



City of Cambridge

30.

IN CITY COUNCIL

April 1, 1996

COUNCILLOR SULLIVAN
COUNCILLOR TOOMEY
VICE MAYOR BORN
COUNCILLOR DAVIS
COUNCILLOR DUEHAY
COUNCILLOR GALLUCCIO
COUNCILLOR REEVES
MAYOR RUSSELL
COUNCILLOR TRIANTAFILLOU

WHEREAS: It has come to the attention of this City Council that yet again the Cambridge Hospital has received national attention for its excellence; and

WHEREAS: In its February 20, 1996 issue, *Health and Hospital Networks* magazine pointed to the leadership and cooperation of Commission of Health and Hospital's John O'Brien and the Hospital's Governing Board; and

WHEREAS: The article noted that this leadership and cooperation was a key to the success the hospital and is very rare in today's health care world; now therefore be it

RESOLVED: That the City Council go on record expressing its congratulations and appreciation to John O'Brien and the Hospital's Governing Board; and be it further

RESOLVED: That the City Clerk be and hereby is requested to prepare a suitably engrossed copy of this resolution for presentation to **John O'Brien** on behalf of the entire City Council.

In City Council April 1, 1996

Adopted by the affirmative vote of nine members.

Attest:- D. Margaret Drury, City Clerk.

A true copy;

ATTEST:-

D. Margaret Drury
City Clerk

City of Cambridge

CAMBRIDGE CITY COUNCIL COMMITTEE ON FINANCE BUDGET HEARING SCHEDULE

The Committee on Finance comprised of the entire membership of the City Council will conduct several public meetings on the City budget covering the fiscal period July 1, 1996 to June 30, 1997.

These meetings will be held in the Sullivan Chamber, City Hall and will follow the schedule outlined below and will include recommendations from the City Manager concerning the capital budget, as well as the operating budget.

All interested individuals are invited to attend and be heard and/or submit written testimony. Copies of the budget may be reviewed at the main library and will be available on a one to each person basis at the Budget Office at City Hall on/or after April 9, 1996.

WEDNESDAY, APRIL 24, 1996 - 4:30 TO 9:00 P.M.

Budget Overview
Mayor
Executive
City Council
City Clerk
General Services
Animal Commission
Law

Finance
Employee Benefits
Election
Public Celebrations
Fire
Police
Traffic, Parking & Transportation
Reserve

THURSDAY, APRIL 25, 1996 - 5:00 - 9:00 P.M.

License
Police Review & Advisory
Weights & Measures
Emergency Management
Historical
Conservation

Cable T.V.
Electrical
Emergency Communications
Inspectional Services
Debt Service
Cambridge Hospital Community
Health Network

City of Cambridge

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TUESDAY, MAY 7, 1996 - 4:30 - 9:00 P.M.

Peace Commission
Women's Commission
Human Rights
Veterans
Public Works
Water

Community Development
Library
Human Services
Cherry Street
MWRA
Public Investment

WEDNESDAY, MAY 8, 1996 - 6:00 - 9:00 P.M.

Public Schools

THURSDAY, MAY 9, 1996 - 4:00 - 8:00 P.M.

if necessary

MONDAY, MAY 13, 1996

Budget Adoption

CHAIRMAN
MAYOR SHEILA DOYLE RUSSELL
VICE CHAIRMAN
E. DENISE SIMMONS

SCHOOL COMMITTEE
455 BROADWAY
CAMBRIDGE, MASSACHUSETTS 02138
OFFICE OF THE SECRETARY
Tel. (617) 349-6620 • Fax: (617) 349-6624

MEMBERS
ALFRED B. FANTINI
JOSEPH G. GRASSI
DAVID P. MAHER
SUSANA M. SEGAT
ALICE L. TURKEL

2.

1996-1997 Sub-Committees

Asset Management	Ms. Segat, Chair Mr. Grassi, Mr. Maher
Athletics and Physical Education	Mr. Grassi, Chair Ms. Segat, Ms. Turkel
Bilingual Education	Mr. Fantini, Chair Mr. Grassi, Ms. Segat
Budget (Committee of the Whole)	1996 Co-Chairs: Mr. Maher, Ms. Simmons 1997 Co-Chairs: Mr. Fantini, Ms. Segat
Buildings & Grounds	Mr. Maher, Chair Mr. Fantini, Ms. Turkel
Computer Education	Mr. Fantini, Chair Mr. Maher, Ms. Turkel
Curriculum Evaluation	Ms. Turkel, Chair Mr. Maher, Ms. Simmons
Dropout Prevention	Ms. Simmons, Chair Mr. Grassi, Ms. Turkel
Family and Citizen Involvement	Ms. Simmons, Chair Ms. Turkel, Mr. Maher
Long Range Planning	Mr. Maher, Chair Ms. Segat, Ms. Turkel
Occupational Education	Ms. Turkel, Chair Mr. Fantini, Mr. Grassi
Personnel Policy	Ms. Segat, Chair Mr. Maher, Ms. Simmons
Policy and Rules	Ms. Simmons, Chair Mr. Grassi, Mr. Maher

RECEIVED BY
OFFICE OF CITY CLERK
CAMBRIDGE, MA.
96 MAR 28 PM 4:04

CHAIRMAN

MAYOR SHEILA DOYLE RUSSELL

VICE CHAIRMAN

E. DENISE SIMMONS

SCHOOL COMMITTEE

456 BROADWAY
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- page 2 -

Safety and Student Health

Mr. Grassi, Chair
Mr. Fantini, Ms. Segat

Special Education

Ms. Segat, Chair
Mr. Fantini, Ms. Turkel

Ad Hoc Committee on Alumni Affairs

Mr. Grassi, Chair
Mr. Fantini

Cambridge Partnership Representative

Ms. Segat

EdCo Executive Board

Ms. Segat

RECEIVED BY
OFFICE OF CITY CLERK
96 MAR 28 PM 4:04
CAMBRIDGE MA.

MS

TT

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Whereas: It has come to the attention of the City Council that yet again the ~~Cambridge~~ Cambridge Hospital has received national attention for its excellence; and

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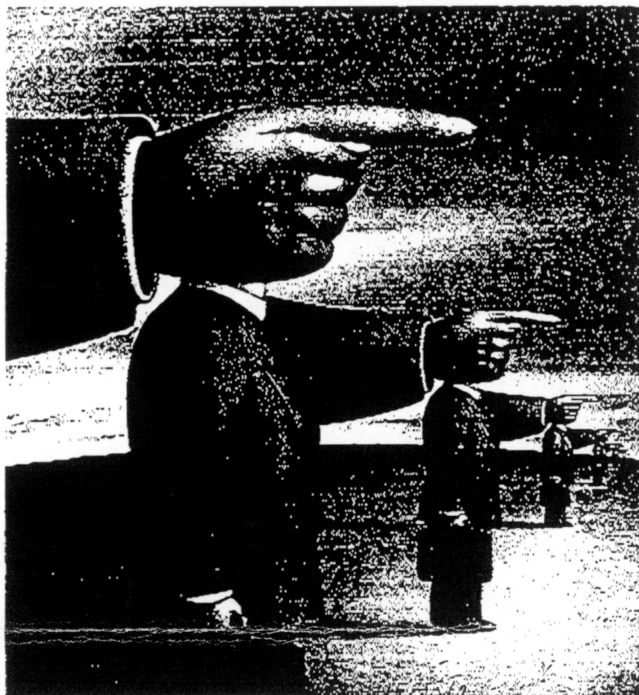
Whereas: The article noted that this leadership and cooperation ~~was~~ was a key to the success of the hospital and is very rare in today's health care world; now measure be it

Resolved: That the City Council go on record expressing its congratulations ~~to~~ and appreciation to John O'Brien and the Hospital's Governing Board; and be it further

Resolved : SEC to JOB

Governance

BLESSED BE THE BOARD



DEVELOPING A TALENTED,
WELL-ROUNDED AND ACTIVE
TEAM OF TRUSTEES THAT
UNDERSTANDS THE NEW
REALITIES OF HEALTH CARE
—AND SHARES YOUR VISION—
MAY BE THE MOST IMPORTANT
LEGACY YOU CAN LEAVE
YOUR ORGANIZATION.

BUT WHERE DO YOU BEGIN?

BY ANNE NORDHAUS-BIKE

Forget business as usual. In today's health care world, where mergers make headlines and managed care is nipping at executives' well-shined heels, what's needed is business as *unusual*. John O'Brien found that out the hard way nine years ago when he became CEO of a hospital on the brink of disaster. In 1987, Cambridge (Mass.) Hospital was \$10 million in the red. But by 1991, the red had turned to black, the back-breaking debt was eliminated, and the institution won the American Hospital Association's Foster G. McGaw Prize. It even changed its name to better communicate the reason for the turnaround: Cambridge Hospital Community Health.

Unlike chief executives who try to take credit where it isn't due, O'Brien attributes Cambridge's success story to his "truly visionary" board of trustees. "They're role models for the rest of us because they're very businesslike, set high standards and hold themselves accountable," he says. "At the same time,

they're very supportive because they balance those qualities with a genuine understanding of the enormous changes going on in health care."

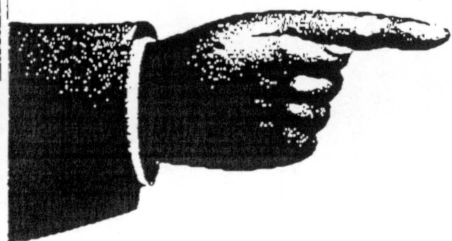
Unfortunately, such inspiring comments by CEOs about their boards are rare. "The barrier has been the trustees," says consultant Gerald McManis of McManis Associates in Washington. He cites one Southern California health system as an example: "[It] had a visionary CEO. He understood where health care was going, developed a bold strategy, and initiated mergers. But most of the trustees wouldn't support him, which

respected hospital where the long-time physician CEO retired, chose his own successor, and then remained on the board. With no experience as head of a major health care organization, the new CEO plunged into acquisition of another facility that was deeply in debt and should have closed. The once cash-rich hospital soon found itself in dire financial straits, and 250 employees eventually lost their jobs—including the CEO. Today, the hospital continues to struggle toward a turnaround.

"This was a case of trustees who allowed the original chief executive

sion. Many trustees struggle to balance enhancement of their community's health status with the health of their organization's bottom line. Says governance consultant Dennis Pointer, Ph.D., of San Diego State University, "There are no easy answers to this conflict, but it's helpful if the board remembers it is ultimately an agent of [community members] and must protect their interests."

Size is another obstacle for many boards. In a recently completed series of studies, Pointer found that the average hospital board membership is 18, which he believes is too large. "About



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THAT TRUSTEES ARE LOST IS WHEN THEY CROSS THE LINE
BETWEEN GOVERNING AND MANAGING.**

locked the system into inactivity." The upshot? "He took early retirement."

The situation is only getting worse, despite the onslaught of managed care, which presents complex issues that require equally thoughtful and complex answers. After all, it's easier to stay still than take the risk of moving forward. "Relationships that were not well thought out to begin with have only been weakened by the rapid pace of change and its increasing pressures," says Winnie Hageman, a health care governance consultant based in Seattle.

At the very least, disjointedness between management and boards threatens specific projects. Hageman recalls one hospital group that had received a five-year grant to improve nursing using an interdisciplinary approach. At the same time staff was bending over backwards to make the project succeed, lack of leadership at the board level was stirring up distrust, parochialism and turf battles. By the halfway point, the project floundered and lost its funding.

At their most extreme, problems between the board and top management threaten an institution's very survival. Hageman once worked with a well-

to usurp some of their responsibilities—especially choosing the new CEO," says Hageman. "[They] tried to reassert their authority when it was too late." The board was a rubber stamp, giving in to the doctors as it always had. It didn't help that being on the hospital board was very tied up with social status: the members were a who's who of the community. "Positions were handed down in families," she says. "The board became very inbred and out of touch."

Governance experts agree that such problems are common and have multiple causes, chief among them having little understanding regarding the new realities of health care. "The industrywide consolidation now occurring is real, profound and irreversible, but the implications are not fully appreciated at the governance level," says Stephen Ummel, co-CEO of Advocate HealthCare system in suburban Chicago. CEOs must overcome this, he adds, by making "a hard-dollar investment" in the ongoing practical and conceptual education of trustees.

Beyond education, many boards are bogged down by the lack of a clear mis-

25 years ago, having 25 to 30 board members was typical because they were needed to raise money," he says. "Although one size doesn't fit all, and you still even sometimes see 30 to 40 members, I think the task of governance can be handled by 10 to 14 trustees."

Size can even become a major barrier to efficiency. Pointer cites two West Coast health systems: One has 152 trustees on 13 boards; the other had 32 separate boards (since streamlined to 17). "These tiers of boards can be a source of strength by representing each system component," he says, "but they're very expensive and slow down the process."

It's not only the number of people on the board, though, that contributes to its success. In other words, does the membership represent a broad spectrum of interests? Diversity is a key strength of the Cambridge board, according to CEO O'Brien. Nine of the 15 members are women, and one-third are people of color. "So in addition to bringing a lot of expertise in policymaking, clinical care and finance, they reflect our community," he says. "That gives us a strong public health focus and fits with our vision of creating a healthier community."

Governance

Beyond the need to improve education, size and diversity, experts say that achieving the right mix of professional skills and experience is the most critical need now facing health care boards. Advocate's Ummel suggests that boards seek out potential members among professionals in information services, underwriting and actuarial science, insurance, marketing, and sales. He also recommends that trustees try more creative approaches to representation: "Boards should expand their clinical representation—and not just with physicians." Though the IRS limits participation by doctors, boards can look to clinicians in public health, nursing and other disciplines. Social scientists and industrial psychologists are also strong additions to hospital boards.

ples is another matter. In the case of health care systems, the newest and perhaps most daunting challenge is what Ummel calls "the current obsession with local hospital autonomy." In a managed care-driven environment, hospitals have become cost centers and survival depends on cutting expenses, merging or aligning with other providers in integrated delivery systems, and putting their communities' health at the center of their missions. The problem is that many mergers are based on agreements with individual hospitals not to make drastic cuts or other major changes. "Hospital leaders feel they're being good and noble when they try to protect their institutions at all costs," he says. "But that flies in the face of consolidation, network formation and any

that's going to require trustees with a new mind-set who can reinvent health care governance."

Taken to its ultimate conclusion, this new mind-set could require boards at both the local and system levels to consider closing certain hospitals based on the economics of consolidation. At the very least, trustees will have to balance loyalty to a single hospital with responsibility to maintaining their communities' health and the financial well-being of the system.

The emotional toll of such demands, added to exponential increases in the time, expertise and education required of health care trustees, is causing many to rethink the tradition of volunteer boards. McManis and others believe that the sheer size of some systems and the



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But even the most broad-based and diverse boards won't be truly effective if trustees don't understand their roles and responsibilities. According to Pointer, the most common indication that trustees are lost is when they cross the line between governing and managing. For example, some boards spend a huge amount of time approving salary increases and pay levels. Pointer helps trustees develop a clear model of where they should spend their time, energy and attention by giving them a "5-by-3 matrix." The matrix defines their five areas of responsibility (formulating the organization's vision, mission and goals; ensuring its financial health; promoting efficient management; ensuring quality of care; and monitoring their own effectiveness) and the three tasks needed to execute those responsibilities (setting policy, making decisions and engaging in oversight).

Practically applying these princi-

kind of integration effort."

A mid-Atlantic system of five hospitals learned this lesson after some prodding from McManis. "It was a system in name only because it had five independent boards that had all made separate deals to 'do them no harm.' It was a very awkward, high-cost way to operate. Eventually, they couldn't function anymore." But once he educated trustees about the economic implications of retaining local hospital autonomy, they decided to transfer fiduciary responsibility to the system board. Several of the hospitals' deals were eventually struck down when the trustees realized that they needed the power to make changes for the good of the system.

In this kind of environment, McManis says, "The greatest challenge for trustees is recognizing that their primary asset is not bricks and mortar but the health status of their community. But

accompanying board responsibilities will cause a "judicious increase" in systems that compensate their directors. Even Winnie Hageman, who contends that many trustees still see their participation as a community service, agrees that large systems may need to pay to attract the necessary mix of skills.

Boards are necessary—no one disagrees on that. But the advent of managed care has redefined their role. The trustees need to react proactively to change, not react after the fact. Part of that requires boards to rethink the nature of their very existence, according to McManis. "That's what local hospitals need to do if they're going to succeed in getting the costs out of today's health care systems. It was Thomas Jefferson, after all, who said that to gain power, you must give up power." ■

Anne Nordhaus-Bike is a Chicago freelance writer.



City of Cambridge

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IN CITY COUNCIL

April 1, 1996

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COUNCILLOR TOOMEY

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Born, Davis, Dunphy, Galluccio
Consent Order #30
Rever, Russell + Triantafyllou

Councillors Sullivan and Toomey re:
Congratulations and appreciation
to John O'Brien and the Hospital's
Governing Board on receiving
national attention for its
excellence in the February 20, 1996
issue of the Health and Hospital
networks magazine.

R-337

In City Council April 1, 1996

Order adopted