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U.S. ARMY-BAYLOR GRADUATE PROGRAM
IN HEALTH CARE ADMINISTRATION

GRADUATE MANAGEMENT PROJECT

CASE STUDY:

AN EVALUATION OF THE SIZE, COMPOSITION, AND FUNCTION
OF THE EXECUTIVE COMMITTEE
AT EISENHOWER ARMY MEDICAL CENTER

SUBMITTED TO MAJOR MARK PERRY
IN PARTIAL FULFILLMENT
OF REQUIREMENTS FOR THE DEGREE
OF MASTER OF HEALTH CARE ADMINISTRATION

BY

MAJOR MICHAEL J. KRUKAR

FORT GORDON, GEORGIA

MAY 1996

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I would like to dedicate this project to my dearly departed mother, Ann Krukar, whose prayers and support were only a phone call away.

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ABSTRACT

The United States Army Medical Department is dedicated to delivering quality medical care to its patient beneficiary population. However, budget reductions and personnel shortages are affecting the way that care is being delivered. To effectively address these issues, military medical treatment facilities require a governing body streamlined to respond to changes affecting military medicine.

The purpose of this case study is to examine the size, composition, and function of the Executive Committee at Eisenhower Army Medical Center to ensure that quality medical care is being provided. This study includes a historical view of hospital governing entities, legal ramifications that affect board responsibilities, roles that members exercise in carrying out their duties, and board characteristics that differentiate hospitals.

The study further discusses ideas designed to make the Executive Committee more effective. Different, inexpensive tools are presently available to the Committee to use. The study concludes with a set of recommendations to be examined prior to implementation by the EAMC leadership. For effective governance to emerge, the Executive Committee must become a dynamic, evolving entity that can adapt as circumstances warrant change.

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CASE STUDY:
AN EVALUATION OF THE SIZE, COMPOSITION, AND FUNCTION
OF THE EXECUTIVE GOVERNING BODY AT
EISENHOWER ARMY MEDICAL CENTER

I. INTRODUCTION

1. Background Information

The Department of Defense is committed to providing good, quality health care to its service members and patient beneficiaries. It has been a leader in establishing a world class, cost effective medical system. However, certain changes in the world, such as the fall of the Soviet Union, have caused the United States Congress to search for cost containing reductions (U.S. Army Medical Department 1995). The military's force structure has been dramatically downsized, significantly reducing the numbers of Active Duty personnel and their family members. Military medicine has also had to reduce its numbers. However, demand for military health care remains greater than its supply. The Department of Defense is initiating TRICARE, a capitated managed health care plan for all military service beneficiaries, to respond to the significant changes that are affecting the military health care system.

Change is also dramatically affecting the Army Medical Department (AMEDD). Downsizing and deployments to Desert Storm,

Somalia, and Bosnia are causing the leadership of the AMEDD to think "outside the box" to develop new, innovative ideas. During this period of dramatic change, the Army remains committed to improving its health care delivery efforts.

Eisenhower Army Medical Center's (EAMC) Commander, Brigadier General Stephen N. Xenakis, is also committed to improving the local health care delivery system during these turbulent times of budget reductions and personnel shortfalls. He is currently the Lead Agent for Department of Defense Region 3, Commander, Army Southeast Health Service Support Area (HSSA), as well as Commander of EAMC. As his roles have changed, so have others within the organization.

How to best streamline and realign itself in order to effectively govern is one of the major challenges facing leadership of the military health care system. Traditionally, governing bodies establish organizational goals and develop strategies for their achievement. This is also true of Eisenhower Army Medical Center. The governing body at EAMC is its Executive Committee. This Committee must be structured in the most effective way to respond to the current changes affecting both the military and civilian health care delivery systems.

2. Conditions Which Prompted the Study

Change has dramatically affected the healthcare delivery systems for both military and civilian organizations. As the business of healthcare delivery continues to evolve, hospitals and healthcare executives are struggling to realign their organizations to better meet their emerging needs. Issues such as capitation, collaboration, and increased accountability for community health status present challenges to healthcare executives and their management teams.

A traditional role of the governing board within a not-for-profit hospital is to ensure that the institution serves its community. However, this role is changing dramatically as a result of a more competitive environment. These institutions, to include those within the AMEDD, are placing an increased emphasis on fiscal responsibility. Delivering efficient, cost effective medical care is now a standard requirement throughout the healthcare industry. Hospitals need to be managed in a more business-like manner if they are to survive in a time of reduced reimbursement rates and cost-containment. Healthcare executives need to measure, evaluate, and determine the nature and scope of services which will best serve their patient beneficiary population.

The literature is replete with articles that address structure and performance of governing boards. Many of these

articles include suggestions on how boards should be organized, how the board should operate, and what indicators should be used to ensure survival in a competitive environment.

The leadership at Eisenhower Army Medical Center is also addressing the purpose and composition of its governing entity as Lead Agent and HSSA activities impact the roles and functions of the medical center's Executive Committee. Military medical treatment facilities located within the three state area of DoD Region 3 include hospitals from the three military services. They include:

ARMY

<u>Name</u>	<u>Location</u>
Eisenhower Army Medical Center	Fort Gordon, GA
Martin Army Community Hospital	Fort Benning, GA
Winn Army Community Hospital	Fort Stewart, GA
Moncrief Army Community Hospital	Fort Jackson, SC

NAVY

<u>Name</u>	<u>Location</u>
Naval Hospital Jacksonville	Jacksonville, FL
Naval Hospital Charleston	Charleston, SC
Naval Medical Clinic	Kings Bay, GA
Naval Hospital Beaufort	Beaufort, SC

AIR FORCE

<u>Name</u>	<u>Location</u>
20th Medical Group	Shaw AFB, SC
78th Medical Group	Robbins AFB, GA
347th Medical Group	Moody AFB, GA
6th Medical Group	MacDill AFB, FL
45th Medical Group	Patrick AFB, FL
437th Medical Group	Charleston AFB, SC

Army medical treatment facilities located within the seven state area comprising the Southeast HSSA include:

<u>Name</u>	<u>Location</u>
Eisenhower Army Medical Center	Fort Gordon, GA
Martin Army Community Hospital	Fort Benning, GA
Winn Army Community Hospital	Fort Stewart, GA
Moncrief Army Community Hospital	Fort Jackson, SC
Blanchfield Army Community Hospital	Fort Campbell, KY
Lyster Army Community Hospital	Fort Rucker, AL
Noble Army Community Hospital	Fort McClellan, AL
Fox Army Community Hospital	Redstone Arsenal, AL

EAMC has no direct command and control authority over Navy and Air Force medical treatment facilities. EAMC's role is an advisory one, in that it coordinates services that could reduce total health care expenditures throughout the region. It does have, however, command and control authority over the Army hospitals located within the Southeast HSSA. This authority includes control over operational, budgetary, manpower, and readiness issues.

EISENHOWER ARMY MEDICAL CENTER

The Commander of Eisenhower Army Medical Center is poised to implement initiatives that are intended to improve the efficiency and effectiveness in providing healthcare within the Region and HSSA. One of these initiatives is reorganizing the organizational structure of the medical center to include the Executive Committee. This is intended to improve the organization by making it more competitive, patient focused, and user friendly. The goal is to ensure the organization's long-term viability, while making it a model DoD health care delivery system for the 21st Century (EAMC 1996).

The governing board at the medical center is its Executive Committee. It is comprised of the Commander, the Deputy Commander for Administration/Chief of Staff, the Deputy Commander for Clinical Services, Chief, Department of Nursing, and the Command Sergeant Major. Other individuals who attend, but without a vote, are the Quality Improvement Program Manager, Administrative Residents, and the Secretary to the Commander who serves as the Recorder (EAMC 1990).

The Committee's purpose is to enhance the communicative process among the administrative and medical staffs of the medical center. It assists the Commander in the maintenance of high quality medical care, ensuring effective utilization of hospital resources. The Committee also receives, acts upon, and

coordinates the recommendations of the clinical and administrative committees, and monitors the implementation of the Commander's decisions (EAMC 1990).

The Executive Committee requires validation of its current composition and purpose. The committee must be able to maintain a strategic focus and still have necessary control at the operational level to carry out its plans for health care delivery within the region.

3. Problem Statement

1) Is the current size, composition, and function of the executive governing body at Eisenhower Army Medical Center effectively ensuring that quality medical care is being provided to its patient beneficiary population?

2) What changes, if any, can be incorporated to make the governing board more effective?

4. Literature Review

In order to appreciate the complex nature of an organization's governing board's role, a thorough review of the evolution of hospital governance is required.

HISTORY

A review of the historical patterns of governance within hospitals reveals that board roles and functions have changed as the roles and functions of hospitals have changed. Hospitals in the mid- to late 1800s transitioned from almshouses, where only the poor and indigent were treated, to institutions designed to care for all types of patients who were sick and ailing (Williams and Torrens 1993). Physicians, needing capital to improve the hospital's plant and equipment, sought help from the local community. Merchants, bankers, lawyers, and political leaders from the community contributed money to support these efforts. This resulted in organizational structures in which boards of private managers, trustees, and commissioners, rather than physicians or professional administrators, retained final decision-making authority (Barocci 1981).

In the late nineteenth century, changes to organizational and hospital financing, as well as rapid development in medical technology, transformed hospitals. Physician control expanded as the trustees' power diminished. Physicians became important players on hospital boards, both as policy makers and as directors.

Another shift occurred in the mid-twentieth century as hospitals not only experienced increasing complexity in performing internal operations, but also experienced instability

and increased complexity with outside regulators and physician groups (Fennell and Alexander 1989). Business corporations, along with state and federal governments, became more concerned with rapidly escalating costs. They demanded that costs be controlled and unnecessary health care spending be eliminated. Thus, competition became very keen.

The passage in 1983 of the Medicare Prospective Payment System (PPS), based on diagnostic-related groups (DRGs) further intensified competition. The DRG system is designed to reimburse hospitals on the basis of preset rates rather than on cost-incurred rates. This shift is causing hospitals to compete for increasingly limited resources by identifying alternate sources of funding, developing business plans, and adapting to a rapidly changing health care environment. Some of these changes include joint venturing, merging, corporate restructuring, and even closure (Starkweather 1988).

LEGAL RAMIFICATIONS

Over the past thirty years legal precedents have helped reinforce the need for new changes in hospital governance. The case of *Darling v. Charleston Community Memorial Hospital* in 1965 and other similar cases have clearly established that hospitals and their boards have a direct responsibility for the quality of care that is practiced within their institutions. *Darling*

changed the focus of legal responsibility. Before this landmark case took place, physicians were defined as acting as independent contractors. Hospitals were not charged with being responsible for a physician's negligent acts. *Darling* shifted the focus of responsibility, making the hospital and its board members responsible for monitoring and assuring quality medical care.

Other more recent legal cases such as *Schwinger v. U.S.* and *Simpson v. U.S.*, both occurring in 1987, have established fiduciary responsibilities for hospitals and their trustees. These cases have determined that hospital governing boards have an obligation to be diligent in performing their duties (Fennell and Alexander 1989).

ROLES

Historically, the role of trustees was to maintain or to enhance the legitimacy and prestige of the hospital and to attract resources to the institution from the surrounding environment (Kaufman et al. 1979). Today, governing boards function to link the organization to its environment, set overall policy and direction for organization, and to protect the institution from uncertainties and disturbances posed by the environment.

Literature suggests that boards must now execute three slightly different roles in order to fulfill their

responsibilities. Boards must formulate policy, execute good decision making, and provide adequate oversight (Pointer and Ewell 1995). The interrelationship of these roles is portrayed in the Appendix (Pointer and Ewell 1994).

Policy Formulation

Policy formulation is the primary mechanism through which boards influence their organization. Policy statements guide the organization and reflect the values and preferences of policy makers. These statements can be directed through three different levels of policy - statements of board responsibility, board policy, and operating policy (Chait, Holland, and Taylor 1991).

Statements of board responsibility define the nature and scope of board obligations (Orlikoff 1990). They help formulate and ensure high levels of executive management performance. They also help ensure that quality of care is carried out within the organization. These statements, designed so that the organization is operated in a financially responsive manner, describe the focus and differentiate board responsibilities.

Board policies are derived directly from the organization's statements of responsibility. These policies provide direction and convey expectations to the medical staff. However, boards must use caution when developing such policies. If boards formulate only a few broad policies, they may be abdicating

certain responsibilities to the medical staff. If they formulate a plethora of detailed policies that direct the staff on how to perform every conceivable step, then boards assume the risk of operating their institutions. Boards must be careful as to which direction they take. They do not want to create inappropriate or dysfunctional situations that, in turn, create confusion among staff members.

Boards must be able to establish a level of comfort that allows staff members to function with a degree of latitude. As boards begin to formulate more specific policies, the staff is provided less and less freedom in which to function. Boards must determine how directive and restrictive they want and need to be. John Carver points out that boards should continue to formulate policies which sequentially narrow the discretion of management and the medical staff up to a point where it is comfortable with any reasonable interpretation, application, and/or implementation of that particular policy (Carver 1991).

When boards narrow the discretion of management and the medical staff, the number of policies that are formulated is increased dramatically. Every board must be able to determine when a policy becomes more of a burden than a benefit to the organization. Pointer and Ewell suggest that boards should formulate policies with great care (Pointer and Ewell 1995). They suggest that policies should be written, explicit, brief,

and periodically reviewed.

Decision Making

Decision making plays a central role in governance. Much of what a governing board does involves making choices. Some important choices governing boards make include:

- 1) Did the CEO achieve his or her performance objectives?
- 2) How much should salaries be increased due to superior performance?
- 3) Should a particular physician be reappointed to the medical staff?
- 4) Should the board realign itself, either reducing its size or adding additional members, to gain expertise? All of these decisions will usually require an analysis of operational, market, and financial indicators.

Governing boards can make decisions in two different ways. A board can either choose to retain authority or choose to delegate decision making authority to the management staff or the medical staff. If a board retains authority, then the members must make most of the decisions. These decisions can focus on questions such as board size, selecting new members, or what types and numbers of standing committees the institution will have. Boards can also choose to delegate decision making authority to management or the medical staff. They can allow

management or the medical staff to make decisions within certain limitations. Boards must establish a comfort zone as to whether they choose to delegate decision-making authority.

Employing different types of decision-making approaches allows boards to optimize leverage over their institutions. They may retain authority in some areas, completely delegate decisions in other areas, or seek recommendations from management or the staff before making decisions in other areas.

Oversight

Execution of oversight is the final step that closes the loop with respect to the board's ultimate responsibility. Since hospital management and the medical staff are held accountable to the governing board for their actions, proper oversight ensures accountability. Boards ensure oversight through different mechanisms such as monitoring, assessment, and feedback. Monitoring and assessment ensure that delegated tasks are being executed in a fashion that boards have communicated in their policy statements. Feedback is the final and most crucial function associated with oversight as it provides information relative to policy implementation.

A governing board must put into place a good information system to effectively and efficiently execute its oversight role. Boards can be overwhelmed with information. Typically the

information they receive is not the type they need to govern effectively. In many instances the governing board is presented information that is designed for management or the medical staff.

Many researchers advocate that information provided to the governing board be selective, comparative, clear, concise, user-friendly, valid, and presented graphically when appropriate (Chait, Holland, and Taylor 1991). Information presented to a board in this fashion should help the board determine whether its expectations are being fulfilled and its intended results are being achieved. Information that is portrayed over time allows board members to put information into context and helps them to make meaningful decisions.

BOARD CHARACTERISTICS

Literature suggests that there are differences between the governing boards of For-Profit (FP) and Not-for-Profit (NFP) hospitals. Board size, heterogeneity, Chief Executive Officer (CEO) participation, term limits, and board compensation are examples that differentiate FP and NFP organizations (Rakich, Longest, and Darr 1992).

NFP hospitals generally have governing boards that are made up of large numbers of members who are chosen to represent the hospital. These representatives are traditionally drawn from the community and have special skills that the hospital needs but

often cannot afford. They enhance the legitimacy and prestige of the institution as well as attract resources to the hospital from the surrounding community.

FP governing bodies tend to be smaller than NFP governing boards. They draw their members from investors/owners and from physicians within the organization. This smaller size allows the governing board to become more focused since it is accountable to the stakeholders of the institution (Ewell 1987).

Decision-making within a NFP hospital can incorporate a wide range of constituents from within the organization. This broad approach helps reflect the backgrounds and perspectives that the members have for the organization. However, they may differ in many characteristics such as age, gender, racial or ethnic background, or area of residence.

FP hospitals tend to have a more business-like approach to decision-making. Stakeholders within FP hospitals want to maximize returns on their investments. The boards, facing pressure from these market forces, streamline their structure to become closely linked with management to bring skills and expertise to the process of strategic development (Weiner and Alexander 1993).

CEOs in FP hospitals play a more important role in the decision making process than their counterparts in NFP organizations. CEOs in FP organizations are usually voting

members of the board who can exert tremendous influence over the board. They have the direct ability to influence decision making. They can improve policy making or facilitate selection of directors who share similar organizational philosophies. CEOs in NFP hospitals typically share power with others. They may not even be a voting member on the governing board. When this occurs their ability to influence the board is greatly diminished (Alexander and Morlock 1985).

Term limits differ between both types of boards. NFP boards tend toward self-perpetuating bodies where board members may serve indefinitely. They may even choose the individual who will replace them on the board. This type of practice is not evident in the corporate setting (Ewell 1982). FP boards will normally set limitations on the number of consecutive terms members may serve. In many cases these terms are for three years, with no member serving more than three consecutive terms. This allows members to have a degree of flexibility without becoming too conservative in their decision-making process.

FP boards are more likely to compensate board members than are NFP boards. FP members may not be fully compensated for their time and effort, but it is felt that payment strengthens the bond between the member and the organization (Ewell 1982). It has long been thought that compensating NFP members would be a conflict of interest.

5. Purpose

The purpose of this study is to provide the leadership of Eisenhower Army Medical Center with sufficient information to support the restructuring of the Executive Committee. The following criteria will be used to make this assessment: size, effectiveness, composition, function, and self evaluation.

Knowledge of the history, roles, characteristics, and current focus of governing boards is essential to this study. The objective of the study is to determine how the governing body of Eisenhower Army Medical Center can maintain a strategic focus on issues and still sustain necessary control at an operational level.

II. METHODS AND PROCEDURES

This Graduate Management Project provided me an opportunity to combine my previous experience as a health care administrator with the skills acquired in the didactic and early portions of the residency program. The goal was to produce a project that objectively evaluated the size, composition, and function of the executive governing body at EAMC and identify possible improvement alternatives to make the committee more effective.

The following tasks were accomplished during this study:

1. An extensive literature review was conducted analyzing professional journal articles, government regulations,

and other pertinent references using the EAMC Medical Library, local civilian health care facilities, and internal and external documentation that focused on improving the Executive Committee of the medical center.

2. Key personnel involved internally and externally with the process were interviewed.

3. An extensive effort was made to identify civilian healthcare lessons learned and to examine their value if similar alternatives were to be applied at EAMC.

Study Design

This project incorporated a qualitative study design to evaluate and determine the proper size, composition, and function of EAMC's Executive Committee. Institutional governing boards were compared and contrasted to determine an appropriate mix of membership and function. The two primary research publications used in this Graduate Management Project were Case Study Research: Design and Methods (1989) by Robert K. Yin, and Qualitative Evaluation and Research Methods (1990) by Michael Q. Patton.

Validity and Reliability

Construct validity and reliability techniques outlined by Yin were utilized to ensure the study measured what it "purported

to measure", and also "measured the right things." To improve construct validity, Yin suggested use of the following techniques: multiple sources of evidence, established chain of evidence, and have the draft case study reviewed by key informants. The techniques of multiple sources of evidence identified in the bibliography were applied, and the review of the case study by key informants, to include the preceptor, were performed. To ensure reliability, a case study data listing of all research notes and documentation was established and maintained.

Ethical Issues

To ensure that this survey complied with all ethical guidelines and principles, the following actions were taken: all personnel interviewed were informed of the purpose and nature of the study and of the right not to participate in any or all parts of the process. Anonymity and confidentiality were maintained unless proper release of information was granted.

III. RESULTS

1. The Literature Review and Interview Process

The literature review for this study was conducted at various military and civilian health care libraries located throughout the Augusta, Georgia area. The vast majority of

background data, as it pertains to governing a healthcare organization, were found during the literature search.

Interviews with key personnel provided invaluable insight into the importance of directing an organization and also provided me viable alternatives to consider as possible options.

2. Major Findings

It is speculated that governance will be one of the leading vehicles that will transform hospitals into becoming fully integrated healthcare delivery systems. However, there is little agreement on what an ideal governing structure for an integrated delivery system should look like. This is because governance tends, as it should, to reflect the philosophical, religious, or corporate motivations of the organization. It is important to note that the governance structure of any healthcare organization does not in itself determine an organization's governing function. Issues such as size, philosophical orientation, and composition are important characteristics that make up a governing entity. However, the proper governing structure should be determined primarily by the unique and defined needs, culture, and mission of each system.

Current Size

The size of the board in the civilian sector has been shaped

by role, history, constituency factors, and availability of members. Historically, when Not-for-Profit institutions needed fund raising monies to offset the lack of established resources, they selected members who were able to generate large amounts of cash. Conversely, a large hospital board was needed to reach out to many influential community interests. Successful fund raisers swelled the ranks of board members, as a large contribution often earned the donor a seat on the board (Bader 1991).

In other instances, board members underwrote the deficit of the institution they represented. To spread out this fiscal responsibility, boards simply added members. In time, board members frequently numbered more than 100 individuals (Witt 1987). This type of thinking has made many hospital boards too bulky and unwieldy to react quickly enough to exploit the financial opportunities in today's competitive environment.

There is a current trend within the health care industry that recognizes a need to balance the number of board members within an organization. Boards should be large enough to have a diversity of talent, i.e., backgrounds in financial affairs, business management, marketing, and education (Bader 1991). This group, however, must be small enough to work efficiently to provide constant direction to the group. Bader characterized board size into several categories (Bader 1991). They include:

BOARD SIZE

Small Boards	10 or fewer members
Medium Boards	11 to 19 members
Large Boards	20 to 35 members
Extra-Large Boards	36 or more members

As resources become scarce, owners and trustees expect their institutions to deliver cost-effective, quality healthcare to their patient beneficiary population. At the same time, hospitals are faced with the need to change business practices to cope with the rapid changes in technology. Increasing pressures are being put on boards to improve performance and enhance effectiveness.

To respond to these challenges, board size in recent years has decreased. From 1985 to 1989, the average size of hospital boards decreased by one member. Not-for-profit hospitals experienced the largest drop, with board membership decreasing by almost 1.5 members (Pointer and Ewell 1994). Normally, without wholesale organizational change, such as a merger or acquisition, boards have generally been able to reduce their size only as members retire. However, there is no magic number as to the composition of board members. Hospital organizations and functions vary, and thus also should the size of their boards.

Size is one of the most important characteristics of a board. The Korn/Ferry study found that hospital board members

ranged from 2 to 55 members, with average membership numbering 14 members. For-profit and governmental hospital boards were found to have membership numbering less than the average, while not-for-profit hospitals averaged approximately 17 members (Korn/Ferry 1990).

Eisenhower Army Medical Center's Executive Committee is currently comprised of five members. This composition is consistent with the Korn/Ferry Study findings in that EAMC has fewer members than the average hospital board. Are there enough members to perform the functions that are necessary to properly govern? Ultimately, the Executive Committee should have enough members to do the work required. It should ensure that a reasonable mix of skills and experience comprise committee membership. However, the board should not become so large that it becomes unwieldy.

Effectiveness

The business of healthcare delivery is evolving as hospitals become transformed. Capitation, integration, and collaboration are just a few of the driving forces effecting the healthcare marketplace (Gill et al. 1995). Up until the late 1980s, decisions to acquire capital equipment were normally based on keeping up with technological advances. The idea was to ensure that the institution provided comprehensive services to its

patient beneficiary population. Hospitals are now being dominated by the need to practice with business and professional expertise and must deal primarily with problems of containing costs to be price competitive. There is a perceived need for the leadership of medical treatment facilities to have the required managerial, financial, and operational backgrounds and skills to be able to deal with these needs.

The greater the in-depth knowledge that an institutional body has, the more likely good economic decision-making will occur. There needs to be a premium placed on balancing the clinical needs of patients with the economic realities in providing that care. Richard Johnson speculates that board effectiveness is largely determined by individual board member actions (Johnson 1995). These actions will become vitally important as managed care grows, becoming the dominant form of payment. Board members must be able to tie together the needs of its patient beneficiary population while providing good quality care.

Given the importance of balancing good decision making with patient care, there is an absence of high quality information and research concerning hospital governance and effectiveness (Alexander 1991). One reason for this is because no national body routinely collects information on board structure. Whenever information is collected, it is collected from only a small

number of hospitals. This precludes researchers from monitoring change in board practices.

One way organizations have been able to compensate for this lack of external information on board effectiveness is to internally develop a good orientation plan for their members. An effective orientation plan helps focus new and current members on the duties and expectations they undertake when sitting on a board. To effectively serve as a board member, individuals need to know the current trends, issues and challenges facing the organization. Providing carefully crafted reading packages, attending day-long seminars, and pairing new individuals with experienced board members will lay the groundwork for enabling members to participate effectively.

There is, however, no orientation plan for new or current EAMC Executive Committee members to review. Members are required to learn on the job. This will become critical during the upcoming summer months as EAMC's two Deputy Commanders depart this command. The Chief of Staff will retire at the end of May, with the Deputy Commander for Clinical Services changing duty assignments during the June timeframe. The loss of these two key individuals will create a tremendous leadership void within the organization. To further complicate matters, there will be little, if any, overlap with their successors.

The implementation of the TRICARE contract will also consume

much of the attention of the Executive Committee. Members will need to be knowledgeable on the different aspects of the contract so they can make informed decisions. An orientation plan can serve as an effective mechanism in ensuring members are knowledgeable about their duties and responsibilities in relationship to the contract, as well as their roles and obligations as board members.

Composition

Composition of governing boards has not changed much over the years. In a survey involving 50 not-for-profit community hospitals by the Governance Institute of La Jolla, CA, surveyors found that a typical board is comprised of 18 members; one inside director, three medical staff directors, and 14 outside directors. The CEO is a board member within 77 percent of the hospitals surveyed. Board members are overwhelmingly Caucasian and male, with 93 percent of the trustees being Caucasian and 82 percent being male (Pointer and Ewell 1994).

As hospitals transform into increasingly complex organizations, should the composition of its governing board change? Should the governing entity of an organization reflect the ethnic and racial composition of the community it supports? Edward Hodges, Chairman of the Board at Botsford General Hospital in Farmington Hills, Michigan, feels hospitals should

aggressively take charge to see that their boards take the necessary steps to become inclusive, rather than exclusive. In this way organizations can benefit from the broader perspectives, talents, skills, and life experiences these individuals have to offer (Hodges 1993).

To meet community expectations, many organizations are experimenting with new, innovative ideas that are designed to broaden representation. Some health care organizations are creating community advisory forums, while others are trying to make themselves more representative of the community they serve.

There are several questions that the board members can ask themselves to help them become more representative. These questions should be discussed and agreed upon before any changes or restructuring to the governing board takes place (Farrell 1995). These questions include:

- a. What is our region?
- b. Who is the defined population that the medical center serves?
- c. What are the medical center's capabilities, strengths and weaknesses?
- d. Where should the medical center compete and where should it collaborate?

Eisenhower Army Medical Center serves as the Lead Agent for the Department of Defense's TRICARE Region 3 area, which incorporates the states of South Carolina, Georgia, and Florida minus the panhandle. It also serves as the referral center for seven Army medical treatment facilities throughout a seven state region in the MEDCOM Health Service Support Area concept.

None of the Army, Navy, or Air Force institutions are represented at the EAMC Executive Committee Meeting. To have each institution represented at every Executive Committee Meeting would be costly. Travel and per diem costs of having each individual institution with a single representative are as follows:

<u>MTF</u>	Travel Costs	Per Diem
Eisenhower Army Medical Center	\$0	\$0
Winn Army Community Hospital, Ft Stewart, GA	\$67	\$76
Martin Army Community Hospital, Ft Benning, GA	\$150	\$76
Moncrief Army Community Hospital, Ft Jackson, SC	\$51	\$76
Blanchfield Army Community Hospital, Ft Campbell, KY	\$268	\$76
Lyster Army Community Hospital, Fort Rucker, AL	\$209	\$76
Noble Army Community Hospital, Fort McClellan, AL	\$240	\$76
Fox Army Community Hospital, Redstone Arsenal, AL	\$203	\$76
Naval Hospital Jacksonville, Jacksonville, FL	\$148	\$76
Naval Hospital Charleston, Charleston, SC	\$82	\$76
Naval Medical Clinic, Kings Bay, GA	\$138	\$76
Naval Hospital Beaufort, Beaufort, SC	\$71	\$76
20th Medical Group, Shaw AFB, SC	\$63	\$76
78th Medical Group, Robbins AFB, GA	\$100	\$76
347th Medical Group, Moody AFB, GA	\$133	\$76
6th Medical Group, MacDill AFB, GA	\$257	\$76
45th Medical Group, Patrick AFB, FL	\$249	\$76
437th Medical Group, Charleston AFB, SC	\$82	\$76
Subtotal	\$2511	\$1292
Total		\$3803
(Joint Federal Travel Regulation 1995)		

Is it practical for each institution to send a

representative to each Committee Meeting? Considering that the Executive Committee meets monthly and that travel and per diem costs alone would approximate \$3,800 for each meeting, this may not be a viable alternative.

Function

What should a hospital board do? Boards are to govern the hospital, develop policies that allow it to discharge its multiple responsibilities, and to provide a logical framework to make decisions among competing demands for resources. Bader lists corporate responsibilities of a governing board as follows (Bader 1991):

1. Define and safeguard the mission and values.
2. Establish long-term direction through a strategic planning process.
3. Promote and ensure financial viability through budgeting, financial oversight, investment management, and fund development.
4. Promote and ensure the quality of organizational services.
5. Monitor the effectiveness of major programs and take appropriate action to support organizational excellence.
6. Promote positive external relationships.
7. Ensure the organization meets legal and accreditation requirements.
8. Take responsibility for effective governance, including Board recruitment, selection, orientation, structure, procedures, relationships, and periodic self-assessment.
9. Act with the utmost integrity on behalf of the organization's best interests.

Just as there are governing entity responsibilities that need to be understood and carried out, so too are there

individual responsibilities. Some of responsibilities include (Bader 1991):

1. Be committed to the mission and values of the organization.
2. Understand and observe the respective roles and responsibilities of the Board and CEO.
3. Treat fellow members with the utmost respect.
4. Participate actively by questioning and counseling.
5. Act on behalf of the broad, long-term interests of the organization.
6. Come well-prepared to meetings.
7. Become more educated about the organization and its environment.
8. Enhance external communications by importing outside views, and, in turn, communicate Board and organizational policies to key external constituencies.
9. Avoid conflicts of interest by removing oneself from a discussion and/or vote.
10. Respect the confidentiality of deliberations and information provided during meetings.

Developing board success is incumbent upon governing boards understanding both corporate and individual responsibilities. In this way, boards can work effectively to provide the organization with broad direction to ensure success while furnishing individuals with a chance to grow and develop as members.

EAMC's Executive Committee is chartered to carry out ten functions. They include (EAMC 1990):

1. To insure maintenance of the standards of medical care prescribed by JCAHO standards.
2. To receive, act upon, and coordinate the recommendations of medical staff and administrative committees concerned with patient care.
3. To perform ongoing review of the Total Quality Management Program.
4. To perform ongoing review of the Master Strategic Plan to ensure compliance and approve additions to/deletions from the plan.

5. To perform ongoing review of the Regional Integration Program.
6. To perform an ongoing review of the structure of all hospital committees.
7. To appoint other committees as required.
8. To monitor the implementation of the EAMC Commander's decisions.
9. To promote improved communication between the professional and administrative staff.
10. To review the minutes of the Quality Assurance Committee, the Utilization Management Committee, and other committees not reporting to the Commander.

The Executive Committee performs most of these functions on a regular basis. One function, though, has not been performed regularly. The Committee has not performed an ongoing review of hospital committees. The Administrative Residents will now be responsible for coordinating these efforts for the Executive Committee. Another function, performing ongoing review of the Regional Integration Program, is no longer a valid requirement. This function is presently being performed by the Southeast HSSA Staff.

A key and essential element of any board is to develop a meaningful mission statement. The mission statement may require verification to ensure validity. Periodically, modifications need to occur to ensure that the plans and practices of the organization are consistent with the mission. What is essential is a clear, concise mission statement that differentiates the product from other competitors. However, in many institutions, mission statements are so general, they become useless. These statements provide the organization no definition or direction.

EAMC has a mission statement that was developed during its 1994 Strategic Planning Conference. The medical center's mission is to maintain a state of readiness for contingencies and mobilization while providing facilitated access to quality and cost effective primary, secondary, and tertiary care for patients, and training for AMEDD personnel (EAMC 1995). This mission statement gives the organization purpose and meaning. It explains the business that it is in and focuses on the delivery of care during a period of constrained resources.

Self Evaluation

If an organization wishes to measure the worth of its governing function, it must periodically evaluate board members to determine: How are we doing? What can we do better? To do this may require a self-evaluation of one's own contribution. However, evidence suggests that many boards do not conduct effective evaluations (Alexander 1990; Deegan & Gollattscheck 1985; Korn/Ferry 1990).

Evaluation studies can include mechanisms such as self-evaluation studies, performance improvement studies, and external audits. Self-evaluations can be performed inexpensively, and do not take much time to complete. These evaluations prompt members to reflect how well they perceive themselves as doing their job. Evaluations, when reported back to the committee, usually

stimulate conversation. This conversation can help lead to the formulation and development of performance indicators.

However, self-evaluations are not a cure-all for problem solving. The evaluations are usually brief, supplying members with only superficial information. They also do not provide the in-depth diagnoses needed to identify and correct problem areas. Therefore, self-evaluations alone, do not suggest problem solving solutions.

Despite these discrepancies, boards are encouraged to conduct yearly self-evaluations (Pointer and Ewell 1994). Members will be able to collect information and discuss process improvements among themselves. The board can then formulate specific actions for changing certain processes.

University Hospital, the largest Augusta area hospital, conducted a self-evaluation of its board members. Dr. Malcolm Page, Vice President for Medical Affairs, found the self-evaluation, "to be very useful. The instrument presented findings that members will be able to reflect on. What we do, and where we go are important issues here at this institution. Executive Committee Meetings are now conducted in less time with more business being conducted" (Page 1996).

The Executive Committee does not conduct periodic self evaluations. These evaluations can be performed relatively easily, and do not require a great deal of time to complete. If

performed, information can be tabulated and summarized so members can discuss and develop recommendations for improvement.

IV. DISCUSSION

Five criteria were examined when conducting this study. They included size, effectiveness, composition, function, and self evaluation.

Size

A size of about seven to 15 members is generally considered ideal for a governing body (Bader 1994). EAMC's Executive Committee has five members. Can the Executive Committee be expanded? It is smaller than normal hospital governing boards, thus, the Committee does not require input from a great many standing members. This small number also allows the Committee to be decisive when making decisions. But are there enough members to conduct work that needs to be done? The addition of several members can add different viewpoints, talents, and experiences to the Committee, enabling it to better govern effectively.

Effectiveness

Since there is little empirical data that explains what makes the Executive Committee govern effectively, one must be able to come up with alternate suggestions. One effective way to

govern is to hold regularly scheduled meetings. At EAMC, Executive Committee Meetings are to be held monthly. However, the Committee has met only once in the past seven months due to scheduling conflicts. Another way of assessing effectiveness is by bringing in outside consultants to directly observe Committee meetings. These consultants can see first hand the interpersonal dynamics that occur within the meetings. However, direct observation can be time consuming and labor intensive.

Composition

All five members that comprise the Executive Committee are internal to the organization. Should the Committee have a broader focus of the patient concerns and medical issues as it relates to the Fort Gordon catchment area, Region 3, and the Southeast HSSA? It is anticipated that expanding the composition of the Executive Committee will allow it to have a more "global" view of the needs facing other military medical treatment facilities. Technological advances in teleconferencing now allow us to communicate face-to-face over great distances. These advances make it possible to communicate inexpensively using real time. These avenues of opportunities need to be explored and, if possible, exploited.

Function

The roles of the five members who comprise the Executive Committee will likely change as EAMC prepares for the implementation of the TRICARE contract. In the past the Committee focused on issues related to the delivery of care within the Fort Gordon catchment area. Future issues may require the Committee to expand those roles. They may be required to act in the best interests of the medical treatment facilities located within Region 3 and the Southeast HSSA since changes in contracting have opened the door for outsourcing medical services.

Self evaluation

Continual improvement within an organization requires periodic self evaluation. A question each organization should ask itself is, "How do you know where you are going if you don't know where you've been?" Evaluations can serve a roadmap in helping an organization determine which direction to take. When performing evaluations, Committee members can evaluate their own personal performance or they can rate the Committee's performance. There are dangers, however, if failures to correct or improve performance occur. Morale may be lowered if no discernible improvements are achieved.

V. RECOMMENDATIONS

In order for the organization to improve its operational effectiveness and improve its delivery of care to its patient beneficiary population, it is recommended that the structure of the Eisenhower Army Medical Center's Executive Committee be transformed. This research suggests the following courses of action be entertained:

1. The Executive Committee should increase its size to become more representative of the beneficiary population it supports. It should consider inviting several enlightened health care executives from the different Southeast HSSA and Lead Agent facilities to sit as board members. These members could be Army, Navy, or Air Force individuals who are well versed in managed care issues. Also recommended is the addition of a representative from Fort Gordon who could provide the Committee with expertise on local military member concerns.
2. The Executive Committee should develop an orientation plan for new and standing members to increase board effectiveness. This plan should clarify the nature and scope of each members' responsibilities, whether it be performance, quality of care, or financially related.
3. The Executive Committee should conduct periodic/annual self-evaluations to enhance greater board efficiency and effectiveness. The organization must continuously reassess its

needs in these fast-changing times.

4. When evaluating such transformational changes, the Executive Committee should consider holding a retreat at an off-site location. During this retreat, the Committee should consider how it presently functions, what skills and talents should be added to the Committee, and who should be the individuals to fill these needs. Once accomplished, the Committee should give itself a six month trial to allow events to unfold. After six months, hold another retreat to assess the progress made and to determine future requirements.

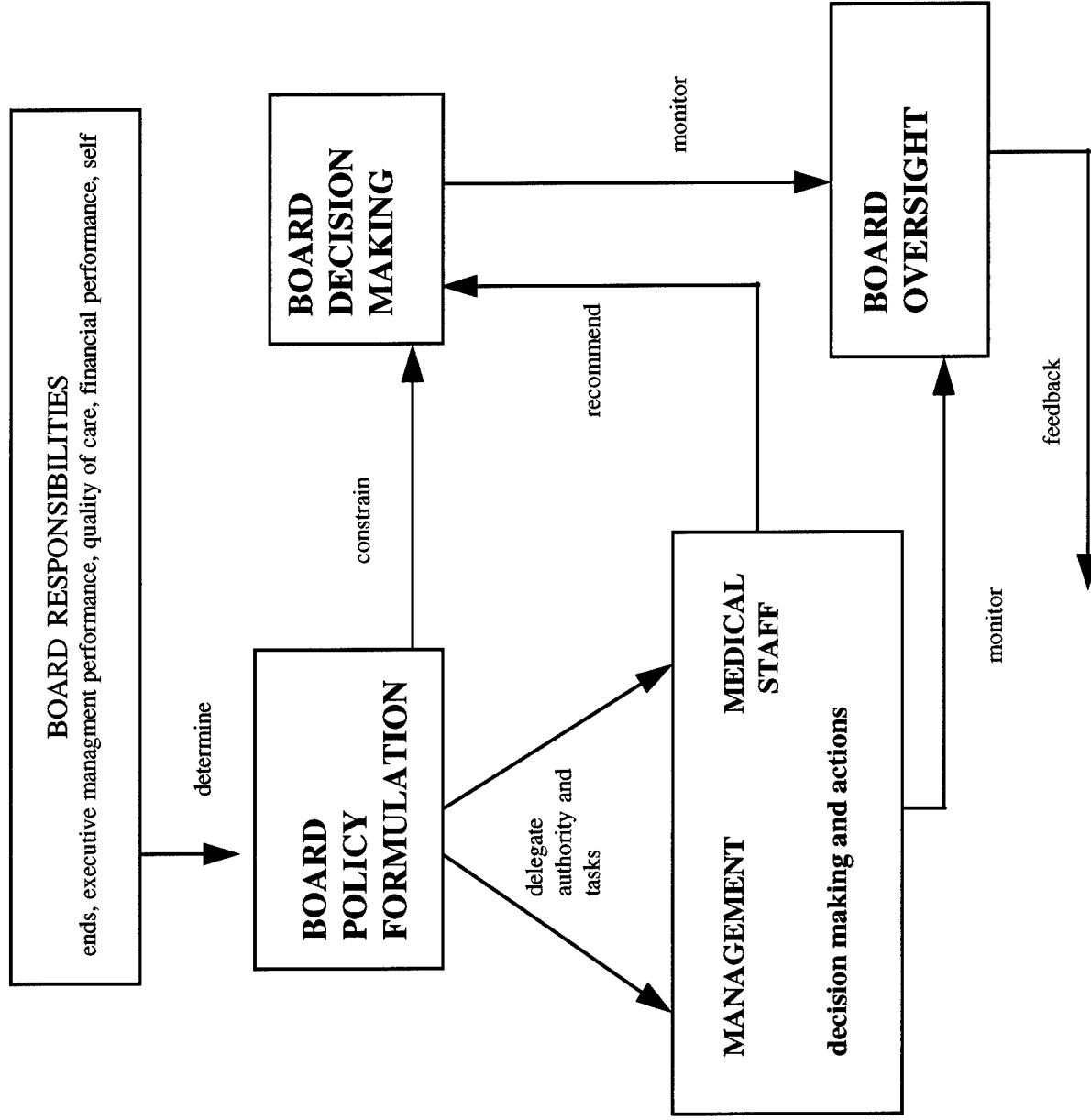
VI. CONCLUSION

The definition of governance will change and evolve as the organization changes and evolves. This may mean that what was effective governance this year may be ineffective the next. The last thing the Executive Committee wants is to hamper the delivery of care to patient beneficiaries. For effective governance to emerge, the Executive Committee must become a dynamic, evolving entity that is able to adapt as circumstances warrant change. Change requires a high level of commitment, effort, and time. Disruptions will invariably occur as members will disagree with one another as to which direction the organization should take. However, the leadership must be sufficiently resilient and disciplined to provide stability to

the organization. The best solution is to create a flexible governing function that allows both to live in harmony.

The delivery of health care is changing rapidly within the military health care delivery system. The Executive Committee will play a pivotal role in reshaping this delivery of care as we prepare to embrace TRICARE. The challenges facing the governing entity of this organization are formidable. Formulating policy, making decisions, and ensuring oversight is properly performed are only some of the mandates of the Executive Committee. Armed with the ideas presented in this paper, the Executive Committee will be in a position to carry out its responsibilities of effectively governing this organization into the 21st Century.

**Appendix
Board Roles
and Responsibilities**



SOURCE: Pointer, D.D. and C.M. Ewell. 1994. Really governing: How Health System and Hospital Boards Can Make More of a Difference. Albany, NY: Delman, p. 65.

REFERENCE LIST

- Alexander, J. A. 1990. The Changing Character of Hospital Governance. Chicago: Hospital Research and Education Trust/American Hospital Association.
- Alexander, J. A. 1991. Symposium: The Craft of Governance. The Journal of Health Administration Education. 9:395-424.
- Alexander, J. A., and L. Morlock. 1985. Multi Institutional Arrangements: Relationships Between Governing Boards and Hospital Chief Executive Officers. Health Services Research 19:675-699.
- Bader, B. S. 1991. Five Keys to Building an Excellent Governing Board. Rockville: Bader & Associates.
- Bader, B. S. 1994. Governance of Community-Based Integrated Healthcare Delivery Systems. Health System Leader 9:4-12.
- Barocci, T. A. 1981. Non-Profit Hospitals: Their Structure, Human Resources, and Economic Impact. Boston: Auburn House.
- Carver, J. 1991. Boards that Make a Difference: A New Design for Leadership in Nonprofit and Public Organizations. San Francisco: Jossey-Bass Publishers.
- Chait, R. P., T. P. Holland, and B. E. Taylor. 1991. The Effective Board of Trustees. New York: Macmillan Publishing.
- Deegan, W. L., and J. F. Gollattscheck. 1985. Ensuring Effective Governance. San Francisco: Jossey-Bass.
- Department of the Army. 1995. U.S. Army Medical Department Marketing Plan.
- Eisenhower Army Medical Center Regulation 15-1. 1990. Boards, Councils and Committees.
- Eisenhower Army Medical Center. 1995. Strategic Plan Fiscal Year 1995-1996.
- Eisenhower Army Medical Center Memorandum. 1996. Directive #1, 20 February.
- Ewell, C. M. 1982. Wonderboards: How to Build Strong Governing Bodies Twelve Ways. Trustee 35:33-37.

- Ewell, C. M. 1987. The Governance Challenge: Integrating Multiple Levels. Healthcare Executive 3:14-17.
- Farrell, J. P. 1995. Reshaping Governance: The Hay Group's Study. Trustee 48:22-24.
- Fennell, M. L., and J. A. and Alexander. 1989. Governing Boards and Profound Organizational Change in Hospitals. Medical Care Review 46:157-187.
- Gill, S. L., J. C. Goldthorpe, R. J. Umbdenstock, B. D. Wong. 1995. Governance 1995: New Hurdles to Clear. Healthcare Executive 10:8-12.
- Hodges, E. N. 1993. The Need for Diversity on the Board. Trustee 46:28.
- Johnson, R. L. 1995. Hospital Governance in a Competitive Environment. Health Care Management Review 20:75-83.
- Kaufman, K., S. Shortell, S. Becker, and D. Neuhauser. 1979. The Effects of Board Composition and Structure on Hospital Performance. Hospital and Health Services Administration 25:23-27.
- Korn/Ferry International, Inc. 1990. Survey of Hospitals and Hospital System Board Practices. San Francisco.
- Orlikoff, J. E. 1990. Quality from the Top: Working with Hospital Governing Boards to Assure Quality. Chicago: Pluribus Press.
- Page, M. 1996. Interview by M. J. Krukar. University Hospital, Augusta, Georgia.
- Patton, M. Q. 1990. Qualitative Evaluation and Research Methods. Newbury Park: Sage Publications.
- Pointer, D. D., and C. M. Ewell. 1994. Really Governing: How Health System and Hospital Boards Can Make More of a Difference. Albany, NY: Delmar Publishers.
- Pointer, D. D., and C. M. Ewell. 1994. Governance 100 Survey: Membership Makeup of Hospital Boards Hasn't Changed Much - Yet. Hospitals & Health Networks 68:76.

- Pointer, D. D., and C. M. Ewell. 1995. Really Governing: What Type of Work Should Boards Be Doing? Hospital & Health Services Administration 40:315-331.
- Rakich, J. S., B. B. Longest Jr., and K. Darr. 1992. Managing Health Services Organizations. Baltimore: Health Professions Press.
- Starkweather, D. 1988. Hospital Board Power. Health Services Management Research 1:74:86.
- Weiner, B. J., and J. A. Alexander. 1993. Corporate and Philanthropic Models of Hospital Governance: A Taxonomic Evaluation. Health Services Research 28:325-355.
- Williams, S. J., and P. R. Torrens. 1993. Introduction to Health Services. Albany: Delmar Publishers.
- Witt, J. A. 1987. Building a Better Hospital Board. Ann Arbor: Health Administration Press.
- Yin, R. K. 1989. Case Study Research: Design and Methods. Newbury Park: Sage Publications.