

The Information Needs of Health Agency Board Members: A health information system challenge

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Abstract

Most hospitals and health agencies in developed countries, whether in the private or public sector, have 'advisory committees' or 'boards of management'. Members of these bodies have significant responsibilities for the management of their organisations, but usually serve on these bodies on a part-time and voluntary basis. They may or may not have specific expertise in health care or management but are often selected because they are representative of parts of the community, are members of relevant organisations (medical bodies or, perhaps, staff unions) or belong to the correct political party.

In previous years the amount of information about the health care agency and health systems in general which was given to the board was usually closely controlled by the senior staff of the agency. While the information often emphasised financial statements or gross usage figures, it seldom included projections of future trends or comparisons with information for other like agencies and was frequently very out-dated by the time that it was assembled.

For discussion purposes in this paper all individuals who serve on advisory or management committees as well as members of legally constituted Boards of Directors will be referred to as 'board members'. The responsibilities of these board members differ from the management responsibilities of CEOs and other senior executives, but those involved do require access to some management information if they are to adequately discharge their responsibilities. The role of such 'boards' or 'authorities' is similar to that of a board of trustees or directors in industry with many of the same responsibilities, except that healthcare agencies are 'people' agencies, not producers of 'widgets'.

This paper will outline some of the information needs of board members and discuss how these needs may be addressed as part of a total management and health information system.

Keywords:

Decision Support, Information Systems, Board Members, Trustee, Legal

Introduction

For discussion purposes in this paper all individuals who serve on advisory or management committees as well as

members of legally constituted Boards of Directors will be referred to as 'board members'.

Healthcare administrators depend upon up-to-date and reliable information to perform their management duties yet the board members of such institutions, typically serving in a voluntary part-time capacity, often do not enjoy adequate access to information sources.

While most people have some experience of being office-bearers in community or professional organisations, such organisations are usually relatively small, have no paid staff and have a limited amount of information to be acquired or understood. The situation is different when organisations are larger, have a professional staff and where there is potentially a large amount of information to be assimilated and understood by 'lay' (that is non-professional in whatever the field) board members. This paper addresses the information needs of board members in this second situation.

The first author is an educator who has considerable experience in developing appropriate computer applications for 'end users'; the second author has been a health professional and administrator. This paper is based on our joint experience as board members for community and government agencies, including as an appointed member of the former Central Region Health Authority (Queensland Health), a member of a hospital board for a 500-bed hospital, board member for a sports agency with a \$3.5 million/year cash flow and member of a board of directors for a rehabilitation agency.

Responsibilities of Board Members

In the past board members for health agencies have frequently been appointed on an 'honorary' basis, with the expectation that the individuals would do little more than rubber stamp decisions made by senior administrators at meetings which may only have occurred quarterly. Today, however, there is increasing pressure on such boards to 'be accountable' for the use of resources, for the personnel and ethical policies of the institutions and for an understanding of the health industry; meetings are normally held monthly and, with various sub-committee responsibilities, board members may find themselves involved in board-related decision-making activities almost every week.

Board members, particularly for public agencies, are surrogate members of the community and have some

particular and rather daunting responsibilities. For example, The Queensland *Health Services Act* 1991, No. 24 said, in part:

3.18 Functions of Authorities.

1. It is the function of an Authority to promote the health and well-being of the people within the region concerned and in particular to oversee--

- (a) implementation of the Queensland Health Corporate Plan in the region;
- (b) development and implementation of a regional strategic plan for health services in the region in consultation with the chief executive;
- (c) funding of public sector health services in the region;
- (d) provision, management and delivery of public sector health services in the region and ensure services are administered within the resources allocated;
- (e) assessment of health needs in the region.

2. It is also the function of an Authority to--

- (a) ensure that health services in the region are of a high quality, delivered equitably and under regular evaluation and review;
- (b) consult and co-operate with individuals and organisations (including voluntary or private health services, public authorities and local authorities) concerned with the promotion, protection, and restoration of health;
- (c) ensure residents outside the region have access to such of the health services it provides as may be necessary and desirable;
- (d) make available to the public, reports, information and advice concerning health and health services available within the region;
- (e) provide for the training and education of persons providing health services;
- (f) perform any other functions prescribed for the Authority by this Act or any other Act
- (g) perform such other functions as may be necessary or incidental to the foregoing functions.

One such Board (the now defunct Central Region Authority in Queensland Australia), which was typical of such organisations, had responsibility for a region which covered 100,162 square kilometres and had a population of 172,011 with 4,538 Aboriginal and Torres Strait Islander people(1991 estimates). The combined institutions and services for which the Central Authority had responsibility included:

- 12 hospitals (total 594 beds and 1,304 staff)
- 3 nursing homes (329 beds)
- 12 out patient departments (single nurse facilities)

- 1 unit serving those with intellectual handicaps
- 4 child health services
- 6 community medicine services
- 2 Aboriginal health services
- 1 alcohol and drug service and
- 1 environment and occupational health service.

The Authority was also in the process of expanding community and school dental health services and psychiatric/mental health services.

While this board served a large geographic area with a small population, large metropolitan agencies (hospitals, regional health units, specialised clinics, etc.) face similar issues as they attempt to provide a range of health services from community health and primary health care to complex specialist services to meet the need of large populations who may have a great range of ethnic diversity, always with significant budget restrictions.

The background of the appointed members of the Central Region Authority in 1990 illustrate the diversity of skills and experience in a typical board:

- an accountant in private practice
- a businessman who was an elected leader in an Aboriginal community
- a community development worker who had been active politically
- a church-based social worker with extensive experience in the area
- an administrator of a private sector health facility
- a rural businessman
- a nurse with an education administration background.

Three were female, five were male and they lived in four different communities in the Region with more than 200 km separating members. Their ability to understand the available information, and their ability to know what information they required to make an effective decision, varied just as greatly.

It could, and probably should, be argued that board members and senior staff often have very similar information needs. Indeed, an ex-Chief of Surgery acting as the Chief Executive Officer of a hospital would be in a very similar position to the average board member. In most healthcare institutions today, however, the professional management staff has been trained in financial, resource and information management.

Board Members Differ from Professional Staff

While collectively the Central Queensland Authority members had considerable skills and experience, they lacked the day-to-day experience with the agencies and had little access to the information sources which informed and

empowered the Authority's professional (paid) staff in exercising their responsibilities.

In our experience board members differ from the health professionals and administrators in a number of significant ways (Table 1) which affect their information needs.

Board members are also more likely involved in policy and general procedures rather than in implementation issues. In order to understand both the current situation and the implications of change they often need qualitative rather than quantitative data. A wise manager gets a 'feel' for the effect of a change through daily interaction with operational staff. A board member who cannot get a similar feeling for the operation of the institution may base decisions upon gossip or dogma.

There is almost inevitably a tension (one hopes that it is a creative tension) between senior management and members of boards in both public and private sectors. We are aware that the professional staff may perceive the board to be lacking in understanding and appreciation of their efforts, while board members sometimes feel that they are being kept in the dark and do not know what questions they should be asking. Unfortunately, however, 'knowledge is power' and controlling the flow of information to members of boards is one way for the professional staff to maintain control.

Information Needs and Technology

Discussion at board meetings often focuses on financial matters since financial reports are readily available and understood by board members, particularly those with a business background. Issues related to program planning and evaluation are often overlooked or avoided since information is not available in readily understood form. Requesting such information may be seen as interfering at a management or program level, rather than a need for information to understand the context of a proposed decision.

Table 1 - Differences between board members and professionals/managers

| | |
|-------------------------------------|---|
| statistics available in reports | statistics in reports + background knowledge to interpret |
| need financial information | may need financial information |
| questions of confidentiality | processes for confidentiality usually well established |
| need evaluative information | may need evaluative/Quality Assurance information |
| need to know what they need to know | know what they need to know |

Board members are sometimes the recipients of complaints about services (or the lack thereof). Wise board members will usually refer the matter to the senior staff of the agency for an initial report, but if the board is doing its job conscientiously, there needs to be some provision for independent inquiry and thorough understanding of the situation.

Current health information technology will permit:

- the presentation of statistical information in chart or graph format with minimal effort
- the inclusion of floor plans, pictures and diagrams in individual documents so that they may be easily studied by individuals prior to meetings
- the incorporation of data specific to one site with overall regional or state data to permit comparisons
- incorporation of census or other data to permit easy understanding of such things as immunisation rates
- participation by board members through Internet communications, cutting down on the need for lengthy, expensive and tiring travel to get to meetings
- development of alternate scenarios for different development and financial possibilities.

One of the main responsibilities of a board member is to help establish organisational policy, thus the ability to look at 'what if' scenarios based on accurately calculated possibilities should be of key importance. As recent reports in the public media in Australia indicate, however, even professional managers do not often use the 'what if' capabilities of their spreadsheets and information systems. Obviously then, it is not only board members who do not know what the current possibilities are for health informatics, nor what information would be of most value to them in their role. The institutional information system should be able to provide both historical and current data and a mechanism for examining the 'what if' questions.

The use of electronic transmission of information has become standard within many health care settings. However, board members are routinely left out of this

| Board Members | Professionals/ Managers |
|--|---------------------------------------|
| very part-time, often unpaid volunteer | full-time, paid professionals |
| little special health knowledge | specialist preparation |
| limited term of service | career positions |
| may represent special interests | different professional specialties |
| roots in the community | may be 'outsiders' |
| own knowledge is incident-based | knowledge based on cases & cumulative |

channel of communication. The provision of reports and background information to those in remote locations, perhaps unfamiliar with electronic communications and/or computer databases, is one of the issues which should be explored by information managers and newly appointed board members.

National Hospital Associations and other bodies often provide orientation or training sessions which are suitable for board members as part of their national conferences and other activities. Regrettably our experience is that few board members are members of such organisations and even fewer can take the time from their work to attend the sessions.

We would strongly suggest that an analysis of the board's information needs be done on an annual basis along with a briefing on changes to the information system capabilities. In addition, an orientation for new board members should include an orientation to the agency's information system and an indication of how they can obtain appropriate information (and training in how to access and utilise the information if required). For many boards the orientation and training may be more appropriately conducted through distance or other flexible delivery technologies. Board member access to the system must be available from their normal place of work, not just within the institution itself, and confidentiality and security issues must be resolved.

The Information System Challenge

To some extent information deficiencies have been exacerbated by management information systems (financial systems, hospital management systems, health information systems) which 'drown' board members in large amounts of financial and other data when they do not have the background to pick out the important trends and issues. It is in this aspect of information management that the preparation of summary information, charts and graphs can be most helpful.

On the other hand, developments in health informatics should mean that detailed information, and more importantly the expert analysis, which has been prepared for senior health administrators can be easily re-formatted into a 'broader picture' suitable for discussion at board meetings. This should not preclude individual board members being able to obtain additional, more detailed, information on specific topics as required by their individual responsibilities.

Since board members are, by definition, outsiders to the healthcare institution, it is sometimes argued that security, confidentiality and privacy issues restrict what they may be allowed to see. In our experience, however, board members do not usually need detailed information on individual cases where these issues would be a concern. What they need is aggregated data and the same detailed analysis required by senior management, and appropriate access restrictions (password access to appropriate levels of data and functions) can control access to the corporate databases or information systems.

Similarly, in the private sector (or increasingly in the public sector) some aspects of the agency's 'business' will need to be treated as 'commercial in confidence'. It is important that the individual board members receive an orientation to the ethical handling of information and that appropriate security be relatively transparently built into the information system(s) they may access.

The challenge is to develop an information system which will:

- be compatible with information systems developed for professional staff
- be compatible with information required for state and national statistical and audit requirements, and
- meet security, confidentiality and privacy needs,

while addressing the needs of board members.

As one way of accomplishing this we suggest that Health Informaticians should examine the corporate sector and the needs of similarly placed board members for public and private corporations. While not all commercial organisations have resolved the challenge of providing appropriate access to information for their boards, many have utilised their Executive Information, Decision Support, and Collaborative Workplace Systems to assist board members to carry out their functions.

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