BEST PRACTICES IN PUBLIC HOSPITAL GOVERNANCE

ASSESSMENT OF PROPOSALS TO RESTRUCTURE THE COOK COUNTY BUREAU OF HEALTH SERVICES

A Report to the Union League Club of Chicago and Concerned Citizens of Cook County LLC

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I. BACKGROUND AND INTRODUCTION

The National Public Health and Hospital Institute (NPHHI) was asked to provide the Union League Club of Chicago (ULCC) – via the Concerned Citizens of Cook County LLC, an organization comprised entirely of ULCC members – with a report on the essential factors that should be taken into consideration in designing and implementing a plan to restructure the Cook County Bureau of Health Services (the "Bureau"). The recommendation for such a restructuring has been included in a number of recent studies of the Bureau, including most recently the recommendations of the Cook County Bureau of Health Services Review Committee convened by County President Todd Stroger. A number of proposals to achieve such a restructuring have also been recently announced by President Stroger and various other members of the Cook County Board of Commissioners (the "Board"). On February 29, 2008, an Ordinance Concerning the Bureau of Health Services introduced by President Stroger and County Commissioner Larry Suffredin (the "Ordinance") was adopted by the Board. This Ordinance sets out a mechanism to establish the Cook County Bureau of Health Directors ("CCBHD") to govern the Bureau for a three year period.

The National Public Health and Hospital Institute (NPHHI) is a private, nonprofit organization established in 1988 to address the major issues facing public hospitals, safety net organizations, underserved communities, and related health policy issues of national priority. Its membership includes over 100 healthcare organizations that comprise the National Association of Public Hospitals and Health Systems (NAPH). NAPH's membership includes public hospitals and health systems organized under a wide range of legal structures. A number of NAPH members have achieved substantial degrees of success as authorities, districts, public benefit corporations, health commissions and semi-autonomous governing boards that are able to operate more effectively and efficiently than public hospitals operated directly by cities or counties. Many NAPH members have been successful because of varying degrees of autonomy in governance, operations, finance, personnel, procurement, capital planning and other areas that have been identified as areas of concern for the Bureau in numerous studies. At the same time, NPHHI and NAPH are also fully cognizant of the balance of constraints required to ensure that the mission of an essential safety net system is protected and preserved and that restructured public hospital systems remain accountable for the expenditure of substantial local funds. This Report was prepared for NPHHI primarily by partner Larry Gage and associate David Gross of NPHHI Counsel Ropes and Gray LLP.

In preparing this report, NPHHI has undertaken a number of tasks:

- We have systematically reviewed the findings and recommendations of previous reports and studies of the Bureau undertaken within the last five years, as well as proposals made to restructure the Bureau's governance (see Attachment A for a complete list of studies and documents reviewed).
- Based on the successful experience of restructured public hospital systems in other parts of the country, we have developed a list of the most important "best practices" that should be taken into account in restructuring any public hospital or health system. This includes the identification of factors likely to be essential to success in such areas as legal structure, board composition, governance, clinical services, strategic planning and the relative degree of autonomy vs. retained county accountability in areas such as operations, budget and finance, purchasing, human resources, and other areas.
- Since the development of this "model option" was done largely before we had an opportunity to review and analyze the Board's recent adoption of the CCBHD Ordinance, in Section III we have also offered comments and recommendations for improving the structure set out in that Ordinance.
We have attempted to synthesize the various problem areas that have been identified with the current governance of the Bureau, in light of the "best practices" we have identified to date, to develop a "model option" for the Bureau. In Section IV of this paper we have also briefly addressed some potential longer term options, such as the creation of an Authority, Taxing District, or conversion to (or merger with) a non-profit corporation.

Finally, we have also provided a side-by-side comparison of the specific proposals introduced or announced by various members of the Board (including the Ordinance) alongside the "best practices" we have identified.

The remainder of this report is divided into three sections and two attachments:

- Section II is an overview of best practices in public hospital governance. These best practices reflect a national analysis of the most successful policies adopted by other public hospital systems.
- Section III provides several specific recommendations with respect to the recently adopted Ordinance creating a new Hospital Board for the County health system.
- Section IV is a summary of our recommendations for possible future action with respect to a "model structure" for the Cook County system based on best practices.
- **Attachment A** sets out a list of the previous studies, reports and other documents reviewed in preparing this report.
- **Attachment B** provides a comparative chart summarizing the major provisions of a number of recent proposals for restructuring the Cook County Health System in comparison with the best practices identified in this paper.
II. BEST PRACTICES IN PUBLIC HOSPITAL GOVERNANCE

A. Models of Governance

Public hospital systems have been successfully restructured around a number of models. Apart from outright sale or closure, these models fall into four general categories. In the order in which they represent the greatest degree of genuine reform and autonomy, those models are:

- **Semi-autonomous Board Within Local Government** – A unit of local government can create a semi-independent governing board and then delegate control of the hospital system to this board. Such a board can operate with sufficient autonomy to achieve its stated goals only if permitted to do so by the unit of government that created it. To be successful, substantial specific powers and duties must be delegated to such a Board. Otherwise it is generally considered advisory.

- **Independent Non-taxing Unit of Government** – A new non-taxing unit of local government can be created through state legislation, such as an authority or public benefit corporation. While the Board members of such an entity may be appointed or approved by local government, it can function with substantial autonomy.

- **Independent Taxing District** – A hospital system owned and operated by a unit of local government may also be placed under the control of an independent hospital taxing district. Such a district, generally authorized by statute, is unique in that it has the ability to levy taxes.

- **Nonprofit corporation** – Local government can also contract with an independent nonprofit corporation (either newly created or pre-existing) to purchase, lease or otherwise manage the hospital system.

The best practices described below generally apply to taxing and non-taxing units of government, although many also are relevant to hospital systems run by a nonprofit corporation. Contracting with a nonprofit corporation raises a unique set of considerations, however, because local government usually retains little control over hospital operations. Important nonprofit considerations are specifically identified in the best practices set out in this section.

As a general rule, regardless of the model selected, the most important overall "best practice" is as follows:

**The success of any reorganization in achieving the goals and expectations set out for it is directly dependent on achieving an effective balance between AUTONOMY and ACCOUNTABILITY.** The success of a restructuring will depend primarily on the extent to which any new board is granted genuine autonomy in vital areas like budget and finance, strategic planning, procurement and purchasing, and personnel. At the same time, where ongoing governmental support is required, it is equally important that there be sufficient mechanisms in place to assure elected officials and the community that the new entity will fulfill its mission and make the most prudent and efficient use of public funds.

B. Ease of Implementation

How rapidly a restructuring needs to occur plays an important role in the selection of the new model of governance. As a general rule, the creation of an independent unit of government, completely separate from local government, requires state legislation. This legislation can be detailed, meticulously setting forth the procedures for creation and operation of the hospital system, or broad, delegating this power to local
government or the hospital system itself. Other models of governance, such as operation by a nonprofit or creation of a new board within local government, may not require new legislation if already authorized under state law. The need for state legislation will most likely delay implementation of a restructuring, and the length of this delay may be extended for detailed legislation.

Taxing districts face additional barriers. In many states, voter approval has been required for the creation of a taxing district, and often a separate vote is required to approve its levying of a tax. The need for voter approval also may delay implementation of a hospital system restructuring.

- **Urgency of Restructuring** –
  - If the need for restructuring is pressing, the options that do not require new legislation should be strongly considered.
  - A taxing district should be pursued with an understanding that implementation may be delayed due to the need for voter approval.

- **New Legislation** – If a new state law is envisioned, it should be broad, delegating rulemaking for the creation and operation of the new legal entity to local government and the new entity itself.

- **Local Government Control** – While a hospital system that is authorized by state legislation can be designed to operate autonomously, a hospital board that is created by local government usually remains subject to substantial government control. There is a substantial risk that such a board will be considered purely advisory if powers and duties are not specifically delegated to it. The more such a board is thought to be advisory, the more likely it is to be subject to political manipulation and to be hamstrung by many of the same bureaucratic obstacles that led to the need for a reorganization in the first place. Also, it can be considerably more difficult to recruit outstanding and dedicated board members if a board is considered advisory. Nevertheless, despite these caveats, if there is an urgent need to move quickly, this is the simplest form of new governance to establish.

**C. Board Organization**

The organization of the board of directors of the new legal entity is critical to the reorganization's success. Proper organization ensures that the board is insulated from political pressures, qualified to manage a health system, and focused solely on the system's success.

The Governance Institute ("TGI") conducts a biennial survey of the governance practices of hospitals and health systems. Its 2007 survey included 181 government hospitals. In general, TGI found that governmental hospitals had significantly fewer board members on average than non-governmental hospitals – an average of 7.6 compared with 13.3 for all hospitals. We believe this is desirable for governmental hospitals. Smaller boards tend to be able to function more efficiently and effectively. At the same time, governing boards need to be of a size sufficient to ensure a reasonable range of skills and talents among board members; to appropriately represent a range of system and community stakeholders; and to permit board members to appropriately share the task of governing (i.e., to spread the burden of committee membership among a sufficient number of members).

- **Size** - The board should have between 7 and 13 voting directors.
Appointment –

- The board should represent a broad range of interests. This can be accomplished by including ex-officio directors who are community representatives or by requiring the selection of all or a portion of the directors from a slate of candidates offered by a nominating committee comprised of community representatives.

- No single political entity should unilaterally select the directors. Directors should be appointed by both the local executive and the local legislature or by the local executive subject to the approval of the local legislature.

- The board of a nonprofit corporation primarily should be self-selecting, with ex-officio directors representing local government's interests.

- The head of the hospital system should be a non-voting, ex-officio director.

Removal - Removal of directors should only be "for cause."

Term and Term Limits - The term of directors should be 4 years, with a 3-term limit for political appointees. The initial terms of directors who are political appointees should be staggered.

Qualifications – There need not be specific qualifications for individual directors. Rather, the Board as a whole should represent a diverse group of stakeholders, have a high degree of interest in improving the hospital system, and, as a group, have the requisite experience and knowledge to operate the hospital system effectively. For example, the enabling legislation of the Westchester County Health Care Corporation specifically states the "objective of ensuring that the corporation includes diverse and beneficial perspectives and experience, including, but not limited to, those of business management, law, finance, medical and/or other health professionals, health sector workers, and the patient or consumer perspective." The best restructured boards have also included individuals who were prominent in their communities and not politically beholden to the elected officials who appointed them.

Officers – Officers of the board should be selected by and from the directors. The board should be authorized to remove officers by a majority vote.

Bylaws – The board should be specifically mandated to develop bylaws setting forth the powers and duties of board members and other officers of the system.

Committees – The board should adopt (and be prepared to conduct most of its business through) a committee structure consistent with current industry practices, including at a minimum the following committees: an Executive Committee, Audit and Finance, Quality and Patient Safety, Joint Conference, Strategic Planning, Executive Compensation, Human Resources, Facilities and Maintenance, and Compliance.

Board Education – Board education is vital to the effective functioning of a new governing board. The Governance Institute identifies no fewer than 85 "best practices" that should govern the specific duties of board members, whether public or private. The need for board education also means that there should not be the expectation that any newly constituted board will be able to function effectively on the first day it is constituted.

Board Action – All board action should require a majority vote of the voting directors.

Conflicts of Interest – Directors should receive training regarding conflicts of interest and their fiduciary duties as directors. All conflicts should be identified and included in the board's public records. Directors should not be permitted to participate in decisions in which they have an interest.
• **Indemnification** – Members of the board should be indemnified against liability for his or her good faith actions or omissions to the same extent as in non-profit hospitals generally.

**D. Accountability and Transparency**

Although board independence is a hallmark of a successful public hospital system, mechanisms should be put in place to ensure that the board remains accountable to the public and subject to some control from local government. For example, the enabling legislation creating the Hennepin Healthcare System, Inc., to operate Hennepin County Medical Center specifically requires that "the county board shall retain specific controls over the corporation's mission, ability to incur indebtedness through the county, indigent care, and governance. These county board controls must be specified in the bylaws or other transactional documents, which shall be approved by the county board."

• **Public Accountability and Transparency –**
  - The board's meetings and records should be open to the public, unless dealing with confidential clinical, personnel or legal matters or other matters that would place the hospital system at a competitive disadvantage.
  - The board should submit an annual report to local government detailing its operations and including audited financials.
  - If the hospital is to be run by a nonprofit corporation, public accountability should be maintained through corporate bylaws, the management agreement, and/or as a condition for local government appropriations and support.
  - If the hospital system is to be run by a taxing district, any new tax should be subject to voter approval. Statute or local ordinance should specify the maximum permitted district tax.
  - The general rule for a successful public hospital system should be to operate with organizational transparency, including adopting appropriate measures for public information and disclosure.

• **Hospital Mission –**
  - The hospital system's mission should be written into its enabling legislation or other organizational documents. The mission should be crafted to balance its public interest mission with the need to remain competitive in the healthcare marketplace.

• **Local Government Reserve Powers –**
  - Local government should appoint and be permitted to remove (for cause) some or all of the directors.
  - Local government should be required to approve the hospital system's annual budget.
  - Local government should retain the authority to approve any substantial amendments to substantive policies governing operation of the hospital system, including amendments to the system's mission.
  - Local government approval should be required for any bond issuance in excess of a specified amount (generally based on the overall size and budget of the organization).
  - Local government approval should be required prior to the execution of a sale, lease or management agreement (or other similar agreement) for operation of all or a substantial portion of the hospital system by a separate entity.
E. Budget and Appropriations

A hospital system should have significant autonomy over developing its annual budget and the use of its revenues. A steady funding stream, free from political considerations, helps to protect system autonomy.

- **Approval of Budget** – Local government should only have the authority to approve or disapprove of the hospital system's budget as a whole and should not be permitted to reject budgetary line items.

- **Financial Incentives** – Once the annual budget is approved, the new board should be free to manage as it sees fit, returning to the local government only for approval of major variations. Specifically, the new entity should have the power to accumulate reserves, as well as to retain revenues that may exceed costs. At the same time, except in an emergency, the new entity should be required to take necessary steps to reduce costs or generate additional revenues if needed to stay within its budget.

- **Patient Care Revenues** - The system should set its own charges and collect its own fees. It should have full authority to enter into third party payer contracts.

- **Issuance of Bonds** - The system should be authorized to issue bonds, although approval of local government should be required for a bond issuance in excess of a specified amount (based on the size of the system).

- **Local Government Support** –
  - If financial assistance is provided to the system by local government prior to a reorganization, local government should commit to maintaining a specified level of financial support for the treatment of the uninsured and underinsured for at least a minimum period of time (e.g., five years).
  - Local government should retain the authority to support the system's operational or capital needs, including the issuance of bonds or levying of new taxes on the system's behalf.

F. Personnel

There are two principles regarding personnel that are critical to the success of a public hospital system. First, with respect to managerial personnel, the board must have autonomy in selecting the system CEO and the CEO must have autonomy in hiring and firing senior staff (all of whom should be non-classified personnel for civil service purposes if a civil service system is maintained). Second, the personnel policies for all other system employees must be designed to the extent possible to reflect the unique considerations of the healthcare workplace.

- **Chief Executive Officer** –
  - The CEO should be selected by a majority vote of the board. The CEO should serve at the will of the board, which should be authorized to remove him or her by a majority vote with or without cause.
  - The CEO should have an employment contract with a term of no longer than 3 years, but which may be renewed.
  - The CEO should have autonomy to hire and remove the system's senior staff.

- **Personnel Policies** – If the hospital system is structured as a unit of government, political realities likely will require that its employees receive civil service protection. However, to the
extent possible the local government's civil service rules should not be applied across the board to hospital system employees under the restructured corporation. Rather, the new entity should have the ability to adopt new personnel policies, consistent with (but not identical to) civil service requirements, that recognize the unique needs of the healthcare workplace. For example, competitive examinations generally are an ineffective means to evaluate hospital system employees. Also, job categories should be easier to create or amend than is typical for a unit of government.

- **Existing Employees** –
  - Existing employees should be offered employment in the new hospital system and should retain their benefits and receive a comparable civil service classification under the new personnel system, if one is adopted.
  - Alternatively, existing employees should be given the option of transferring to a different division of local government, thereby remaining within the general civil service administration.
  - If the hospital system is run by a nonprofit corporation, while the management agreement should protect the rights of transferred employees, the nonprofit corporation should not be expected to adopt personnel policies consistent with civil service requirements.
  - If it is possible politically to achieve a new personnel system that differs from civil services requirements, the new entity could adopt a system similar to the one adopted by the Denver Health and Hospital Authority. DHHA's enabling legislation stated that "Any employee of the Denver health system who is an employee of the city on the transfer date may elect to remain a city employee or may elect to become an employee of the authority. An employee may elect to become an employee of the authority at any time on or after the transfer date but may not return thereafter to the city's personnel system while employed by the authority."

- **Labor Organizations** – The hospital system should recognize the existing labor organizations and collective bargaining units. The hospital system should be bound to existing labor agreements. However, the new entity should have the power to engage in collective bargaining with labor organizations subsequent to the expiration of current agreements. The following provision was adopted in the enabling legislation creating the Alameda County Hospital Authority: "Upon the expiration of the memorandum of understanding [between the county and unions], the hospital authority shall have sole authority to negotiate subsequent memorandums of understanding with appropriate employee organizations."

G. **Operations**

The new entity should be given the broadest possible power to oversee the management and operations of the hospital system without interference from the governmental entity that created it. The following provisions from the enabling legislation of the Virginia Commonwealth University Health System Authority are excellent examples of the scope of autonomy required if the reorganization is to succeed:

"The Authority shall have all the powers necessary or convenient to carry out the purposes and provisions of this chapter, including, without limitation, the following powers: To make and execute contracts, guarantees or any other instruments and agreements necessary or convenient for the exercise of its powers and functions including, without limitation, to make and execute contracts with hospitals or health care businesses to operate and manage any or all of the hospital facilities or operations, and to incur liabilities and secure the obligations of any entity or individual."
H. Procurement and Contracting

The hospital system should have autonomy in procurement and contracting. It should not be subject to the same competitive bidding requirements generally used by local government for the purchase of goods or services.

- **Autonomy** – The new entity should have complete autonomy with respect to purchasing and contracting, with the potential exception of contracting for the management of all, or a substantial portion, of the hospital system. If politically necessary, the local government can reserve for itself the power to approve the very largest purchases (e.g., those involving major capital expenditures), but as a general rule substantial savings and efficiencies require substantial autonomy.

- **Procurement Rules** - The hospital system should be permitted to develop its own procurement and competitive bidding rules. Procurement should be permitted on a no-bid basis, as appropriate.

- **Group Purchasing Organizations (GPOs)** – The new entity should be granted the power to contract with, and make the fullest possible use of, GPOs.
III. SPECIFIC COMMENTS ON NEW COUNTY ORDINANCE

As noted above, a new Ordinance was adopted by the County Board on February 29, 2008 to reorganize the Bureau. The ordinance authorizes the creation of a Cook County Bureau of Health Directors (CCBOHD), governed by an Interim Board of Directors (IBOD), to oversee all of the entities currently within the Bureau's jurisdiction. The new IBOD would be authorized for three years.

As a general matter, we note that several aspects of the new Ordinance are consistent with the best practices outlined in Section II of this paper. However, we do recommend that the proposed new structure be amended in several ways to enhance its ability to succeed and accomplish the goals set out in the various studies and reports that have recommended improved governance. While the Cook County Board of Commissioners continues its efforts to implement the IBOD and to fashion a more permanent reform of the County's public health system, we offer the analysis below to help support Commissioners in engaging this important and complex task.

The following analysis is divided into two sections. The first section includes suggestions for strengthening the ordinance's governance provisions. The second section includes suggestions for strengthening other aspects of the proposal, consistent with best practices. Please note that we did not, at this time, attempt to outline a full revision of the Ordinance, based on all of the elements of an "ideal structure" set out in Section III above.

A. Governance Provisions

Section 38-2: This section should be amended by delegating operation as well as oversight to the IBOD. Taken alone, the word "oversight" could be read to imply that the new board is purely advisory, when we do not believe that is the intent of the County Board.

Section 38-2.a(i): We suggest amending this provision to permit the Nominating Committee to initially submit just 9 candidates to the County President. The County President would have the power to reject individual candidates, in which case the Committee would be required to submit one additional name for each individual rejected.

Section 38.2.b: This provision mandates that the Nominating Committee's slate of candidates collectively have the requisite experience to effectively operate the Cook County healthcare system. Only 9 of the 20 candidates are selected for the IBOD. If the recommendation above is not adopted to limit the Nominating Committee to just 9 names, the provision would be strengthened if the 9 nominees ultimately selected by the President and approved by the Board collectively had to have similar qualifications.

Section 38.2.d: This provision states that each director will have a fiduciary duty to (a) the Bureau; (b) the President; (c) the Board; and (d) Cook County citizens. Multiple fiduciary duties may cause directors to make decisions that conflict with the best interests of the hospital system and also that conflict with IBOD's mandate (under Section 38-3(4)) to conduct operations free from political interference. The provision would be strengthened if the directors' fiduciary duty was solely to the Bureau/IBOD. The interests of the President and the Board are represented through their role in the nominating process. Alternatively, each can be given the authority to appoint a non-voting, ex-officio director. The interests of Cook County residents should be represented through the diverse groups serving on the Nominating Committee and the Bureau's mission.

Section 38.2.e: This provision states that the Nominating Committee will re-convene and suggest a new nominee should a director resign from IBOD. This may result in an unnecessary administrative burden on
the Nominating Committee. The provision would be strengthened, and the process streamlined, if in the case of a mid-term resignation, the President is directed to appoint (and the Board to approve) a new director from the earlier slate of candidates. A stronger alternative, and one more consistent with best practices, would be to authorize the IBOD, once created, to establish a nominating committee of its own to suggest replacements.

Section 38.2.f: This provision states that the Nominating Committee may remove a director for cause by a majority vote. It would be highly unusual for such power to be given to what is essentially an ad-hoc Committee brought together for a specific purpose. We strongly recommend that the removal of a director for cause be delegated instead to a majority of the IBOD itself.

Section 38-3(12): This provision appears to contain an important typo. It states that "The Board shall elect its chair from its own ranks." The Board is defined as the Cook County Board of Commissioners. The provision should state that "IBOD shall elect its chair from its own ranks."

B. Other Suggested Amendments

Temporary Authorization: BOHD and IBOD only are authorized for a 3 year period (Section 38-2, 38-8). Its temporary nature may lead to organizational weakness, including (a) limited buy-in from IBOD directors, the appointed Bureau Chief and senior staff, and system employees; (b) limited long-term strategic planning; (c) resistance/inability to undertake systemic reform, such as the development of new personnel and contracting/procurement policies (discussed further below). The ordinance would be strengthened if BOHD was made permanent. This would substantially strengthen the new organization, while not diminishing the County Board's underlying authority to amend or repeal the Ordinance creating the Hospital Board. If the Board wants IBOD to address certain issues immediately (e.g., collections), its priorities also could be included within the ordinance. Alternatively, if the purpose of the temporary authorization is to provide the Board with time to continue exploring alternative models of governance, a companion ordinance should be introduced describing how this continued exploration will proceed.

Public Transparency: The ordinance does not address whether IBOD meetings and records are subject to the Illinois Open Meetings Act and Freedom of Information Act. The ordinance would be strengthened if public transparency was specifically addressed. As a general rule, IBOD meetings and records should be public. However, to the extent permitted by law (the authority of home rule units to amend the Open Meetings Act is limited), clear exceptions should be included for confidential information and other strategic information that would put the Bureau at a competitive disadvantage if publicly available.

Bureau Mission: The ordinance does not address the Bureau's current mission. IBOD instead is charged with "ensuring the availability and access to high quality health care services . . . for all medically indigent Cook County residents." It is unclear when the Bureau's mission was prepared and whether it has become outdated. The ordinance would be strengthened if IBOD is directed to evaluate and, if necessary, amend the Bureau's mission. IBOD's authority and responsibilities should reflect this amended mission statement.

Personnel Policies: The ordinance provides IBOD and the Bureau Chief with authority to hire and fire and to develop and implement personnel policies (Sections 38-3(7), 38-4(2),(3)). However, this authority remains subject to "existing laws, county ordinances, personnel codes, collective bargaining agreements and court orders." The ordinance may not give IBOD and the Bureau Chief the authority to develop new personnel policies tailored to the needs of the healthcare workplace. Part of the reason for this restriction may be IBOD's temporary authorization. Nevertheless, our best practices recommend granting a hospital system wide discretion in developing personnel policies, including polices that are different from those otherwise

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1 The proposed ordinance actually has a number of typos, but this was the only one that appeared to have a substantive impact on its implementation.
applicable to government agencies. The ordinance would be strengthened if IBOD and the Bureau Chief were given similar authority. This authority could reasonably be limited if Board approval was required prior to the implementation of any new personnel policies.

Procurement/Contracting: The ordinance provides that the Board must prior approve all leases, intergovernmental agreements and contracts (including all vendor and private third party payer agreements) as well as the acquisition, sale, repair and maintenance of Bureau property and assets (Section 38-3(8),(9)). In addition, the Bureau Chief must select outside vendors and consultants in conformity with County ordinances and purchase, sell or repair equipment consistent with the Cook County Procurement Code (Section 38-4(4),(6)). Again, the limited authority may be due to the temporary authorization of IBOD. However, our best practices dictate that IBOD should be permitted to develop new contracting and procurement policies consistent with the unique needs of the healthcare workplace.

The Hospital Board should be specifically empowered to join and make full use of a GPO for purchasing. The County Board should be permitted to approve the Hospital Board’s selection of and participation in a GPO, but thereafter approval should not be required for specific purchases through such GPO. Conservatively, we would estimate that the system could achieve several million dollars a year in savings through use of a GPO.

After approval of the Hospital Board’s annual budget, County Board approval only should be required for the very largest contracts or purchases, such as contracts lasting longer than 3 years or for agreements entered into outside the context of a GPO that would exceed a specified annual amount (e.g., $1 million).

County Funding: The Ordinance only states that the County Board "shall provide necessary funding to allow the IBOD to accomplish its purposes." We recommend that this provision be amplified to address both the need for adequate County funds to operate the system (perhaps tied to the current funding required for a period of time) and also to separately authorize funding for the operation of the IBOD itself (which will require its own funding, especially during the start up phase).

Certain Terms: Finally, we have questions about the use of certain terms in the Ordinance. Specifically, we are concerned about the use of the term "ensuring" in several provisions related to powers and responsibilities of the IBOD. On the one hand, at least in the short term, it may be impossible for a brand new Hospital Board to "ensure" that any of the goals expressed in this section are met. Moreover, the use of this word appears to sidestep the fact that the "powers and responsibilities" provision appears to fall short of actually and specifically delegating the necessary powers and responsibilities to the IBOD. Even where such delegation could be inferred, in several provisions the Ordinance requires the "prior approval" of the County Board. It is not clear what this requirement means. If such "prior approval" is limited to the annual budget and the adoption of major policies by the IBOD, it is possible that the IBOD could function effectively. However, if it is construed to apply to individual actions taken by the IBOD (whether in personnel, procurement, finance or operations) it is unlikely that the reorganization will succeed in accomplishing its stated goals. We recommend amending the ordinance to specifically delegate genuine autonomy to the IBOD in these areas, as discussed throughout this paper, with "prior approval" by the County Board limited only to major policies and issues.
IV. POTENTIAL FUTURE STRUCTURES FOR THE COOK COUNTY SYSTEM

The primary goal of this paper was to identify potential “best practices” for governance and legal structure within a large county health system like the Bureau. We were also asked to identify what might be considered a “model” structure for Cook County based on those best practices (and the experience of other large public health and hospital systems around the country). As noted above, this initiative was undertaken before the County Board passed the Ordinance establishing a proposed new Hospital Board. Nevertheless, we were able to incorporate the structure established under the Ordinance into our comparative analysis of past proposals (See Attachment B) and we have also provided preliminary comments on the structure created by that Ordinance (See Section III above). At the same time, we believe it may still be helpful to set out more general options for restructuring the Cook County health and hospital system, which the County Board and the new Board created by the ordinance may want to contemplate in the future.

All of the Cook County reform proposals we reviewed recognize the importance of vesting control of the hospital system in the hands of an independent Hospital Board devoted entirely to the system’s success. All four basic models of governance identified in Section II above can be structured to satisfy this criterion. In the present circumstances, it appears that the determining factor should be the timeframe within which the restructuring must occur.

As a home rule county, Cook County has a significant amount of autonomy to "perform any function pertaining to its government and affairs." Illinois courts have held that this autonomy extends to many of the basic functions of local government, including appropriations, civil service, procurement and, as a general rule, taxing. Thus, the County Board appears to have significant discretion regarding its operation of the hospital system. Home rule authority appears to permit the County Board to (a) create a new subunit of government and delegate operation of the hospital system to this subunit; and (b) contract with a nonprofit corporation for operation of the hospital system.

We have divided this analysis (and our recommendations) into three parts. First, based on what we believe can be accomplished directly by the Cook County Board under its current home rule authority (and is likely to be the most politically feasible), we have suggested what might be an ideal structure for the creation of a new Hospital Board within County government. As noted above, this recommendation was largely prepared before the County Board passed the recent Ordinance; however, since we believe that this new Ordinance follows some – though not all – of what we could consider “best practices,” we have incorporated some of its provisions into this model proposal.

A. New Hospital Board Within County Government

The urgent need for restructuring is evident in several of the proposals, including Commissioner Suffredin’s proposal and the report of the Cook County Bureau of Health Services Review Committee. In light of the need for quick action, we recommend adoption of a model that can be implemented entirely through County ordinance. In addition, given the length of time it would take to implement, we do not recommend pursuing taxing authority for the Hospital Board at this time. To balance the need for Hospital Board autonomy with the urgency of the situation, we recommend creation of a subpart of County government, governed by an independent Hospital Board, to oversee the Cook County hospital system. To facilitate buy-in by the Hospital Board and system employees and to encourage comprehensive long-term planning, this unit of government should be considered permanent.
1. Organization of the Hospital Board

In recognition of the need to quickly implement a restructuring proposal, we recommend that the County Board create a new Hospital Board made up of 12 directors, 11 voting and 1 non-voting.

- 1 director should be appointed by the County President (notwithstanding recommendations of the nominating committee), subject to County Board approval.
- 1 director should be appointed by the chair of the County Board Committee on Health and Hospitals, subject to County Board approval.
- 6 directors should be appointed by the County President from a slate of candidates offered by a nominating committee. The nominating committee should be comprised of representatives of community stakeholder organizations and public health experts. Appointment of these directors would be subject to County Board approval.
- 1 voting, ex-officio director should represent the medical staff of the hospital system and/or Stroger Hospital (e.g., by election of the medical staff or designation of the chief medical officer of Stroger Hospital serving ex-officio).
- 1 voting, ex-officio director should represent the system's teaching affiliates and/or other major academic medical center in the community.
- 1 voting, ex-officio director should represent the hospital system employees.
- The CEO of the hospital system should serve as a non-voting, ex-officio director.

The initial term of the 8 directors appointed by the County President and County Board should be staggered, half in each category serving 2 years, the remaining serving 4. Thereafter, the term for all directors should be 4 years. All appointed directors should be limited to 3 terms. Removal of any appointed director should only be permitted for cause.

The initial Hospital Board chair should be selected by the County President, to be appointed for a 2-year term. Thereafter, the Hospital Board should vote to elect all officers. All Hospital Board action should require a majority vote of the voting members.

Conflict of interest policies should be developed and directors should receive training regarding conflicts and their fiduciary duties. All conflicts should be disclosed and recorded in the public records of the Hospital Board.

2. Structure of Board

The ordinance creating the Hospital Board should specifically authorize the Hospital Board to adopt bylaws and establish a committee structure consistent with the best practices identified in Section II above.

3. Accountability and Transparency

To assure accountability and proper governance, the new entities should operate on the principle of organizational transparency. All Hospital Board meetings and records should be open to the public, unless involving confidential clinical, personnel or legal matters or information that, if disclosed, would put the hospital system at a competitive disadvantage. The Hospital Board should be required to submit an annual report detailing system operations and including its audited financials. This report should be delivered to the County President and County Board and made available to the public. The Hospital Board also should
develop measures with which to gauge the CEO's performance. Reporting on these measures should be included in the annual report.

The County Board, in consultation with the Hospital Board and CEO, should review the system's mission to ensure that it strikes an appropriate balance between the public interest and the need to maintain system competitiveness. The mission should be made enforceable through inclusion in County ordinance.

Accountability of the Hospital Board should be assured through a combination of public transparency and local government reserve powers. As a general rule, Hospital Board meetings, records, and reports should be open to the public. The County Board should retain the authority to approve the annual budget as well as Hospital Board adoption of any major new personnel, procurement, or other operational policies that differ from existing law.

4. Budget and Appropriations

The Hospital Board should have the authority to develop the hospital system budget, which would be subject to approval by the County Board on an annual basis. The budget should include the level of County support requested, along with the expected uses for this funding. The Hospital Board should not be given the authority to levy taxes or issue bonds. Only the County Board should have this authority, although the Hospital Board should be authorized to include the request for additional tax revenue or a bond issuance within its budget. The County Board should only be permitted to approve or reject the budget as a whole, and should not be permitted to strike budgetary line items. The Hospital Board should have the authority to set hospital charges and collect patient care revenue (including the ability to contract with third party payers).

The hospital system should be guaranteed a predetermined level of financial support from County government, subject to annual approval, sufficient to cover otherwise un-reimbursed operating and capital costs (including maintenance and working capital as well as a commitment to meeting longer term capital needs).

Once the annual budget is approved, the Hospital Board should be permitted to oversee management of the system with considerable autonomy. The Hospital Board should be permitted to retain surpluses and accumulate reserves, but it should also be required to address shortfalls through cost containment actions or revenue enhancement initiatives without returning for approval to the County Board. Limits can be set on both surpluses and shortfalls – that is, above a certain limit, and after prudent reserves have been established and working capital needs have been taken into account, the County Board may take retained surpluses and reserves into account in adjusting its level of direct financial support for the following year. If shortfalls occur below a certain level, the Hospital Board should be permitted to return to the County Board for increased financial support.

5. Delegated Powers and Duties -- Operations

The County Board should delegate to the Hospital Board and its CEO the responsibility for preparing policies for operation of the hospital system, including (as noted below) policies for personnel and procurement. Formal adoption of these policies should be subject to approval by the County Board. However, once adopted, the Hospital Board and CEO should be permitted to implement them without further input from the County. With respect to operations, the Hospital Board and CEO should be granted considerable autonomy to make changes in the range and scope of services provided by the system as needed to improve quality, efficiency and financial viability.
6. Delegated Powers and Duties -- Personnel

The Hospital Board should select the system's CEO. The CEO should serve at the will of the Hospital Board, subject to removal by a majority vote (with or without cause). (If removed without cause, it can be stipulated that such action would not abrogate any rights of the CEO under his or her employment contract.) While the County Board and County President can be required to approve the Hospital Board’s selection, they should not have control over the selection process itself.

The CEO should be given broad authority to manage the system's operations, subject to oversight and approval of the Hospital Board. In particular, the hospital system should not be required to operate under the County's general personnel policies. The CEO and Hospital Board should be delegated with the task of developing a comprehensive personnel system (which can be consistent with but need not be identical to the current County system) that meets the needs of the hospital system. Implementation of this system should require approval of the County Board. The County Board also should grant the Hospital Board and CEO autonomy in hiring and firing senior staff.

The new personnel policies should not harm current system employees. Upon transfer to the new system, these employees should receive comparable classification and should retain their benefits, including accrued vacation and sick time. The new system should recognize the existing employee organizations and collective bargaining agreements, although the CEO and Hospital Board should be free to negotiate future agreements.

7. Delegated Powers and Duties -- Procurement and Contracting

The Hospital Board and CEO should be delegated the task of developing new procurement and contracting policies for the hospital system. The system should have discretion in choosing vendors and consultants and should not operate under the County's general procurement and contracting policies.

The Hospital Board should be specifically empowered to join and make full use of a GPO for purchasing. The County Board should be permitted to approve the Hospital Board’s selection of and participation in a GPO, but thereafter approval should not be required for specific purchases through such GPO. After approval of the Hospital Board’s annual budget, County Board approval should only be required for the very largest contracts or purchases, such as contracts lasting longer than 3 years or for agreements entered into outside the context of a GPO that would exceed a specified annual amount (e.g., $1 million).

B. Operation by an Independent Non-Profit Corporation

As a possible alternative to creating a new board within County government, we suggest that the County Board may want to give future consideration to the transfer of oversight and management of the Bureau and its programs and services to an independent non-profit corporation. While the goal of this paper was primarily to focus on an alternative Board structure within the current County government, and it is beyond the scope of this assignment to discuss this option in any detail, there are numerous examples of successful public hospital reorganization through the use of nonprofit corporations. There are two possible forms such a corporation might take:

- A newly-created non-profit corporation, or
- An existing non-profit corporation.

A newly created non-profit corporation could be established with a Board of Trustees composed of a combination of individuals affiliated with other major hospitals in the County (e.g., Rush, the University of
Illinois, the University of Chicago, etc.) and community stakeholders designated through a nominating process similar to that envisioned by the Ordinance enacted by the County Board in the end of February. Cook County government would not necessarily be required to approve appointees to the Nonprofit Board but may occupy a limited number of seats (e.g., 2 seats on an 11 member board) on the Nonprofit Board. The transfer of oversight and management of the facilities and programs of the Bureau through a new nonprofit corporation could initially be accomplished through a management contract (including a services and funding agreement). This approach has recently been approved for the Grady Health System in Atlanta by both the Fulton County and DeKalb County Boards of Commissioners. It has also been adopted by a number of state university systems around the country, including Maryland, Georgia, Florida and West Virginia.

Alternatively, an existing non-profit corporation (most likely a major current hospital system that is recognized as a clear stakeholder in the success of the County system) could be used in such an initiative. This could be accomplished through an outright merger of assets, purchase (or donation), lease or (most likely initially) a management contract such as the one described in the preceding paragraph. This approach has been adopted by county (or city) health and hospital systems in Boston, Seattle, Milwaukee, Austin and Fresno.

As a general rule, operation of the system by a separate non-profit corporation (whether new or existing) will mean that the County Board has less control over the system's operations. If a new non-profit corporation is created, County control and public accountability should be maintained through a mission statement contained in the nonprofit's charter and bylaws, the terms of a management agreement, and/or as a condition for County appropriations and support. The County specifically should make sure that the nonprofit is subject to adequate public scrutiny, that the system's public mission is maintained, and that the nonprofit offers appropriate protections to existing system employees. However, the non-profit corporation should be permitted to establish its own personnel and procurement policies and systems. It would be required to submit justification for needed County funding to the County each year for approval, but would otherwise be permitted to operate with substantial financial autonomy. The County would be expected to make commitments for needed operational and capital funding.

If hospital operations are delegated to a nonprofit corporation, it is important that at least a portion of the County support is guaranteed by law (i.e., not based on contractual provisions). This guarantee should help to protect the hospital's governmental status and its eligibility to fund and receive certain Medicaid payments.

C. Freestanding Authority or Taxing District

Finally, possibly as a longer range alternative, both the County Board and the Hospital Board currently being created to oversee and operate the system in the near term should think about permanent long term options that would create an autonomous unit of government to own and operate the current system. Such an entity would need to be established under a new state law, and if taxing power or the issuance of bonded indebtedness is involved, may also require the approval of the voters.

Given the unique nature of taxing authority in each state, we offer no opinion as to whether Cook County's home rule authority permits the County Board to create and delegate taxing authority to a taxing district run by an independent board. Further, it is unclear that home rule authority permits the County Board to establish a new unit of state government (taxing or non-taxing), separate and distinct from local government. The delegation of taxing authority to an independent board or the creation of a new unit of state government will most likely require authorizing legislation from the Illinois General Assembly.

A full discussion of this option is also beyond the scope of this paper. However, numerous examples of the successful use of such structures exist among the NAPH membership, including the City and County
of Denver; Hennepin County, Minnesota; Maricopa County, Arizona; Alameda County, California; New York City, Westchester County and Nassau County, New York; and most of the major Counties in Texas.
ATTACHMENT A

LIST OF MATERIALS REVIEWED

Interim Board of Directors (IBOD) Ordinance passed February 29, 2008

Cook County Commissioner Larry Suffredin's proposed ordinance establishing the Cook County Bureau of Health Trusteeship

Report of the Cook County Bureau of Health Services Review Committee, dated October 2007 (the Blue Ribbon Panel Report)

Health Care Committee Transition Team Report to President Stronger

Memo regarding "Cook County Bureau of Public Health" from David Kohn to ULCC Board of Directors, dated February 1, 2008

Resolution of ULCC supporting the findings of the Blue Ribbon Panel Report

Resolution titled "Support for Recommendations of the Cook County Bureau of Health Services (CCBHS) Review Report," introduced by Delegates Dray, Dunlap and Orris of the Chicago Medical Society

Resolution titled "Service Cuts Proposed for the Cook County Bureau of Health Services," introduced by Delegates Dray and Orris of the Chicago Medical Society

Resolution titled "Support for Independent Governance for the Cook County Bureau of Health Services," introduced by Delegates Dray and Orris of the Chicago Medical Society

Position statement of the Institute of Medicine of Chicago regarding the Cook County Bureau of Health Services

Resolution of the medical staff of John Stroger Hospital, dated November 13, 2007.

Monograph published in 2006 by the National Association of Public Hospitals and Health System titled "Legal Structure and Governance of Public Hospitals and Health Systems"


Report titled "Comprehensive Health Care: A Responsive and Responsible Plan for Cook County," dated November 2005

Miscellaneous Chicago newspaper articles

Select provisions of the Illinois Constitution, Illinois Compiled Statutes and the Cook County Ordinances and related Illinois case law

Authorizing statutes and related organizational documents of new legal structures created by or for the health care systems of: Hennepin County, MN; the City and County of Denver, CO; Alameda County, CA; Westchester County, NY; King County, WA; Maricopa County, AZ; Dallas, Harris and El Paso Counties, TX; Boston, MA; and the Virginia Commonwealth University.

The Governance Institute's "2007 Biennial Survey of Hospitals and Healthcare Systems"
### ATTACHMENT B

**OVERVIEW OF RECENT RESTRUCTURING PROPOSALS**

<table>
<thead>
<tr>
<th>Best Practices</th>
<th>IBOD Ordinance Passed February 29, 2008</th>
<th>Cook County Task Force on Hospital Governance</th>
<th>Commissioner Suffredin Proposal</th>
<th>Cook County Bureau of Health Services Review Committee</th>
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<td>Model of Governance</td>
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<td>Dependent on the situation.</td>
<td>Cook County Bureau of Health Directors (CCBOHD), a subpart of County government consisting of an Interim Board of Directors (IBOD). CCBOHD is authorized for 3 years.</td>
<td>Taxing authority whose budget is subject to approval by the County Board.</td>
<td>Cook County Bureau of Health Trusteeship, an independent bureau of County government. Bureau would exist for 3 years, and could be extended or made permanent by the County Board.</td>
<td>An independent board. No model is specified, although the report recommends immediate action.</td>
<td>A voluntary board of directors to oversee the hospital system. Repeated reference to the Bureau of Health indicates that statutory creation of a new legal entity is not recommended.</td>
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<td>Board Organization</td>
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<td>7-13 voting directors, representing a broad range of interests, and with the experience necessary to operate the system effectively. Optimally, the board should include prominent citizens. Power of appointment not vested in a single entity, and removal of directors only permitted for cause.</td>
<td>9 directors. Selected by the County President and approved by the County Board from a 20-person slate of candidates nominated by the Nominating Committee. Nominating Committee is comprised of representatives of 14 stakeholder organizations, elects a chair from its own ranks.</td>
<td>7 board members. Selected by County President and approved by the County Board. Suggestions for nominees made by a committee assembled by Senator Durbin and lead by Rush President. Removal of Hospital Board members by County Board permitted.</td>
<td>9 board members. Each of the following selects one board member: Institute of Medicine of Chicago; Illinois Public Health Association; Metropolitan Chicago Healthcare Council; Health and Medicine Policy Research Group; Chicago Department of Public Health; Cook County Physicians.</td>
<td>The report notes the existing conflicts of interest between responsibilities to the County Board and the Bureau of Health.</td>
<td>6-10 members, drawn from the business, legal, financial, and consumer communities of Cook County. County President appoints 40% of the membership, County Board the remaining 60%. Nominating body for board members comprised of County...</td>
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<td>Terms of 4 years, with initial terms of political appointees staggered and political appointees limited to serving 3 terms. Board action, including the selection of officers, based on the majority vote of voting directors. The board should develop its own bylaws and operate through a committee structure. Conflict of interest policies developed and enforced. Board education should be provided to new directors.</td>
<td>and acts by majority vote. Slate of candidates offered by the Nominating Committee must have the requisite expertise and experience to operate the hospital system. Term of each director is 3 years, the period for which CCBOHD is authorized. If a director resigns, the Nominating Committee reconvenes to propose a replacement. The same appointment process is followed. Removal is permitted by a majority vote of the Nominating Committee for cause. IBOD selects its own Chair from among the directors. (This appears to be the intent of the ordinance, although due to a typo, the provision reads differently) All votes require a</td>
<td>only for cause. Hospital Board selects its own president.</td>
<td>Association; and Chicago Federation of Labor. Ex-officio members include the chairpersons of the County Board Committees on Health and Hospitals and Finance. Hospital Board action requires a majority vote of voting members.</td>
<td>healthcare executives and members of boards of directors of nonprofit hospitals.</td>
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<td>majority vote of the full IBOD.</td>
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<td>Directors have a fiduciary duty to the County President, County Board, Cook County Bureau of Health Services, and Cook County citizenry.</td>
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<td>Conflicts of interest must be disclosed, will be included in IBOD minutes and the conflicted individual may not participate on behalf of IBOD in authorizing the contract or transaction.</td>
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<td>Accountability</td>
<td>Board records open to the public, with the exception of certain confidential and strategic materials. Hospital board annual reports to local government on hospital operations, including audited financials. System mission is</td>
<td>IBOD tasked with ensuring that high quality health care is available to all medically indigent County residents. IBOD reports to County Board on the Hospital Chief's performance every 6 months. County Board approves</td>
<td>County Board approves the annual system budget.</td>
<td>Hospital Board evaluates CEO's performance and reports to County Board every 6 months. County Board approves selection of CEO and annual system budget. County Board approves any leases, contracts or other transactions in</td>
<td>County Board reserve powers include appointment of hospital board members, establishment of budgetary limits on at least an annual basis, approval (along with County President) of capital spending above a specified limit, and approval of alienation of property.</td>
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<td>enforceable, but properly balances public interest with the need to maintain system competitiveness.</td>
<td>annual operating and capital budgets. County Board approves all leases, intergovernmental agreements and contracts, including all vendor and third party payer agreements. County Board approves acquisition, sale, repair and maintenance of Bureau property and assets. IBOD conducts financial audits and submits a copy to the County President and Chairmen of the Finance and Health and Hospitals Committees. Hospital Chief submits a quarterly report to the Health and Hospitals Committee on Bureau operations.</td>
<td>excess of $25,000.</td>
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<td>After appointment of permanent leadership, system mission is reviewed and, if necessary, revised.</td>
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**Budget and Appropriations**

<p>| The board has the authority to develop its own budget (subject to approval by local | Hospital Chief develops annual operating and capital budgets, subject to IBOD and County | Hospital Board has taxing authority. | Hospital system collects all revenues. CEO develops the | The report finds that there is no evidence of coordinated long-term strategic planning | CEO develops budget and, along with the Hospital Board, a strategic plan. |</p>
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<td>government), set hospital charges, and issue bonds. The hospital system should generally be accountable for its profits and losses.</td>
<td>Board approval. IBOD tasked with conducting long-range strategic and fiscal planning, including the establishment and maintenance of operational and capital reserves.</td>
<td>hospital system's capital and operating budgets, subject to approval of the Hospital Board and final approval of the County Board. Hospital Board engages in long-term strategic and financial planning, and is permitted to establish and maintain operational and capital reserves for the hospital system.</td>
<td>involving the County Board and hospital management.</td>
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<td>Local government commits to providing a specified level of financial support for a minimum time period.</td>
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**Personnel**

| CEO selected by hospital board, hired for a term of up to 3 years, and granted authority to appoint and remove senior staff. New personnel policies are created, with appropriate protection for existing workers. Hospital system recognizes existing employee organizations and collective bargaining agreements. | IBOD tasked with conducting a nationwide search for a new Hospital Chief. IBOD tasked with ensuring that personnel matters are conducted free from political interference. Hospital Chief has hiring and firing authority, subject to existing law and collective bargaining agreements. | Hospital Board selects its own CEO. Hospital Board has hiring and firing authority. | Hospital Board conducts a nationwide search for a CEO. CEO serves at the agreement of the County President, subject to County Board approval. Personnel matters conducted free from political interference and in compliance with applicable law. CEO develops personnel policies, in conformance with existing law and The report repeatedly emphasizes that the chief of the Bureau of Health needs greater hiring and firing authority. Hiring and firing needs to occur free of patronage allegations. Physicians given employment contracts. | The report repeatedly emphasizes that the chief of the Bureau of Health needs greater hiring and firing authority. Hiring and firing needs to occur free of patronage allegations. Physicians given employment contracts. |
| Hospital Board recommends a CEO, to be appointed by the County President and the County Board. CEO has recruitment, hiring, training, and firing authority over Bureau of Health employees. CEO has full authority to hire and fire senior staff. New human resources system developed. | |

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<td>Hospital Chief may develop and implement personnel policies, subject to IBOD approval and in conformity with existing law and collective bargaining agreements.</td>
<td>collective bargaining agreements, subject to Hospital Board approval. CEO has hiring and firing authority, subject to existing law and collective bargaining agreements.</td>
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**Operations**

| Board has broad power to oversee the management and operations of the hospital system without political inference. | IBOD tasked with "ensuring" delivery of care and fiscal responsibility as well as authority to oversee and approve system operations, subject to existing law and County Board prior-approval in certain areas. | Scope of the delegation of power to Hospital Board is unclear. | Hospital Board tasked with "ensuring" delivery of care and fiscal responsibility as well as authority to oversee and approve system operations, subject to existing law and County Board prior-approval in certain areas. | Oversight and governance of the hospital system would be placed in the hands of an independent Hospital Board. | Hospital Board would oversee the Bureau services, but County Board would retain reserve powers. |

**Procurement and Contracting**

<p>| Board has autonomy with regard to purchasing and contracting and develops its own procurement and competitive bidding policies. | IBOD tasked with ensuring that contractual matters are conducted free from political interference. Hospital Chief may select outside vendors and consultants subject | Hospital Board has contracting authority. | Contracting matters conducted free from political interference and in compliance with applicable law. CEO has authority to select outside vendors and consultants in | The report finds that the chief of the Bureau of Health needs to be given greater autonomy in procurement, contracting, and selection of consultants and vendors. | [Not directly addressed] |</p>
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<td>to all County ordinances.</td>
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<td>conformance with County ordinances.</td>
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<td>Hospital Chief may negotiate and execute leases, intergovernmental agreements and contracts, subject to approval of IBOD and the County Board. IBOD (subject to County Board approval) will set a dollar threshold below which prior approval will not be required.</td>
<td></td>
<td>CEO has freedom to contract, although approval of Hospital Board and County Board required for amounts in excess of $25,000. Purchase, sale, or repair of equipment must be in conformance with County procurement ordinances.</td>
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<td></td>
<td>The report notes that it is unclear how the County Board evaluates and approves capital budgets prepared by hospital management and that management does not appear to be involved in the final approval process.</td>
</tr>
<tr>
<td>Hospital Chief may purchase, sell or repair equipment consistent with the Cook County Procurement Ordinance. IBOD may acquire, sell, repair and maintain Bureau property and assets, subject to County Board approval.</td>
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<td>The report notes that the requirement for County Board approval of expenditures in excess of $25,000 hampers the procurement process (although this limit recently was increased to $100,000).</td>
</tr>
</tbody>
</table>