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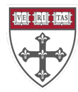

HARVARD T.H. CHAN | SCHOOL OF PUBLIC HEALTH

PH9-006
2009

Managing Governance at Reliance Hospital

Introduction

At the end of another long day in the fall of 2007, Patricia Lynch, CEO of Reliance Hospital, rested her mug on the table and leaned forward. "In my view, some on the hospital's board are confused about the CEO's role and the board's role; but this is coming from someone who's used to turnaround situations and having the board say 'you go girl.'" Continuing, she added, "Reliance is a fabulous place. It has the resources to allow me to do many things that I want to. But the hospital could be producing better margins... All of our margins come from CT and MRI scans."

Lynch came to Reliance in 2005 with more than 20 years of experience as a senior executive in the healthcare industry, having completed several hospital turnarounds. Her selection concluded a long search process during which the hospital's board of directors appointed two interim CEOs before appointing Lynch to the post permanently. As she began her tenure and familiarized herself with the hospital's strategic position, Lynch realized that she would need a highly effective board to resolve some of the facility's important internal and external competitive challenges. But the question that weighed on her mind was exactly how to improve the board's effectiveness. She worried about the board's size, its motivation, the mix and composition of board membership, and physician participation in hospital governance. She was similarly concerned about her role relative to the board's, and wondered about the changes she and the board would need to make in order to appropriately position the organization for its competitive future.

Background

Reliance Hospital's mission was to "promote health and well-being in the community by being an accessible resource for the most advanced high quality health care." A non-profit, acute care community hospital with nearly 100 years in operation, Reliance was guided by four core values: Quality, Expertise, Care, and Community. The hospital provided care to patients requiring a broad range of medical and surgical specialties, including significant programs in cardiac medicine, gastroenterology, obstetrics and gynecology, orthopedics, pulmonary medicine, and psychiatry. The hospital also had programs in radiology—including CT, MRI and Digital Mammography capabilities—and emergency services, with a 24-hour emergency room.

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The 177-bed hospital included a 20-bed transitional care unit (skilled nursing facility) as well as two specialty centers on the hospital's main campus: the Cancer Center, and the Birthing Center. A suite of full-service operating rooms provided surgical services; approximately 75% of procedures were performed on an outpatient basis. On-site outpatient facilities included a breast health center and rehabilitation services. In addition, the hospital operated three satellite clinics located within its primary service area. Each housed clinicians in multiple specialties, including adult and pediatric internal medicine, cardiology, surgical practices, and other specialties.

Organizational Structure and Medical Staff

Reliance Hospital was part of the Reliance Health System. Reliance Health System consisted of four entities: (1) the for-profit Reliance Property Development Corporation, a real estate holding company that acquired and managed properties for purposes that supported the hospital; (2) the non-profit Reliance Health Care Foundation, organized to manage the fundraising activities of the hospital; (3) the for-profit Reliance Occupational Health services, organized to sell health programs to employers and purchase services from the hospital; and (4) the hospital itself. The hospital and its system operated as an independent community health system. The hospital was, however, affiliated with a large academic medical center in the region in order to gain access to its bargaining leverage for the purposes of payer contract negotiations.

As of 2007, the hospital's independent medical staff consisted of 358 physicians, dentists, and podiatrists, including 273 on the active staff, and 85 on the courtesy staff. These numbers were down from a total staff of 381 in 2005. The active medical staff included physicians and dentists who had admitting privileges to the hospital, and who voted and held office on the staff. Those on the courtesy staff neither held office nor voted in staff meetings; after one year on the courtesy staff they were eligible for consideration for appointment to the active staff. Physicians were not employed by the hospital, but were organized as part of the Physician Hospital Organization (PHO), which allowed physicians to practice independently while jointly contracting with payers.

The hospital maintained an active and professional nursing staff, with more than 300 full- and part-time nurses. The hospital had set the goal of achieving Magnet status, an award bestowed by the American Nurse's Association to those hospitals that achieve the highest quality of nursing care.

Service Area, Competition and Performance

Reliance Hospital was situated in Levanne, a wealthy suburban community 20 miles from a major metropolitan area. Levanne had a median household income that was nearly twice that of the state as a whole. The hospital's primary and secondary service areas covered approximately 300,000 individuals living in 25 towns. The hospital maintained more than 40% market share of hospital discharges for patients residing within its primary service area, although this number had fallen in recent years, from 46.7% in 2000 and 45% in 2003.

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Competition came from two large medical centers located in the city, as well as a large multi-specialty physician practice that owned its own hospital, and two other nearby community hospitals. With the exception of one of the local community hospitals, each of these competitors was significantly larger than Reliance. In addition, all but one had experienced recent market share growth in Reliance Hospital's primary service area. **Exhibit 1** summarizes Reliance Hospital's volume and utilization through 2006. **Exhibit 2** provides details of Reliance Hospital's financial performance through fiscal 2007.

Governance at Reliance Hospital

Structure

Community representation was a primary component of the Reliance Hospital governance model. Representatives from each of the hospital's primary service area communities were nominated and then elected by existing members to serve as Corporators, of which there were more than 180. Corporators were elected for three-year terms, with no limit to the number of terms served. The role of the Corporators was to act as ambassadors for the hospital in the communities in which they lived, and to elect new members to the board of directors of Reliance Health System. The board of directors of the System in turn elected the members of the board of directors of the hospital. In recent years, the members of the system board had become identical to the members of the hospital board. The hospital/system board met on a monthly basis.

Board members were elected to serve four-year terms. In addition to several physicians and the CEO, the board was composed of current and retired business executives and investment professionals, one university faculty member, and a couple of local residents active in community affairs. Five women served on the board, including CEO Patricia Lynch. **Exhibit 3** provides a summary of the board's membership. The board was led by four officers: the chairman of the board, vice-chairman, secretary and treasurer. New board leadership had taken office in 2006, with Stephen Davis as chairman. Standing committees of the board included: the Audit Committee, the Compensation Committee, the Finance Committee, the Governance Committee, the Human Rights Committee, the Investment Committee, the Joint Conference Committee, the Nominating Committee, the Quality Improvement Committee, and the Strategic Planning Committee.

Board Size

When Patricia Lynch took over at Reliance she inherited a board with 28 members. She described the group as consisting of some "wonderful board members." Nevertheless, she found the group difficult to manage:

> I found it very difficult to manage a board that size. Everyone wants something different and it can be hard to manage expectations. I told them that they needed to continue to shrink the board size or I would like an executive committee.

Lynch's request for an executive committee was rejected by the board. Some board members worried that an executive committee would create an "upstairs board, downstairs board"

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structure, with the full board becoming less relevant. Others believed that the executive committee was unnecessary given that the board met on a monthly basis. Data on board size and other characteristics from 18 community hospitals in the state that participated in a national survey are shown in **Exhibit 4.**

Lynch hired an assistant to work exclusively with board members three days per week. The assistant helped prepare for monthly board meetings as well as various committee meetings, with as many as three board-related meetings per week. Not all board members thought the assistant was appropriate; one physician member asked Ms. Lynch, “What does [your assistant] do all day, help with your laundry?”

Not long after taking over, Lynch and board leadership set a target of reducing the group to 19 members. One board member described his perspective of the situation:

> Patricia has shaken the tree a little, sort of saying “participate or leave.” There is a group of people on the board in their 70s who probably need to leave. What they really need are people in their 40s and 50s who can serve for 9 or 10 years. There’s a natural evolution that’s in process. There was one guy here a few years ago who I think was on the board for about 40 years.

By the end of 2007, the board had been reduced to 22 members, including four physician members, down from six physician members in 2005. Stephen Davis, the board chair who implemented the size reductions, commented:

> I hope that there will be more individual performance scrutiny. I think that when that happens, the stakes will be raised, and those not on the board for the right reasons will get off when their term expires. For new board members, I want to have the conversation with people who show genuine interest in serving on the board.

Board Composition and Skill Mix

One physician board member commented,

> I think that the board doesn’t do a good job of recruiting the breadth of expertise that is required. We don’t look at the gaps and say, how can we fill it? Some on the board are there because it looks good for them to be on the board, but they’re not bringing the appropriate skill-set. I think we need to focus on age distribution and skill-sets… Looking at the age distribution of the board and availability, there are too many who are of an age that they won’t be around for much longer. We’ve also got some young people on the board who are working a lot and just don’t have a lot of time. We don’t use a matrix for selecting new board members. There is a board assessment process, but in terms of new board members no one is asking what our deficiencies are. It’s sort of who knows whom.

Another board member added:

> The board represents 20 towns, and they’re trying to get representation from all of them… In the past, the board has always been looking for “rich cats.” Most of them they got from the financial industry, and this group brought a very narrow view to the board.

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Lynch valued industry and strategic expertise that could help her "get this place where it should be." Yet she worried about the current composition of the board, and the accompanying effect on the board's ability to understand its role in governing the hospital.

Board Meetings and Processes

The board at Reliance Hospital met on a monthly basis, with committee meetings on a quarterly or more often basis. The agenda for board meetings was determined jointly by the board chair and CEO. Lynch appreciated having a committed and talented board chair, describing Stephen Davis as indispensable and an important ally in her desire to improve the hospital's performance. The basic agenda for each meeting was laid out well in advance, with each agenda adjusted and finalized prior to each meeting. Board meetings typically were scheduled on a Tuesday, with meeting information packets mailed out during the latter half of the preceding week.

Board members described the information packets received under Patricia Lynch as considerably more organized than under previous administrations. However, a board member commented that he "gets so much paper from the hospital," with meeting packets ranging in length from 60 to 100 pages, that he couldn't possibly absorb or remember it all. The agenda typically included the CEO's report, reports from members of the CEO's executive team, and presentations and discussion around specific action items.

Board meetings were scheduled to last for an hour and a half. Some board members described the allotted time as insufficient for the material on the agenda. Davis described most of the meeting time as devoted to presentations and reports, although he recognized the need to move toward more strategic discussion:

> You need dialogue. If CEOs had their way they would report to the board without having to listen to them. I think it's a natural tendency for them to want it to be that way. A good agenda-setting process takes considerable trust and thought so that the process doesn't go off the deep end.

Lynch agreed that more discussion was needed and made efforts accordingly:

> The board wants to move towards 60% discussion and 40% reporting. I've tried to make an effort to set up discussion questions for the board, and they have also pushed for a two-step process for addressing decision item: we present at one meeting, and vote during the next. We've also started evaluating every meeting, asking what went well, what did not, and how the board can improve.

Attendance at board meetings was generally good, with roughly 90% of board members present for each meeting. Active participation, however, was mixed. One board member described his perspective: "Some board members are comfortable speaking up, and some are not. We have some very strong-minded people on the board who do speak up, but I think that maybe half of

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the board is fairly quiet. It may have to do with their personalities. The chair doesn't force contribution, but there is opportunity to speak up."

Some board members suggested that the size of the board played a role in determining the level of participation, with the large number of board members "cutting down on the level of discussion." Davis believed that the mixed participation may have additionally been influenced by organizational culture: "I think this board has had a culture that includes conflict avoidance; but they have recognized it. Nevertheless, when you have a certain style, you play into that."

Lynch agreed that the culture and processes of the board could use improvement. A recent internal governance survey of board members had confirmed a number of areas of concern. The responses to several survey items related to individual board member involvement and participation fell well below national averages. These areas included (with percent saying *always* or *most of the time* in parentheses):

- Board member participation in meetings (65% versus 82% nationally)
- Communication with the CEO (60% versus 84% nationally)
- Willingness to voice concerns regardless of issue sensitivity (55% versus 82% nationally)
- Involvement in new member identification (35% versus 67% nationally)
- Participation in educational opportunities related to issues of importance to the board (30% versus 60% nationally)

With respect to the entire board and its processes, other areas of concern revealed by the survey included (with percent saying *always* or *most of the time* in parentheses):

- Discussion of strategic issues during board meetings (30% versus 58% nationally)
- Willingness to challenge recommendations of the medical executive committee (15% versus 48% nationally)
- Comprehension of the hospital's financing options (20% versus 68% nationally).

Despite these areas of concern, the survey also revealed that the board believed it was actively involved in establishing the organization's strategic direction and that it was providing appropriate financial oversight for the organization.

Role of the Board in Strategic Planning

Formal responsibility for strategic planning was vested in the board's Strategic Planning Committee. Although it was a committee of the board, the committee's membership included representation from many stakeholders in the organization. The committee was among the hospital's largest. Stephen Davis had previously served as the committee's chair:

> I hired a good outside facilitator [for the Strategic Planning Committee], someone who could get the strategic data out of management and not just the tactical or operational stuff. So in that committee I think we were getting good data…We had about forty or fifty people. This is way too big to get anything done, so I divided it into small groups and saw

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> it as a way to have some fun. From this experience I think I was able to gain some of the board members' trust.

However, at least one board member felt that the board was not sufficiently involved in the implementation of the strategic plan:

> The board has been involved in the strategic planning process, but the implementation has been delegated, and the board has not provided the appropriate oversight…If the board is going to be involved in the strategic planning of the hospital they need to be providing some oversight. In terms of hospital performance evaluation there have not been a lot of metrics that the board looks at. They are just beginning to develop a dashboard, but that's still more operationally-focused and not necessarily strategy-focused.

Lynch was also concerned that some board members were too involved in operational details rather than focusing their attention at a strategic level.

> With this board, I feel like I have to ask permission to do things that I feel are within the purview of the CEO…I think that the CEO should be able to go out and hire VP's. But the board believes that they should be involved at that level and be able to approve VP compensation. There are some venture capitalist types on the board who treat the hospital like a for-profit venture, like it's their investment and they should be able to approve the use of their dollars…When I started in this job, I wanted to bring in a Chief Medical Officer (CMO) and so I asked the board chair at the time what the process for doing so was, and he said you just do it. So I did. Well, some members of the board complained about the process.

Some Board members continued to complain about not being involved in other decisions Lynch had made, including the hiring of a director of marketing, replacing her own administrative assistant, and giving raises to her executive team.

Role of Physicians in Hospital Governance

The number of physicians actively serving on the board was reduced as part of the board's overall size reduction. As of the end of 2007, there were four physicians serving on the board.[1] Some of the hospital's board members recognized the complicated nature of physician-hospital relations. One board member commented:

> The biggest complication in health care is that a big part of your work force doesn't work for you; that's a complexity that corporations don't face. The complexity is in the relationship with the medical staff. The problems arise not so much with the internists, but with the specialists, particularly when it comes to recruiting physicians. The specialists tend to resist that.

Patricia Lynch elaborated on how these complexities manifested at Reliance:

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[1] Based on data from the 2005 Governance Survey, American Hospital Association/Health Research and Education Trust

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> Part of the problem is that these physicians want the hospital to share any and all information with them, including service line profitability data, but then they just use it to further their private interests, and in some cases compete with the hospital. Physicians may have too much power here. We have only five general surgeons. We conducted a market analysis, the results of which said that in growing market share this hospital has room to add 12.7 surgeons. I looked into it and got major push back from the docs.

The medical staff resisted several efforts to increase clinical staffing, including efforts to recruit additional cardiologists. In some cases physicians threatened to leave the hospital if staffing in their area was ramped up. This put Lynch in a tough position: "The reality is that I want this hospital to be around, and I realize that in order to do that I need to be aligned with the physicians; so I basically give them the right of first refusal." However, recently she said to one surgeon that she would not honor his request to not recruit; that surgeon left the area soon after.

In addition to positions on the hospital's board, the hospital's physicians had influence through the medical executive committee (MEC), which governed the medical staff. The president of the medical staff served *ex-officio* on the board. The CEO and CMO served on the MEC, which also included the chairs of each of the hospital's clinical departments. Lynch saw the MEC as a potentially important vehicle for managing relations with physicians and for disseminating information to the hospital's medical staff. However, she felt that the committee did not yet serve that purpose and was weighted too heavily toward specialists.

At a recent medical executive committee (see **Exhibit 5** for agenda), members discussed proposals for a reduction in the food budget for meetings, changes in the way medical staff dues were charged and paid, and whether the medical staff should make a contribution to the hospital's medical library.

The Governance Committee Meeting

In the winter of 2007, the Governance Committee of Reliance met to review results of the recent internal governance survey, comparing their own board responses to those of boards nationally that participated in the Governance Institute[2] board survey. The meeting began with a review of the board's evaluation of the Chair as an effective leader. Results were unanimously supportive of Davis' leadership performance and especially noted his inclusive style. However, three board members expressed some dissatisfaction with the chair's relationship with the CEO, with one writing that Davis "needed to think about the CEO as employee rather than as a peer."

Committee members went on to review the Governance Institute's comparison of their board's self-assessment to their national peers. One of the larger unfavorable differences between Reliance and its peers was the level of agreement with the statement, "Board members receive important background materials at least one week in advance of meetings." Only 45% of

[2] The Governance Institute, "Board Compass: The Governance Institute's Board Self-Assessment", 6333 Greenwich Drive, Suite 200, San Diego, CA 921220.

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Reliance participants strongly agreed or agreed with that statement, compared to 81% nationally. Lynch noted that this result appeared despite the fact that the board received materials in advance of the meeting and were satisfied with the timing of receiving them.

One committee member noted that most Reliance board members did not agree that they received and reviewed copies of the hospital's IRS Form 990[3] to insure its accuracy and completeness. One committee member remarked, "We never see a 990 at the board meeting." Another responded, "But the Audit Committee does." A third asked, "So should we be handing it out at the board meeting?" One member responded, "No, if we did that the physicians would be passing it around to the whole medical staff." The committee decided that the Audit Committee should give the board a report on it. It wasn't clear to committee members why the Governance Institute considered full board review of the IRS 990 as a best practice.

The committee noted that only 25% of Reliance board members agreed to the statement, "The board has a written policy and/or procedure outlining the organization's approach to physician competition/conflict of interest." This issue was highlighted by the Governance Institute as an area where the Reliance board should improve. One group of specialists had recently set up a freestanding endoscopy unit that had taken $3 million out of hospital revenues in one year. In response to a committee member's question of whether the move had affected patients, Lynch commented, "It is not an issue of quality of care; it is more the impact on the hospital and the bifurcation of the medical staff."

Another area of discussion focused on a survey question about the effectiveness of the board's quality committee in providing oversight. Sixty-five percent (65%) of Reliance respondents agreed that the quality committee was effective, compared to 89% of their national peers. One committee member commented, "We need to get our Quality Committee to decide how to establish effective oversight. We need a more structured set of goals. We need to refocus on what the board needs to understand about our hospital's quality." The committee agreed that more effort needed to be paid to quality oversight by the board, but were concerned that issues of quality not become so dominant that they pushed the issues of finance and strategy off the board's agenda.

The committee wondered whether the board should be more involved in developing political relationships on behalf of the hospital. In the survey, only 40% of Reliance board members agreed that board members assist the organization in communicating with key external stakeholders, compared to 59% nationally. Ms. Lynch was hoping to get board members to attend a fundraiser for a local politician who had helped the hospital obtain state resources in the past. As it was getting late by this time, discussion on this topic was limited.

The committee discussed how much board meeting time should be devoted to discussion versus reporting out at board meetings. The Governance Institute's best practice recommendation was that 75% of board time be devoted to discussion. One member commented that it involved

[3] The IRS 990 is a form that tax-exempt organizations are required to submit to the IRS. It provides information on the filing organization's mission, governance, programs, compensation and finances.

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balancing how much education board members needed before they could effectively discuss a topic. Another commented that it was very difficult to get all of this information into a 1½ hour board meeting. A third asked, "How much information do we have to give to the Board? When should we just trust the CEO?" A discussion ensued about how many meetings, between board and committee, the members attended each week. One member commented, "I am worried about so many meetings and their impact on management. Maybe we should meet quarterly like [the other hospital where she was a board member]." The committee concluded that they needed to redefine the board's role to be more strategic, to provide less day-to-day guidance. One member commented, "Some say all the board does is hire and fire the CEO."

The final item on the Governance Committee agenda was proposed changes in the board's policy manual. Most of the changes were on what kind of behavior was expected of board members. The additions included "communicate effectively with the CEO," "work well together as a team," "exhibit a willingness to consider differing opinions of others," and "build trusting relationships with one another and respect the confidentiality of all discussions, information, opinions, and attitudes." One committee member commented that he'd never seen any disrespect at board meetings. Another mentioned that confidentiality issues were a problem, especially with physician board members.

Looking Ahead

Lynch looked to the future with a reserved, yet optimistic outlook. She described herself as a diligent woman—someone who had worked hard to get where she was. Despite the changes she and Davis had achieved in her first couple of years, and the encouraging discussion at the recent meeting of the Governance Committee, she still found engaging the board on strategic issues a challenge. She sensed that in the minds of some board members her role, relative to their role, was ill-defined. Nevertheless, she hoped that the board could properly define and carry out its role, provide constructive oversight of the hospital's strategic direction, and help to bridge the divide between the hospital's management and its physicians. She believed that an executive committee would help improve many of the problems but worried that the board was still not prepared to approve such an action. Looking forward, she envisioned a continued partnership with Stephen Davis in an effort to improve board performance, but wondered what changes she should prioritize and how to achieve them.

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Exhibit 1: Reliance Hospital's Volume: Inpatient Days 2003 through 2006

	2003	2004	2005	2006
Inpatient Days	46,822	45,437	43,897	45,884
Medical/Surgical	20,487	22,874	21,423	21,105
Pediatrics	744	529	598	599
Obstetrics	3,966	3,962	3,725	3,769
Psychiatry	7,493	7,154	7,589	8,161
Skilled Nursing	5,367	4,380	4,173	5,763
ICU	4,100	1,933	1,974	2,112
NICU	1,164	1,147	1,159	1,187
Newborn	3,501	3,458	3,256	3,188

Source: State Department of Health and Human Services

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Exhibit 2: Reliance Hospital's Financial Performance 2004 through 2007

	2004	2005	2006	2007	State Industry Median 2007
Operating Margin	3.5%	3.5%	2.2%	2.0%	1.7%
Non-operating Margin	0.38%	0.07%	1.20%	2.20%	1.6%
Total Margin	3.9%	3.6%	3.4%	4.2%	3.3%
Current Ratio	1.6	2.11	1.71	1.69	1.55
Cash flow to Total Debt	28%	15%	14%	15.0%	20%
Equity Financing	47.01%	37.96%	38.67%	38.45%	49%

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Exhibit 3: Summary of Reliance Hospital Board Membership by Profession

Board Member	Local Resident	Years on Board	Profession
1 Ex-Officio	Yes	<3	Physician; President, Medical staff
2 Ex-Officio	Yes	<3	Physician; President-Elect, Med Staff
3	Yes	7	Physician
4	Yes	8	Physician
5 CEO	Yes	3	CEO, Reliance Hospital
6 Chair	Yes	14	Professor, Local University
7	Yes	<3	Retired Business Executive
8	Yes	17	Retired Business Executive
9	Yes	8	Business Executive
10	Yes	3	Business Executive
11	Yes	4	Business Executive
12	Yes	13	Retired Business Executive
13	Yes	8	Retired Business Executive
14	Yes	10	Business Executive/Owner
15	Yes	14	Business Executive
16	Yes	<3	Investment Firm Executive
17	Yes	8	Retired Venture Capitalist
18	Yes	5	Investment Firm Executive
19	Yes	11	Retired Business Executive
20	Yes	5	Venture Capitalist
21	Yes	3	Mental Health Specialist
22	Yes	8	Retired Local Store Manager

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Exhibit 4: Summary of Governance at Selected Hospitals in the Same State (2005)

		Board Positions		Board Members Who are:			
Hospital	**Bed Size**	**Total**	**Voting**	**Female**	**51 to 70**	**70 plus**	**Physicians**
1	665	21	21	4	15	2	4
2	556	30	30	n/a	n/a	n/a	
3	800	25	25	8	n/a	n/a	8
4	250	18	18	2	13	1	3
5	271	30	28	6	20	5	6
6	323	18	18	4	15	5	4
7	125	11	11	2	n/a	n/a	1
8	318	19	19	8	17	2	3
9	97	12	12	1	11	1	4
10	134	26	26	6	17	7	4
11	167	27	27	3	25	8	5
12	216	27	27	5	18	2	6
13	19	21	21	5	14	0	1
14	97	18	18	4	14	0	3
15	348	12	12	3	6	0	1
16	850	20	20	5	17	4	6
17	438	25	25	5	17	2	6
18	206	20	18	3	15	5	4

Source: Based on data from the 2005 Governance Survey, American Hospital Association/Health Research and Education Trust.

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Exhibit 5: Medical Executive Committee Meeting: Agenda

I. Call to Order: Dr. Peters
II. Approval of Minutes: Committee meeting Tuesday, December 28, 2007
III. Announcements: None
IV. Consent Agenda:
   a. IVSA Policy was distributed for review
   b. ACTION: committee vote on the IVSA Policy as presented
V. Reports
   a. President's Update: Dr. Peters
      i. Thank you to Dr. Smith for his years of service
   b. Administrative Updates: Ms. Lynch and Dr. Martini
      i. Introduction of Hospital/Physician Alignment task force
      ii. Update on new café
      iii. Dr. Martini overview of financial impact of observation days
   c. Credentials Committee
      i. Dr. Gordon reporting
      ii. ACTION: committee vote on the report as presented
   d. PRC Report (2/5): Dr. Foster
      i. Professional Review Committee (PRC) report; summaries from the departments of medicine and psychiatry
      ii. ACTION: committee vote on the report as presented
   e. Treasurers Report
      i. Dr. Harrison presenting
      ii. ACTION: committee vote on the report as presented
      iii. ACTION: committee vote on budgets as presented
      iv. ACTION: committee vote on the fiscal year calendar
      v. ACTION: additional discussion about the food budget
      vi. ACTION: committee vote on contribution to Nurse's Week
      vii. ACTION: additional discussion about dues schedule
      viii. ACTION: committee vote on contribution to medical library
   f. Committee/Department Reports
      i. P&T: Dr. Asadov presented a report from P&T
      ii. Illegible orders:
         1. Too many illegible orders from physicians
         2. Working on CPOE
VI. New Business
   a. ACTION: Approval of Diabetes orders
   b. ACTION: Approval of new GI Service Chief
   c. ACTION: Trauma Committee report annually (instead of semi-annually)
VII. Executive Session: none
VIII. Adjournment

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