families to be directly involved in the creation of hospital Quality Improvement Plans.

The Governance Centre of Excellence's "Guide to Good Governance" outlines this accountability: "A hospital board needs to understand the nature of its relationship with, and obligations to, its stakeholders in order to effectively and appropriately make decisions in the best interests of the hospital, and to determine the appropriate processes for relationship building and engagement."[xi] To fulfill this growing responsibility, hospital boards need to have multiple mechanisms in place to communicate with stakeholders, including strong processes to receive input and ideas that will help to improve the patient experience, quality of care and access to services.

Determining when and how to engage patients, families, the LHIN, Ministry, employees and the community at large can be challenging in terms of resources and effectiveness. While long understood in principle, it can be hard to do in practice.

The reality is that when done properly, engagement offers a number of clear benefits and outcomes, included but not limited to:

- building support for new services (or changes in services) and plans;
- exchanging knowledge and perceptions on concerns, priorities, and values;
- clarifying expectations and points of agreement or disagreement to help develop constructive solutions and strategies;
- promoting awareness and understanding of limitations and viewpoints;
- identifying conflict before strong opinions are entrenched to support better problem-solving;
- building trust and creating a sense of accountability; and,
- achieving some short-term gains and understanding that community engagement is a long-term investment to realize long-term benefits. [xii]

There are many ways to engage stakeholders and hospitals may use a range of strategies for community engagement. According to leading frameworks for healthcare engagement, advisory committees fall under the definition of collaboration. Collaboration offers the promise of seeking advice and ingenuity in solution development from participants and in return, the organization commits to include their suggestions to the greatest extent possible in final decisions.[xiii] By using advisory committees, boards ensure that community input is incorporated in the decision-making process. This approach is further supported by the Auditor General's findings as a mechanism to achieve community input:

> ***"Literature on best practices suggests that a community advisory committee can provide hospital boards with community input without the need for community "shareholder" members."***[xiv]

Survey Results

The second part of the survey of rural hospitals was used to identify the approaches to board level rural community engagement at each hospital. A scan of the organization's websites for formal community committees or panels was conducted.

Organization	Engagement Approach
CKHA	Previously there was no Community Advisory Committee however, CKHA has recently created a Rural Health Advisory Committee. CKHA also has a Patient and Family Experience Council.
Bluewater Health	Community Advisory Panel and a Rural Health Advisory Panel
Grey Bruce Health Services	No Community Advisory Committee. The organization transitioned from a Community to Patient Advisor approach
Huron Perth Health Alliance	Local Advisory Committees (1 per corporation)
Middlesex Hospital Alliance	Local Advisory Committee (Four Counties)
Quinte Health Care	Advisory Council
South Bruce Grey Health Centre	No Community Advisory Committee. The organization has a patient and family council that reports up to its Quality Improvement Committee

Discussion

> ***"Patient and community engagement is a proactive and effective way of addressing concerns before they bubble up into time-consuming and potentially expensive complaints. Board members are key to leading the shift towards a more patient-centred culture throughout Ontario health care institutions."***[xv]

The majority of organizations surveyed have some form of committee or council that provides information and insight to their organization's community leadership.

Bluewater Health has a similar urban/rural composition and has developed both a Community Advisory Committee and a second panel of community representatives that has a specific rural focus. This approach compliments the newly established sub-LHIN regions that are intended to better identify, capture and respond to diverse population needs. According to the Erie St. Clair LHIN, sub-regions were created based on pre-established patterns of care and will offer a more local and tailored approach to meet the distinct needs of a community, including the needs of Francophone Ontarians, Indigenous communities and other individuals or groups that have unique healthcare needs and who experience challenges in navigating the health system or accessing care.[xvi] With the emergence of sub-regions within hospital catchment areas comes

the heightened need to offer meaningful connections to diverse and distinct communities that access services.

A formalized framework for communication with diverse individuals and entities served by a hospital ensures that boards have an ongoing cycle of information, input and feedback with the community.

SUMMARY:

Much has been written on governance in health care both in academic literature and in the Ontario system itself. The complexity of governing today's health care organizations makes the pursuit of best practices in governance increasingly important. Boards need to commit to ongoing examination and evaluation of their structures and practices in order to continuously improve performance, adapt to changing circumstances, and anticipate and respond to an evolving regulatory environment.

The reality is that governance is complex and it is difficult to do well. "Transformational governance requires boards to remain focused on their organization's mission while working with executives and clinical leaders to oversee continuous improvement of performance and the value delivered to stakeholders. At the same time, boards must lead by example and alter their own governance practices to effectively guide their organizations through the challenges ahead."[xvii]

As stewards of the organization, boards are responsible for the hospital's quality of care, performance and its culture. An effective hospital board recognizes the need to continually strengthen, develop and build capacity so that it is better positioned to stay attuned to the evolutions and changes necessary to create and sustain a high performing organization.

From the review of literature and survey of other Ontario multi-site rural hospitals a number of areas for further consideration have emerged including best practices such as skills based boards, optimal board size, recruitment strategies, skills-based corporate structures and the use of advisory committees as an engagement enabler. It is important that boards develop a clear understanding of their key stakeholders and the specific accountabilities to each stakeholder group to enable the board to make resourcing decisions in the best interest of the hospital.

While unpaid, board directors set the leadership and performance tone for the organization to emulate, establish a culture that both supports and challenges management, and provide insight and experiences beyond healthcare. Recruiting and retaining the right people – skill, diversity and mindset – on the board is a critical element of an effective organization; perhaps too often overlooked or underestimated. Learning from leading practices and leading organizations will be crucial to ensure that the Alliance's future governance sets the tone for success and excellence and ensures that the organization does not fall back into the difficulties that it has encountered over the last number of years.

APPENDIX A: EXAMPLE REPORTS ON GOVERNANCE BEST PRACTICES IN ONTARIO

1. **Health Services Restructuring Commission**
    a. http://tools.hhr-rhs.ca/index.php?option=com_mtree&task=att_download&link_id=5214&cf_id=68&lang=en

2. **Hospital Governance and Accountability in Ontario by Maureen Quigley and Graham W. S. Scott, Q. C**
    http://www.mcmillan.ca/Files/GScott_MQuigley_HospitalGovernance_OHA_0404.pdf

3. **Supervisor and Investigator Reports**
    a. **Restoring a Solid Foundation for the Toronto Scarborough Hospital** – Rob Devitt
    b. **Final Report: Cambridge Memorial Hospital** – Murray Martin
    c. **Setting a New Course: Report from the Supervisor, Kingston General Hospital** – Graham W. S. Scott, C.M.; Q.C.
    d. **Investigation Report Brant Community Healthcare System** – Dr Tim Ruteledge
    e. **Chatham-Kent Health Alliance Investigation Report** – Ms Bonnie Adamson

4. **Provincial Auditor**
    a. **2008 Annual Report:**
    http://www.auditor.on.ca/en/content/annualreports/arreports/en08/311en08.pdf
    b. **2010 Annual Report:**
    http://www.auditor.on.ca/en/content/annualreports/arreports/en10/411en10.pdf

5. **Governance Review for Bluewater Health by the Governance Renewal Task Team**
    http://www.bluewaterhealth.ca/documents/136/Bluewater%20Governance%20Renewal%20Report%20to%20Board%20-%20Final%20updated%20Jan%2020%202008.pdf

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[iii] (Alliance, 2017)
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[v] (Corbett, Anne; Mackay, James M; Hawkins, Patrick J.)
[vi] (Ontario A. G., Annual Reports, 2008)
[vii] (Kearns, Vigar, & Scimmi, August 2005)
[viii] (Corbett, Anne; Mackay, James M; Hawkins, Patrick J.)
[ix] (Corbett, Anne; Mackay, James M; Hawkins, Patrick J.)
[x] (Ontario G. o.)
[xi] (Corbett, Anne; Mackay, James M; Hawkins, Patrick J.)
[xii] (Southlake Regional Health Centre, n.d.)
[xiii] (Pan LHIN Communications, 2016)
[xiv] (Ontario A. G., Annual Reports, 2008)
[xv] (Excellence, 2015)
[xvi] (LHIN, 2014)
[xvii] (Totten & Paloski, 2013)